DISTRIBUTION:

Committee Members

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

Management

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

Contact Details:
Telephone 07 834 3600
www.waikatodhb.health.nz

Next Meeting Date: 11 October 2017

Waikato District Health Board

WAIKATO DISTRICT HEALTH BOARD

Agenda

Health Strategy Committee

Date: **9 August 2017**

Time: **12:30pm**

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

Meeting of the Health Strategy Committee
to be held on Wednesday 9 August 2017, at 12:30pm
Board Room, First Floor, Hockin Building

AGENDA

1 APOLOGIES

2 LATE ITEMS

3 INTERESTS
- 3.1 Schedule of interests
- 3.2 Conflicts related to items on the agenda

4 MINUTES AND MATTERS ARISING
- 4.1 Waikato DHB Health Strategy Committee; 14 June 2017
- 4.2 Lakes DHB Community & Public Health Advisory Committee; 19 June 2017 (DSAC meeting was cancelled)
- 4.3 Bay of Plenty DHB combined Community & Public Health Advisory Committee and Disability Support Advisory Committee; 1 March 2017

5 WORKPLAN

6 STRATEGY AND FUNDING OVERVIEW REPORT

7 PAPERS FOR ACTION
- 7.1 Child Health Metrics
- 7.2 Alliances

8 PAPERS FOR INFORMATION
- 8.1 Pacific Island Profile

9 STRATEGIC PROGRAMMES UPDATE
- 9.1 eSPACE (October)
- 9.2 Mental Health and Addictions Model of Care (August)
- 9.3 SmartHealth (August)
- 9.4 Rural Project (August)
- 9.5 Women's Health Transformation (August)
- 9.6 Elective Services Improvement (August)
- 9.7 Patient Flow (October)
- 9.8 Quality Account (October)
- 9.9 Medical School (August)
- 9.10 CBD Accommodation Projects (October)
- 9.11 Primary Care Integration (October)

10 PRIORITY PROGRAMME PLANS

- 10.1 Priority Programme Plan Project Update
- 10.2 Priority Programme Plan 1.4: Enable A Workforce To Deliver Culturally Appropriate Services

11 GENERAL BUSINESS

12 DATE OF NEXT MEETING

11 October 2017

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

THAT:

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

Item 13: Minutes of the Health Strategy Committee: 14 June 2017

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

GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER
Item 13: Minutes public excluded	**Minutes taken with the public excluded.**

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

Item 13 As shown to exclude the public in minutes.

Item

13 MINUTES PUBLIC EXCLUDED
Health Strategy Committee held 14 June 2017

RE-ADMITTANCE OF THE PUBLIC

THAT:

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

Apologies

Late Items

Interests

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

Clyde Wade

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Chair, Health Strategy 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	

Tania Hodges

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

Note 1: Interests listed in every agenda.

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

Bob Simcock

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

Sally Webb

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

Crystal Beavis

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

Note 1: Interests listed in every agenda.

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

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

Pippa Mahood

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

Sharon Mariu

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

Note 1: Interests listed in every agenda.

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

John McIntosh

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

David Slone

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

Fungai Mhlanga

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

Te Pora Thompson-Evans

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

Note 1: Interests listed in every agenda.

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

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

Rob Vigor-Brown

Interest	**Nature of Interest** *(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, Health Strategy Committee, Waikato DHB **Board member, Bay of Plenty DHB** **Armey Co Ltd – pharmacy locum services** **Armey Family Trust – property investments** **Member, Pharmaceutical Society of NZ** **Employee, Bethlehem Pharmacy** **Wife is an employee of Toi Te Ora (public health**	Non-Pecuniary	None	Refer Notes 1 and 2

Note 1: Interests listed in every agenda.

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

Conflicts related to items on the agenda

Waikato District Health Board

Minutes
and
Matter Arising

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 4

COMMITTEE MINUTES

Attached are the following minutes from the Committee meetings:-

- Waikato DHB, Health Strategy Committee; 14 June 2017
- Lakes DHB, Community & Public Health Advisory Committee; 19 June 2017 (DSAC cancelled)
- Bay of Plenty combined Community & Public Health Advisory & Disability Support Advisory Committee; 1 March 2017.

Recommendation
THAT
The minutes be noted.

CLYDE WADE
CHAIR, HEALTH STRATEGY COMMITTEE

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Health Strategy Committee held on 14 June 2017 commencing at 12.46pm

Present:
Mr C Wade (Chair)
Ms T Hodges (Deputy Chair)
Ms S Webb
Ms S Mariu
Mrs P Mahood
Mr J McIntosh
Mr C Beavis
Ms TP Thompson-Evans
Mr M Arundel

In Attendance:
Ms S Christie, Waikato DHB Board member
Mrs MA Gill, Waikato DHB Board member
Ms J Wilson, Executive Director, Strategy & Funding
Mr N Hablous, Chief of Staff
Mr M ter Beek, Executive Director, Operations and Performance
Ms T Maloney, Commissioner, Women's Health Transformation Taskforce
Mr D Hackett, Executive Director, Virtual Care and Innovation
Mr D Tomic, Clinical Director, Primary and Integrated Care
Mr B Paradine, Executive Director, Waikato Hospital Services
Ms M Chrystall, Executive Director, Corporate Services
Mr A McCurdie, Chief Financial Officer
Mr D Wright, Executive Director, Mental Health and Addictions Service
Ms E McKenzie Norton, Strategy and Funding
Ms N Parker, Change Team
Mr W Skipage, Strategy and Funding

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

The Chair welcomed new committee members Ms T Thompson-Evans (an Iwi Maori Council member) and Mr M Arundel (a board member from Bay of Plenty DHB) to the meeting.

ITEM 1: APOLOGIES

Apologies from Mr B Simcock, Mr D Slone, Mr F Mhlanga and Mr R Vigor Brown were received.

Resolved
THAT
The apologies were received.

ITEM 2: LATE ITEMS

There were no late items raised at the meeting.

ITEM 3: INTERESTS

3.1 Register of Interests
There were no changes made to the Interests register.

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

ITEM 4: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Resolved
THAT

1) The minutes of a meeting of the Waikato DHB Health Strategy Committee held on 12 April 2017 be confirmed as a true and correct record.
2) The minutes of a meeting of the Lakes DHB Community & Public Health Advisory Committee held on 18 April 2017 be noted.

ITEM 5: WORKPLAN

The work plan was reviewed by the Committee who confirmed they would like to receive a strategic view of the Pharmacy, Translation Services and Tobacco plans. The proposed "understanding our population" has been covered by the LTIP so that session can be replaced by understanding how the population profile data impacts on the development of service specific plans.

Ms Beavis referenced a document due to be released for consultation shortly that would be relevant in terms of future population growth. The document is the draft Future Proof Strategy and has been published by the Hamilton City Council, Waikato District Council, Waipa District Council, Waikato Regional Council, NZTA and tangata whenua.

With regard to prevention programme assessments the Committee requested a paper on how effective current prevention programmes are, what can be done to make them more effective and were there other prevention programmes that the DHB should doing.

Management noted the programme to improve access to primary care for the intellectual disability community had not progressed.

Resolved
THAT
The Committee received the report.

ITEM 6: STRATEGY AND FUNDING OVERVIEW REPORT

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

Key areas included:

Staff
The appointment of Mr W Skipage as Senior Planning Manager at Waikato DHB.

Annual Plan and Budget Submission
The deadline for submitting the 2017/18 budget had been extended to 30 June 2017.

There were issues with the initial funding envelope released by the Ministry of Health and Waikato DHB is waiting the finalised envelope. This has made the budget process challenging.

Community Health Forum
A new community health forum has been included in Raglan. This forum will be trialled for 12 months to ascertain good engagement with this community.

Management will ensure the timetable and agenda for each forum is circulated to board and committee members. A section will be included in the agenda seeking community views and feedback.

Mental Health and Addictions Programme
This is a large work programme which will run alongside the Mental Health and Addictions service Creating Our Futures programme.

Membership includes DHB services, NGOs and primary care.

Strategic Service Plans
Work has commenced on the structure for developing strategic service plans. These plans will have a system wide focus, will be essential for the long term investment plan and integrate with the DHB's strategy.

The strategic service plans will be built from robust population needs analysis.

Pay Equity Settlement
This is a national settlement which will be rolled out at the beginning of July. It is a very large investment with a nationally determined approach that DHBs will implement. There will be flow on impacts that will cause challenges across the health sector.

System Level Measures Plan
The Systems Level Measures plan focuses on key local health priorities with engagement on the development of the plan for 2017/18 occurring across primary, secondary and other service groups. Working groups have also been established with cross sector representation. The plan will be finalised over the next week and submitted to the June board meeting.

The Committee stressed the importance of ensuring the contributory measures and related activities have a significant impact on the high needs and vulnerable populations.

It was noted that the work to be undertaken does not have a specific budget however the primary care quality fund would support some of this work.

Resolved
THAT
The Committee received the report.

ITEM 7: PAPERS FOR ACTION

No papers for action.

ITEM 8: PAPERS FOR INFORMATION

No papers for information.

ITEM 9: STRATEGIC PROGRAMME PLANS

9.1 eSPACE

Ms S Baker and Mr M Hamid from the eSPACE Programme team gave a demonstration of the Midland Clinical Portal Foundation test system.

Of note:

- The eSPACE programme business case has been approved by the five Midland DHBs for $74m.
- Within the eSPACE programme there are a number of projects to be delivered over the next five years.
- The first project is the Midland Clinical Portal Foundation project which will go live in July 2017.
- Planning is also underway for future releases.

Resolved
THAT
The Committee received the presentation.

9.2 Mental Health and Addictions Model of Care

No paper this month.

9.3 SmartHealth

No paper this month.

9.4 Rural Project

No paper this month.

9.5 Women's Health Transformation

Ms T Maloney attended for this agenda item.

Of note:

- Recent focus has been on the appointment of substantive leadership roles for Women's Health service and midwifery workforce including trialling a shift pattern for midwives.
- A proposal for change to the management and leadership structure (excluding medical leadership) is out for consultation. The closing date is 16 June.
- Training of midwives in a hospital setting is an area that needs to be focused on.
- An overview of progress of all the transformation workstreams will be presented to the Committee.

Resolved
THAT
The Committee received the report.

9.6 Elective Services Improvement

Mr B Paradine attended for this agenda item.

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

Of note:

- Results for ESPI 2 (outpatients waiting more than four months for assessment) show the DHB will be compliant for May.
- Results for ESPI 5 (inpatients waiting more than four months for treatment) show the DHB will be at amber status for June and July.

Resolved
THAT
The Committee received the report.

9.7 Patient Flow

Mr M ter Beek attended for this item.

A report on the DHB's patient flow programme to improve performance was submitted for the Committee's information.

Management noted that the Governance Group of the patient flow programme will refocus effort to where the greatest impact is expected as well as integrating with other improvement work that is underway.

Resolved
THAT
The Committee received the report and noted the next steps for the patient flow programme.

9.8 Quality Account

Ms M Neville attended for this item.

A paper on the preparation of the Quality Account was submitted for the Committee's consideration.

All DHBs have a Quality Account and the Committee will be involved in setting the priorities that will sit alongside Waikato DHB's strategic imperatives. Progression with most programme plans in the Quality Account has been slower than expected but are now beginning to get traction.

An update report will be provided to the Committee every six months.

Resolved
THAT
The Committee received the report.

9.9 Medical School

A progress report on the proposed third Medical School, being led by Waikato DHB and the University of Waikato, was submitted for the Committee's information. The business case was completed and submitted on 31 May 2017. A formal presentation on this matter would be given at the next Committee meeting.

Committee members agreed that information is required on the costs and benefits of the medical school and that this should be submitted to the next Board meeting under public excluded.

Resolved
THAT
The Committee received the report.

9.10 CBD Accommodation Project

No paper this month.

9.11 Primary Care Integration

A presentation was given by Dr D Tomic on the portfolio and activities occurring across Primary and Integrated Care.

Resolved
THAT
The Committee received the presentation.

ITEM 10: PRIORITY PROGRAMME PLANS

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

Mr D Hackett, Executive Director Executive Director of Virtual Care and Innovation and Ms M Berryman, Kaitakawaenga, attended for this item.

The second priority programme plan to operationalise the Waikato DHB's strategy was submitted for the Committee's consideration and approval to progress to implementation phase.

This priority programme plan is concerned with enabling a workforce to deliver culturally appropriate services within Waikato DHB. Management advised that this paper was lengthy due to the attachments (including literature and research) and the templated

process followed to produce a priority programme plan. The attachments could be dispensed for the purposes of providing them to the Committee.

Key points raised by the Committee included:

- Workforce development is more than learning how to pronounce names correctly.
- Cultural competency comes from having a programme or service well equipped to identify where a culture change needs to be made for Maori and all ethnicities.
- With the DHB limited in terms of time and resources a clearer picture is needed of the activities that will make an impact, improve performance and that achievable.
- There are gaps in the activities and objectives gathered for this plan and this needs to be relooked at. For example, a focus on anti racism.
- It is not apparent from the activities listed which will contribute to the organisation's top priority to make radical improvements in Maori Health.
- The plan lacks a sense of urgency.
- The organisation needs to show more courage and strong leadership in terms of the activities that will drive change and improvements.
- The number of priority programme plans for implementation is of concern, especially given the timeframes attached to these.
- The staff orientation programme should include a cultural training session for all new staff members, and this should be implemented immediately.
- The importance of delivering appropriate services and care to other cultures such as disability (approximately 15% of Waikato's population).
- Reviewing the work undertaken by the Waikato University for the Education sector around culturally appropriate teaching methods and relationships to ascertain whether a strand/s of this work could be applied to health education.

Resolved
THAT

1) The report be received.
2) Management to submit a simplified list of targeted activities and actions that will make a direct impact on improving the delivery of culturally appropriate services and associated timelines for the Committee's consideration at their August meeting.
3) Future submissions to the Committee to include the priority programme plan document and specific bibliography only.

Ms S Webb left the meeting at 3.30pm.

10.2 Priority Programme Plan Project Update

Ms E McKenzie-Norton and Ms N Parker attended for this agenda item to provide a recap and update on the priority programme plan project.

Resolved
THAT
The update be received.

ITEM 11: GENERAL BUSINESS

There were no general business items raised.

ITEM 12: DATE OF NEXT MEETING

9 August 2017

LAKES DISTRICT HEALTH BOARD

MINUTES OF A MEETING OF THE COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE HELD MONDAY 19th JUNE 2017 BOARDROOM, ROTORUA HOSPITAL, PUKEROA HILL, ROTORUA

Meeting: **[140]**

Present: L Thurston (Chair), W Webber (Deputy Chair), M Raukawa-Tait, D Epp, J Morreau and A Pedersen

In Attendance: J Miller, J Hanvey, M Davies, B Bayne, K Rex, M Smith, P Tangitu (from approximately 2pm), B Smith, Presenter - Stephen Twitchin, Public Health Analyst, Toi Te Ora and B E Harris (Board Secretariat)

1.0		**MEETING CONDUCT**
		The Chair welcomed everyone to the meeting.
1.1		Apologies: D Shaw, P Marks and R Dunham
		Resolution:
		THAT the apologies be received.
		L Thurston : M Raukawa-Tait
		CARRIED
1.2		Schedule of Interests Register
		The register was circulated during the meeting with no entries made.
1.3		Conflict of Interest related to items on the agenda : Nil
1.4		Items for General Business
	1.4.1	Public Health presentation on water quality - Turangi
1.5		Presentation on A Community Survey of Public Health Issues by Toi Te Ora Public Health Analyst - Stephen Twitchen The presentation by S Twitchin covered:- ➢ Toi Te Ora - Public Health Service ➢ Public Health functions ➢ Survey purpose ➢ Methodology ➢ Overview of survey topics ➢ Some results ➢ Rheumatic fever ➢ Childhood obesity ➢ Schools and health ➢ Tobacco smoking ➢ Some DHB differences ➢ Examples

		➢ Perceived importance of public health activities ➢ Conclusion The Chair thanked S Twitchen for his brilliant presentation. Reducing risk factors had great potential to improve population health and in reducing major conditions and diseases, the burden on primary and secondary health care would be reduced. The survey provided useful information for planning and for advocacy of policies that promote health. The Population Survey 2016 : Issues of Health and Wellbeing was tabled at the meeting.
2.0		**SIGNIFICANT ISSUES**
2.1.		**Public Health**
2.1.1		**Toi Te Ora Public Health Service**
	2.1.1.1	Toi Te Ora Public Health Service report :June 2017
		J Hanvey highlighted the points as below:- ➢ Warehouse Breastfeeding campaign in support of breastfeeding mothers ➢ Offer to Kmart to be supported to achieve breastfeeding accreditation ➢ Current HPV immunisation campaign free for boys and girls, young women and men ➢ Campaign will be evaluated and the findings will contribute to a paper being submitted for presentation at the Public Health Association conference later this year ➢ Appreciation to PHOs and DHB for support ➢ Pleased to see TTO service came together to respond to devastation, in particular the flooding in Edgecumbe
		Resolution:
		THAT the report be received.
		L Thurston : D Epp
		CARRIED
	2.1.1.2	Toi Te Ora Medical Officer of Health report : June 2017
		Dr Miller spoke on the sustainable use of the environment and what we eat, how it is produced and how it gets to our table has a profound effect on the environment. Much of what is bad for us to eat is also bad for the environment.
		Resolution:
		THAT Dr N de Wet be invited to the CPHAC meeting of 14th August to speak to his paper on the environment.
		L Thurston : W Webber
		CARRIED
2.2		**Primary Health**
2.2.1		Minimum requirements for PHOs
		When PHOs were first set up the main focus was to be on achieving results in terms of better health, reduced health inequalities and easier access to services. The process of establishing a PHO was expected to reflect the principles of the Treaty of Waitangi – partnership, participation and protection. M Smith advised that K Rex was looking after this contract with explicit health service requirements.
		Resolution:
		THAT the information be received.
		L Thurston : A Pedersen
		CARRIED

2.2.2		Pinnacle MHN report
		The report covered the following topics:- ➢ **New Born Enrolment (NBE)** – December 2016 the result was 68%, workshops in the first quarter have seen an improvement in our figures and PMHN anticipate meeting the target. This will to help with improvement in our immunisation result and care for children in the first 1,000 days. ➢ **Patient Experience** – A "Push My Button" kiosk has been installed whereby patients are encouraged to rate their experience at the practice. Patient experience is a - MoH System Level Measure. The MHN "push my button" is a piloted method of capturing patient satisfaction in two of the four Lakes practices. Patient portals are available to access one's own health records. ➢ **B4SC** –Lakes DHB's Child Health team and general practices are among the leading regions in New Zealand in the delivery of the B4SC with regards to our reach to high needs. ➢ **Challenges** – 1) engaging with young pregnant mums prior to delivery. 2) Achieving health targets with the wider Turangi population. 3) Availability of (and need for) Primary Mental Health Services.
		Resolution:
		THAT the report be received.
		B Bayne : D Epp
		CARRIED
2.2.3		Rotorua Area Primary Health Services (RAPHS) report
		Matt Watson verbally highlighted the enhanced vision programme and details of high level activities undertaken. He passed around three papers and provided verbal updates on LINC, Health target achievements and focus on equity gap. M Raukawa-Tait asked about the introduction of Te Arawa Whanau Ora into the cervical screening programme and how will this increase uptake? M Watson responded that competition increases uptake as quality report highlights practice performance against each other. RAPHS will be working with Whanau Ora. Cervical Screening support funding will be distributed to practice using a scoring system DALY. M Smith asked how did RAPHS cater for high needs practices with its programme to which M Watson responded that ECST support is available to the population. D Epp spoke on the importance of IT and portals and asked about the very high needs people who do not have access to IT and no stable address. M Watson answered that the services delivered should be patient-centred. The challenge is to take the health care to the people. The reach to patients had been broadened via Facebook and making sure the population knows what is out there.
		Resolution:
		THAT the RAPHS verbal report be received.
		M Watson : M Raukawa-Tait
		CARRIED
2.3		**Maori Health**
2.3.1		DHB Mental Health and Addiction Employees : Some planning and development challenges
		The committee noted the information provided on the above subject.

2.3.2		Kia Ora Hauora Q3 report 1 January to 31 March 2017
		P Tangitu informed the meeting that the Midland Kia Ora Hauora team had been working with Midland Healthshare on the information that is available on Midland people who are in a health career pipeline. This will include those who are studying at a tertiary level, and those in employment who may be seeking further education in a health career. The Midland DHBs will be able to have this information and know who the people are, where they are in the pipeline and when they are due to come out of training. In response to a query from J Morreau, P Tangitu informed the hui that the Ministry of Health funds Kia Ora Hauora, and that there is a website that provides information on all the funding opportunities, grants and scholarships for people pursuing a health career. M Raukawa-Tait asked if older people (aside from high school students) are provided with the same opportunity? P Tangitu advised that yes, there is a community part to the programme that supports people understanding what is required to study towards a health career. P Tangitu informed the committee that the target groups have been students studying year 9 to consider the uptake of science-related subjects, Year 12/13 students who are considering university, those in university and those in community.
		Resolution:
		THAT the excellent report be received.
		M Raukawa-Tait : D Epp
		CARRIED
2.3.3		Midland framework: An equity approach for Midlands Health Network and general practices
		Resolution:
		THAT the information be received.
		B Bayne : M Raukawa-Tait
		CARRIED
2.3.4		Regional Services Plan Summary 2016-2017
		THAT the Regional Services Plan Summary for 2016/17 be received.
		LThurston : A Pedersen
		CARRIED
3.0		**SECRETARIAL**
3.1		Minutes of Community and Public Health Advisory Committee meeting : 18th April 2017
		Resolution:
		THAT the minutes of the Community and Public Health Advisory Committee meeting of 18th April 2017 be confirmed as a true and accurate record.
		L Thurston : J Morreau
		CARRIED
3.2		Matters arising
	3.2.1	Update on Sir Timu Te Heuheu direction – regarding relationship with DHB. P Tangitu to lead discussion.
	3.2.2	Report pending 14th August 2017.
	3.2.3	P Tangitu to talk to A Pedersen re Mangakino.
3.3		Schedule of Tasks
		➢ J Morreau to invite Steve Goodin to present to CPHAC on Drinking water – ensure it is safe - Lakes ➢ Dr N de Wit to be invited to present his paper “Health for All” at the next meeting.

		➢ IT access sorting the myth from the fact – Te Puni Kokiri survey. M Raukawa-Tait to obtain information from Te Puni Kokiri. ➢ M Smith – IT – Facebook : fundamental/lactation consultant. ➢ P Tangitu – SUDI app development – information to be provided by P Tangitu for the next CPHAC agenda. ➢ B Bayne – Mixed media : Source one or two speakers for next meeting.
4.0		**REPORTS**
4.1		Breast Lung and Colorectal Cancer Research Review : Issue One 2017
		Resolution:
		THAT the review be received.
		J Morreau : D Epp
		CARRIED
4.2		Community representative reports : Nil
5.0		**INFORMATION AND CORRESPONDENCE : Nil**
6.0		**PUBLIC EXCLUDED**
		Resolution:
		THAT the committee move into Public Excluded.
		M Davies : W Webber
		CARRIED

L Thurston QSO JP……14th August 2017
Chair

LAKES DISTRICT HEALTH BOARD

SCHEDULE OF TASKS FROM THE COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE 19th JUNE 2017

Agenda Item	Action	Responsibility of	Timeframe
PRESENTATIONS			
Breast Feeding	Presentation on Breast Feeding	Leonie Pritchard	14th August 2017
Pinnacle MHN	Source one or two mixed media speakers for next meeting.	B Bayne	14th August 2017
Toi Te ora	Presentation on Health for All	Dr Neil de Wit	14th August 2017
Drinking water	"Drinking water to ensure it is safe"	J Morreau/Steve Goodin	16th October 2017
Healthy Home/Rheumatic Fever Programme	Presentation by RAPHS	Mary McLean	16th October 2017
Community Initiatives	Presentation by Lakes DHB	Pip King	16th October 2017
ITEMS			
MHN	Update on Midlands Rentinal Screening Peer Review to be provided to next meeting	B Bayne	t.b.a.
Te Puni Kokiri Survey	IT access sorting the myth from the fact – information to be obtained for a future agenda item	M Raukawa-Tait	As soon as convenient
SUDI development	Information to be provided to next meeting	P Tangitu	14th August 2017

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Minutes

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

Venue: Tawa Room Education Centre
Date: Wednesday 1 March 2017 at 10:30am

Committee: Bev Edlin (Chair), Marion Guy, Anna Rolleston, Ron Scott, Judy Turner, Sally Webb (Board Chair), Punohu McCausland, Margaret Williams, Stuart Ngatai, Mark Arundel

Attendees: Helen Mason (Chief Executive), Simon Everitt (GM Planning and Funding), Gail Bingham (GM Governance & Quality), Janet Hanvey, (Business Contracts Manager, Toi Te Ora Health Service), Hugh Lees (Medical Director), Andrea Baker (Portfolio Manager Planning and Funding)

Item No.	Item	Action
1	**Apologies** No apologies were received	
2	**Interests Register** The Committee were asked if there were any conflicts in relation to items on the agenda. No conflicts were declared in relation to items on the agenda.	
3	**Minutes** **Resolved** that the minutes of the meeting held 5 October 2016 be confirmed as a true and correct record. Moved: Sally Webb Seconded: Bev Edlin	
4	**Matters Arising** – As circulated with the agenda Minutes of regional meeting received.	

Item No.	Item	Action
5	**Reports requiring Decision -**Nil	
6	**Reports for Noting** 6.1 Work Plan The Committee noted the information. Updated work plan will be circulated. This will more closely align with the Health Services Plan. 6.2 Primary Care – System Level Measures Framework Plan and Implementation The Committee noted the information There has been good buy in from clinicians in relation to the development of the plan. Need adequate IT platform to enable achievement of the plan. The Committee discussed the incentive payments for meeting the plan, particularly in relation to the risk that the focus flows with the funding. The proportion of incentive funding is relatively low in comparison to GP income. 6.3 Midland Regional Services Plan 16-19Q2 Progress Report The Committee noted the information 6.4 Planning and Funding Monthly Report The Committee noted the information 6.5 Toi Te Ora – Public Health Service Update The Committee noted the information The Committee queried whether any work is being done with local dairies about the selling of surgery drinks to kids before school? It was noted that these programs in other areas have been initiated by the schools, rather than Public Health services. Current work with dairies is focused on reducing/eliminating tobacco sales. 6.6 Disability Focus Progress Report The Committee noted the information 6.7 Health in All Policies Update The Committee noted the information	GMPF: In future provide comment on amber and red areas that affect BOP.

Item No.	Item	Action
	The Committee discussed the risk of making broad brush statements about not working with any provider that accepts money from gambling. 6.8 <u>Review of Aged Residential Care (ARC) Clinical Nurse Specialist (CNS) Position 2016</u> The Committee noted the information. Program is available across the Bay. Looking at advancing pharmacy role in Aged Care. There was a discussion on the challenges of access to GP care for patients in Age Residential Care.	
7	**Presentations –** 7.1 <u>Palliative Care</u> 7.1.1 Hospice Eastern Bay of Plenty The Committee thanked Peter Bassett for the informative presentation. Peter made a request for DHB bed funding and funding for a palliative care specialist, similar to that received by Waipuna Hospice. Their program is based on service delivery in the home. It was noted that there is a need for critical mass to support in-patient units. 7.1.2 Waipuna Hospice The Committee thanked Richard Thurlow for the informative presentation. Services include: in-patient beds, day programmes, education and counselling, hospital liaison nurses. The aim is to provide care close to home. Currently sitting at 60% DHB funding, as % of total revenue. . Made request for addition funding for specialists. Currently palliative care beds are limited to cancer and renal, palliative care covers other specialities. Medical Director spoke to the provision of palliative care in the Provider Arm. The benefits of palliative care being can be commenced when the patient is still in the curative stage were noted. This approach is difficult because community sees palliative care as the end of	

Item No.	Item	Action
	hope. GMPF acknowledged the funding pressure and agreed there needed to be a combined approach to the resolution.	
8	**General Business** The Committee discussed health's involvement in the Te Tumu development. Community membership of the Committee will be discussed at the Board meeting.	
9	**Next Meeting** – Wednesday	

The open session of the meeting closed at 12:55 pm

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

Workplan

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 5.0

WORKPLAN 2017

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

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

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

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

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

Recommendation
THAT
The workplan be received.

CLYDE WADE
CHAIR, HEALTH STRATEGY COMMITTEE

HEALTH STRATEGY COMMITTEE
FUTURE WORK PLAN 2017

	Report	When
1.	Pharmacy Plan Tobacco Plan Translation Services Understanding our population profile	October 2017
2.	Prevention programme assessment Health of Older people Strategy	December 2017

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

- Managing demand

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

- Government Disability Strategy
- Younger people in resthomes *Note A
- Support for immigrants and refugees with disabilities * Note A
- Improving access to primary care for the intellectual disability community.

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

Strategy and Funding Overview Report

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 6.0

STRATEGY AND FUNDING REPORT

Purpose	1) For information

WAIKATO ANNUAL PLAN 2017/18
As previously noted the 2017/18 Annual Plan was required to be a significantly shortened document. The new format required is for a document of 30-33 pages which includes Maori health indicators as a separate Maori Health plan is no longer required by the Ministry of Health.

The narrative section of the Waikato DHB Annual Plan 2017/18 was submitted to the Ministry of Health on 14 July 2017. Financial information is yet to be submitted.

COMMUNITY HEALTH FORUM
The July/August round of Community Health Fora is underway with 6 of the 8 forum completed. A summary of the issues raised is being prepared and will be submitted to the October Health Strategy meeting.

Included for the first time was a forum in Raglan which was well received. Approximately 23 people attended this forum which was positive given it was the initial meeting and a local GP has agreed to take the role of Chair for the first year. Overall attendance numbers at the community health forum were slightly higher than previous fora with a wide range of community member attending, including local councillors and Mayors.

Some of the issues raised in multiple fora include:

1. Access to **affordable rental** properties – stories of overcrowding / sleeping in garages / cars
2. The **quality of the housing stock** – still significant issues with cold, damp and badly maintained houses
3. **Timely access to GP** appointments “in hours” – people being advised to go to Emergency department / or Hamilton Accident and Emergency services (unaffordable for many). Noted that there were a shortage of doctors in some rural areas
4. **Community services for those with long term Mental Health needs** – and those with social isolation – needs some traction on inter-sectoral activity
5. **Support for SmartHealth** but the community feel it needs to be **“marketed”** widely as only known to a few
6. **Surprise** at the level of community pharmaceutical waste.

SYSTEM LEVEL MEASURES (SLM) PLAN

The first fours measures within the system level measures plan has been supported by the members of the Inter-Alliance and is currently with the Ministry of Health for review and feedback. Initial feedback on this section of the plan from the Ministry of Health has been very positive.

For the two new developmental measures

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

Significant work has occurred within the working group with final plans to be tabled at the September Board meeting for October submission. These working groups have pulled together a broad range of people and have been an exciting opportunities to look at system wide impact in these areas.

SUICIDE PREVENTION AND POSTVENTION PLAN REFRESH

As reported last meeting Waikato DHB is updating its Suicide Prevention and Postvention Plan to take us through the next three year period 2018-2021. The development of the draft Plan is underway, however engagement has taken longer than anticipated so the draft plan is now expected for the October meeting. Valuable information is being collected from a wide variety of sources and it is believed that taking the time to assimilate this will greatly enrich the final plan and especially ensure both a Māori and youth voice is incorporated.

ALLIANCES

Consideration has been given to the optimum Alliance arrangements for Waikato DHB to improve the health of the Waikato population. A separate paper is included within this agenda.

PRIMARY AND COMMUNITY SERVICE WORKSHOP

Two workshops have been planned for Thursday 24 August to discuss a district wide plan for enhancing primary and community care and service integration. Feedback from these workshops will be discussed at the subsequent inter-alliance forum and will contribute to a district wide plan. The initial session will be a four hour forum with a 2 hour evening session particularly for general practice staff and pharmacists who would otherwise be unable to attend.

TOBACCO PLAN

A working group has revised the DHB Tobacco plan however this is currently being reviewed to streamline the document in line with the structure of the Annual plan. This has delayed submission to the Health Strategy Committee meeting which will now occur in October 2017.

TE PAE TAWHITI PROGRAMME OF WORK

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

These groups include people with lived experience (and/or family/whanau where this is more appropriate) and primary care.

Engagement will occur around the products of each of the groups as they are further into their development. The work is being done in conjunction with 'Creating our Futures' so that the models of care are consistent and duplication of effort and consultation is minimised.

The first meeting of the Advisory Group has been held to orient the members to the background and context in which they will be working. This group will provide advice and expertise both from within the mental health and addictions sector and from other sectors. Members include Corrections, Police, St John and Education as well as those involved in employment, workforce development (Te Rau Matatini), residential and consumer support within the sector. We are working to include a Ministry of Social Development representative, along with Housing.

It is expected that, dependant on the time taken to set up the Child and Youth and Older person's groups, delivery of the models of care will be prior to Christmas 2017.

Work will then need to occur on implementation planning taking into account alignment between work streams. At this stage there will be the need to ensure that 'Creating our Futures' aligns with the overall model of care that has been developed.

Recommendation
THAT
The Committee notes the content of the report

JULIE WILSON
EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

Papers for Action

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 7.1

STRATEGY AND FUNDING – CHILD HEALTH METRICS

Purpose	1) For assessment and input

Background
As agreed at the June Performance Monitoring Committee and Health Strategy Committees a suite of information would be presented at the August meeting in relation to child and youth health. This report Appendix A focuses on equity including information around performance against targets and national rates where available. This would include additional reporting on key areas on a rolling schedule throughout the year. This approach is intended to increase focus on equity and give a more depth view of key areas and reflecting that the majority of items reported are available on a quarterly basis only and often move only gradually over time. A brief presentation on the data will be provided

Proposed areas to be presented in more detail at the next meetings include:

October: Services for Older People
December: Mental health and addictions

Following introduction of this new approach consideration will be given to whether there is value in continuing this dashboard except for specific items.

Recommendation
THAT
The report be received.

JULIE WILSON
EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

Appendix A

Child health metrics

The report demonstrates equity issues across the suite of indicators. The large inequities that exist over multiple KPIs are of significant concern. It is however positive to note that there are a number of actions underway which should assist in eliminating the equity gap. The dashboard will be used to monitor our progress toward our goal of achieving health equity between Maori and non-Maori.

- ***Increased enrolment with primary care -*** Improving enrolment with primary care is expected to impact positively on a number of the measures. These include:
  - Immunisation. (6 month, 8 month, 2 year and 5 year rates)
  - B4 School check rates
- ***Smoking in pregnancy*** - Education has occurred with Lead Maternity Carers to encourage pregnant women to be provided with nicotine replacement therapy. Whilst initial numbers of referrals to smoking cessation have been minimal, an additional incentives package has been agreed between Midland Health Network and the Ministry of Health to encourage pregnant women to quit.
- ***Wellchild Tamariki Ora services -*** Information at the total population level had historically been difficult to access. There have been a number of improvements in relation to availability of data, a change in purchase methodology and the use of NCHIP to encourage early enrolment with Wellchild Tamariki Ora providers. Further improvement is expected to occur.
- ***Dental*** - The project undertaken in 2016 was aimed to improve early enrolment and engagement in dental services and ensure good information was available to families through a variety of mechanisms to enable them to ensure good oral health for their children. Whilst it will take some time for the total impact to be shown, interim measures including proportion of under 5s enrolled will be monitored.
- ***Respiratory programmes*** - The GASP programme currently being implemented is expected to impact positively in relation to Emergency department, ASH and Acute admissions. Whilst the GASP programme is being implemented by Hauraki PHO, Midlands Health network are exploring a similar alternative.

The data has highlighted a number of key areas where further emphasis is required:

- ***Teenage births*** - Whilst there has been a small reduction in the Maori Birth rate under 20 years of age this reduction has been minimal and the rate of pregnancy under 20 years of age has been consistently higher than 4 times the rate of 'other'.
- ***Early enrolment with Lead Maternity carers*** - Early engagement with care is important for the health of both mother and baby. Whilst early enrolment has increased, there is still a significant equity gap between Maori and 'other'. There has been a significant increase in the number of young Maori women accessing pregnancy and parenting support through Hapu Wananga courses.

Summary of Equity Gap for Maori Aged 0-24 on Key Measures - Waikato DHB

Population Context:
22.7% of the Waikato DHB total population is Maori - Compared to 33.7% for the 0-24 yr age group

See other sheet tabs for further breakdown of each metric

Equity Gap % between Maori and Other* Ethnicity by Year for Waikato DHB

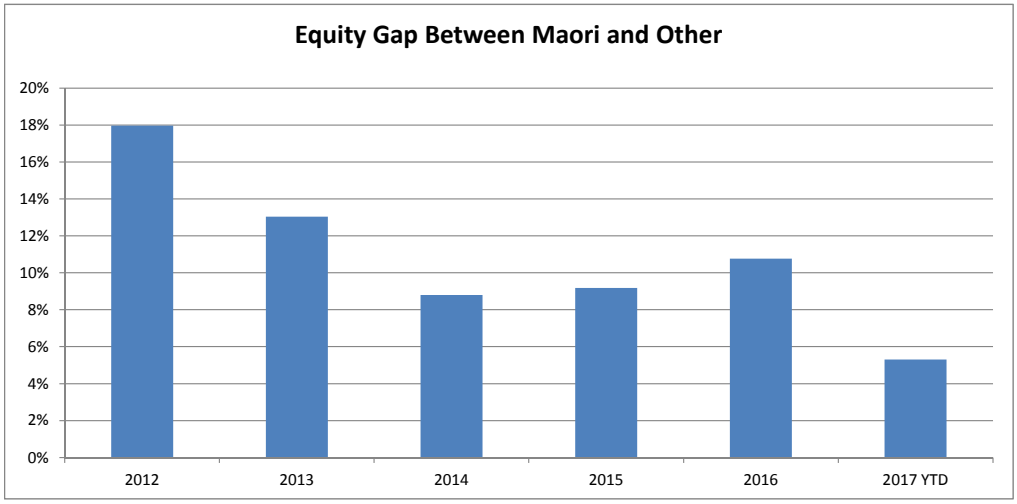
**Other includes all ethnicities other than Maori and Pacific*

	Latest Data - Calendar year or financial year ending							
Metric	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017 YTD**	**Notes:**
Amenable mortality (0-74 years old)			191%					2009-13 cal years
Emergency Department Presentations		18%	13%	9%	9%	11%	5%	Cal years
Ambulatory Sensitive Hospitalisations (ASH)		19%	29%	35%	44%	22%		0-4s only, Fin yrs ending
Acute Admissions		15%	17%	5%	7%	11%	5%	Fin yrs ending
DNA Rates		9%	10%	11%	11%	11%	10%	Fin yrs ending (pp)
Fully Immunised at 6 Months			22%	21%	18%	17%	21%	Fin yrs ending (pp)
Fully Immunised at 8 Months			12%	9%	2%	3%	1%	Fin yrs ending (pp)
Fully Immunised at 2 Years			0.0%	1.8%	0.5%	0.6%	0.2%	Fin yrs ending (pp)
Fully Immunised at 5 Years			3.8%	7.5%	3.5%	4.4%	1.9%	Fin yrs ending (pp)
Raising Health Kids (Obesity HT)						2%	3%	
Teenage Births	433%	455%	330%	425%	602%			Cal year, 10-19 years of age
Teenage termination of pregnancies	24%	26%	8%	3%	12%	0%		Cal year, 10-19 years of age
Smoking in Pregnancy	16%	23%	23%	22%	29%			Cal years (pp)
B4 School Checks			23%	23%	20%	24%	0%	Fin yrs ending (pp)
Well Child Tamariki Ora Enrolment								Awaiting data from MoH
Well Child Tamariki Ora Core Checks 1-5				37%	25%			Cal years
Early Enrolment with LMC	22%	19%	21%	19%	16%			Cal years (pp)
PHO Enrolment for 0-24 years			9%	12%	10%	8%	7%	Fin yrs ending (pp)
PHO Enrolment of 0-1			21%	25%	15%	17%	15%	Fin yrs ending (pp)
Dental Caries Free at 5 yrs	71%	68%	102%	75%	86%	61%		Cal years
Dental Caries Free at Year 8	57%	38%	31%	5%	28%	25%		Cal years
Mental Health - access to services 0 - 19 yrs			0.2%	0.0%	0.2%	0.6%		Cal years (pp)

(pp) = percentage point gap

Choose a Metric to Graph below

Emergency Department Presentations



Amenable mortality, ages 0-74, 2009-2013, 2011 population projections

Source: MoH

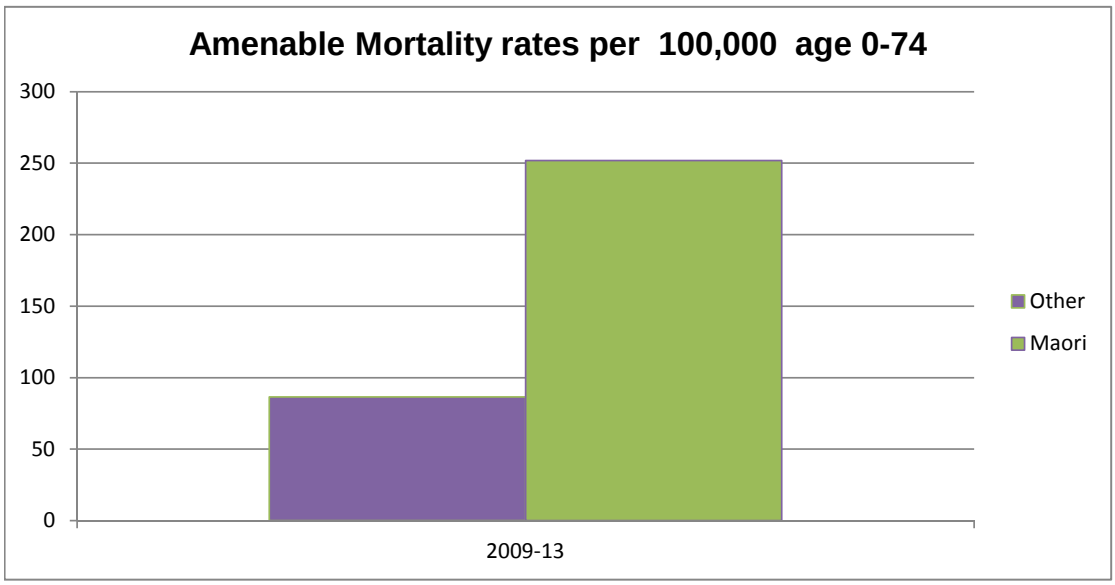
Deaths

Fiscal year	Maori	Other	Pacific	Grand Total
2009-13	795	1,705	74	2,574

Crude Rates per 100,000

Cal Year	Maori	Other	Pacific	Total	Equity Gap %
2009-13	252	87	190	111	190.8%

^Maori compared to Other



Emergency Department Presentations - All Waikato Facilities - Ages 0-24
Source: Waikato DHB iPM System extracted Apr-17

Raw Volumes of Presentations

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2012	11,159	19,278	1,352	31,789	35.1%
2013	11,402	19,302	1,413	32,117	35.5%
2014	11,245	19,576	1,382	32,203	34.9%
2015	11,510	19,805	1,577	32,892	35.0%
2016	12,042	20,266	1,493	33,801	35.6%
2017 YTD	9,364	16,423	1,172	26,959	34.7%
Grand Total	66,722	114,650	8,389	189,761	35.2%

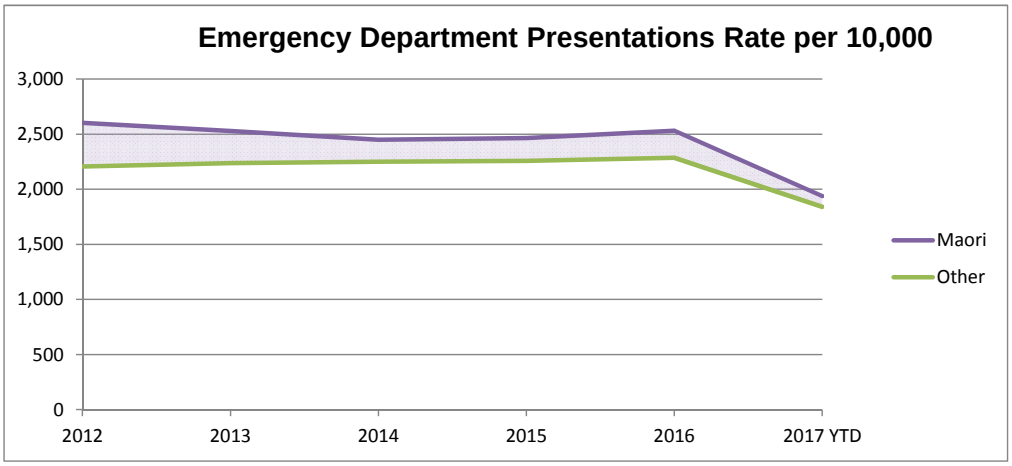
Population Estimates

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2012	42,870	87,370	4,560	134,800	31.8%
2013	45,060	86,230	5,130	136,420	33.0%
2014	45,890	86,920	5,280	138,090	33.2%
2015	46,680	87,690	5,440	139,810	33.4%
2016	47,540	88,620	5,620	141,780	33.5%
2017	48,300	89,200	5,760	143,260	33.7%

Crude Rates per 10,000

Cal Year	Maori	Other	Pacific	Total	Equity Gap %^
2012	2,603	2,206	2,965	2,358	18.0%
2013	2,530	2,238	2,754	2,354	13.0%
2014	2,450	2,252	2,617	2,332	8.8%
2015	2,466	2,259	2,899	2,353	9.2%
2016	2,533	2,287	2,657	2,384	10.8%
2017 YTD	1,939	1,841	2,035	1,882	5.3%

^Maori compared to Other



Is There a Difference in Severitiy of Presentations?

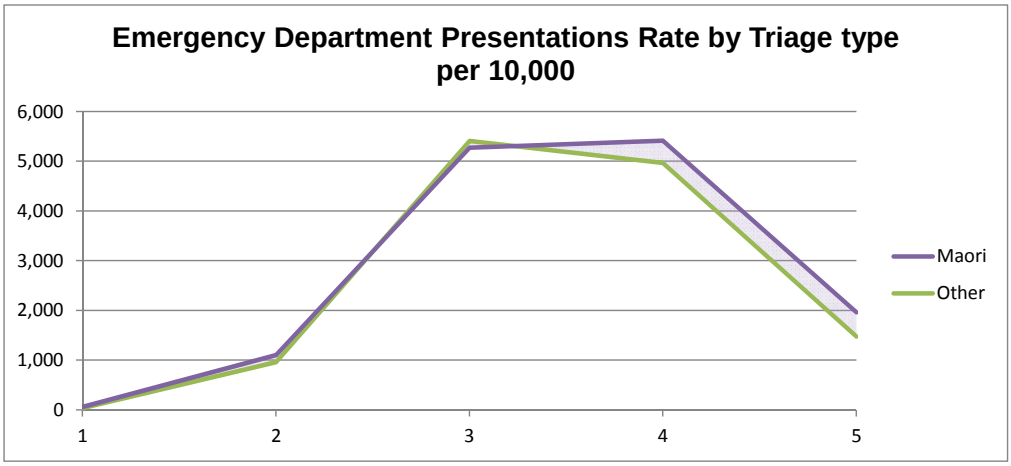
By Triage - Raw Volumes of Presentations for 5yrs and 3mths back to Jan 2012

Triage Score	Maori	Other	Pacific	Total	Maori % of Total
1	297	343	28	668	44.5%
2	5,316	8,546	661	14,523	36.6%
3	25,464	48,271	3,231	76,966	33.1%
4	26,156	44,296	3,467	73,919	35.4%
5	9,489	13,194	1,002	23,685	40.1%
Grand Total	66,722	114,650	8,389	189,761	35.2%

Crude Rates per 10,000

Triage Score	Maori	Other	Pacific	Total	Equity Gap %^
1	61	38	49	47	59.9%
2	1,101	958	1,148	1,014	14.9%
3	5,272	5,412	5,609	5,372	-2.6%
4	5,415	4,966	6,019	5,160	9.0%
5	1,965	1,479	1,740	1,653	32.8%
Grand Total	13,814	12,853	14,564	13,246	7.5%

^Maori compared to Other



Conclusion:

- Maori Children and Youth have a higher rate of ED presentation than Other ethnicities
- Presentation rates have the largest equity gap for the most sever T1 and least sever T5

ASH Admissions - 0-4 age group, Waikato domiciled patients only

MOH published data - SI1 2016Q4

ASH events

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2012	894	1,188	128	2,210	40.5%
2013	878	1,058	133	2,069	42.4%
2014	964	1,094	130	2,188	44.1%
2015	951	1,011	158	2,120	44.9%
2016	866	1,084	135	2,085	41.5%

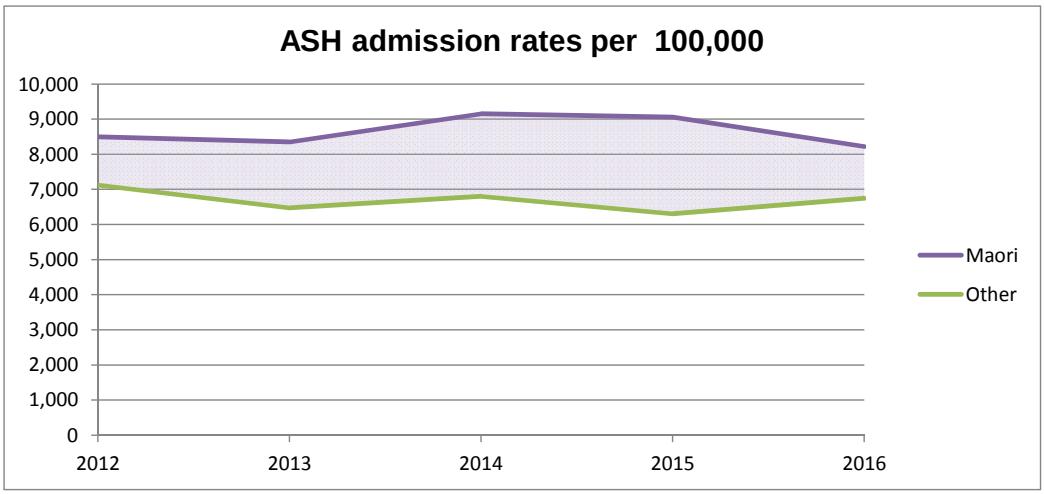
Population Estimates

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2012	10,520	16,670	1,110	28,300	37.2%
2013	10,510	16,350	1,180	28,040	37.5%
2014	10,530	16,080	1,230	27,840	37.8%
2015	10,500	16,030	1,260	27,790	37.8%
2016	10,530	16,070	1,300	27,900	37.7%

Crude Rates per 100,000

Cal Year	Maori	Other	Pacific	Total	Equity Gap %^
2012	8,498	7,127	11,532	7,809	19.2%
2013	8,354	6,471	11,271	7,379	29.1%
2014	9,155	6,803	10,569	7,859	34.6%
2015	9,057	6,307	12,540	7,629	43.6%
2016	8,224	6,745	10,385	7,473	21.9%

^Maori compared to Other

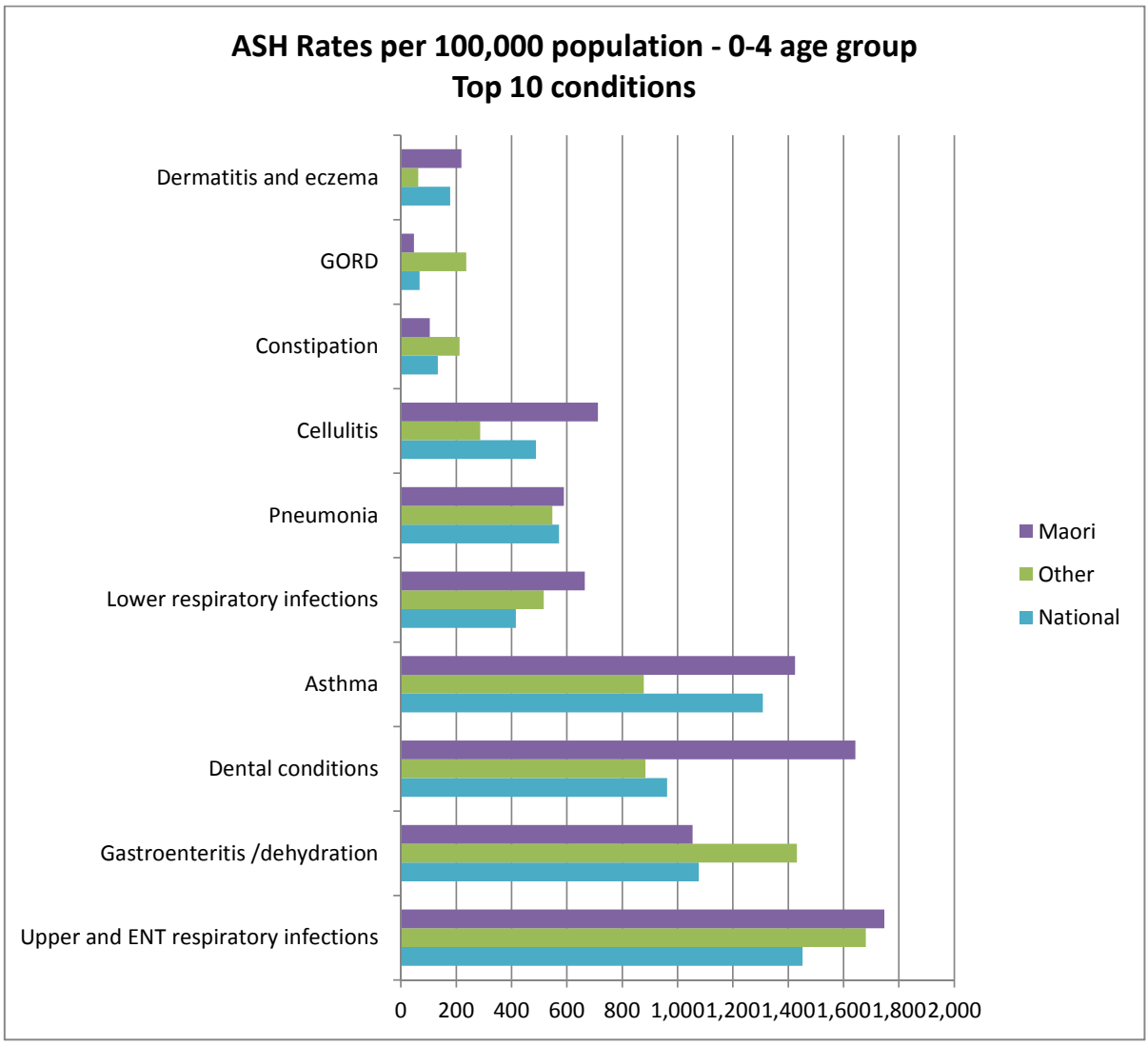


ASH Admissions - 0-4 age group, Waikato domiciled patients only
2016 Calendar year
ASH events - Top 10 Conditions

Condition	Maori	Other	Pacific	Total	National
Upper and ENT respiratory infections	184	270	33	487	4,417
Gastroenteritis /dehydration	111	230	16	357	3,276
Dental conditions	173	142	25	340	2,927
Asthma	150	141	21	312	3,982
Lower respiratory infections	70	83	13	166	1,265
Pneumonia	62	88	15	165	1,740
Cellulitis	75	46	9	130	1,487
Constipation	11	34		45	406
GORD	5	38		43	204
Dermatitis and eczema	23	10	2	35	542
All Conditions - DHB	866	1,084	135	2,085	
All conditions - National	6,024	11,042	3255	23,321	

ASH Rate (Non-Standardised) per 100,000

Condition	Maori	Other	Pacific	Total	National
Upper and ENT respiratory infections	1,747	1,680	2,538	1,746	1,451
Gastroenteritis /dehydration	1,054	1,431	1,231	1,280	1,076
Dental conditions	1,643	884	1,923	1,219	962
Asthma	1,425	877	1,615	1,118	1,308
Lower respiratory infections	665	516	1,000	595	416
Pneumonia	589	548	1,154	591	572
Cellulitis	712	286	692	466	489
Constipation	104	212	0	161	133
GORD	47	236	0	154	67
Dermatitis and eczema	218	62	154	125	178
All Conditions - DHB	8,224	6,745	10,385	7,473	
All conditions - National	7,212	5,690	12,168	6,677	


ASH Rates per 100,000 population - 0-4 age group
Top 10 conditions
Dermatitis and eczema
GORD
Constipation
Cellulitis
Pneumonia
Lower respiratory infections
Asthma
Dental conditions
Gastroenteritis /dehydration
Upper and ENT respiratory infections
0
200
400
600
800
1,000
1,200
1,400
1,600
1,800
2,000
Maori
Other
National

Acute Admissions to Waikato DHB facilities - Waikato domiciled 0-24 years of age

Source: CostproBI (vwEpisodes)

Report Run Date: 19 April 2017

Acute Admissions 0 -24 age group - by Ethnicity Group

Fiscal year	Maori	Other	Pacific	Grand Total
2011/12	4,372	7,761	485	12,618
2012/13	4,601	7,981	564	13,146
2013/14	4,343	7,881	516	12,740
2014/15	4,687	8,249	571	13,507
2015/16	4,848	8,197	536	13,581
2016/17 YTD	3,852	6,808	429	11,089

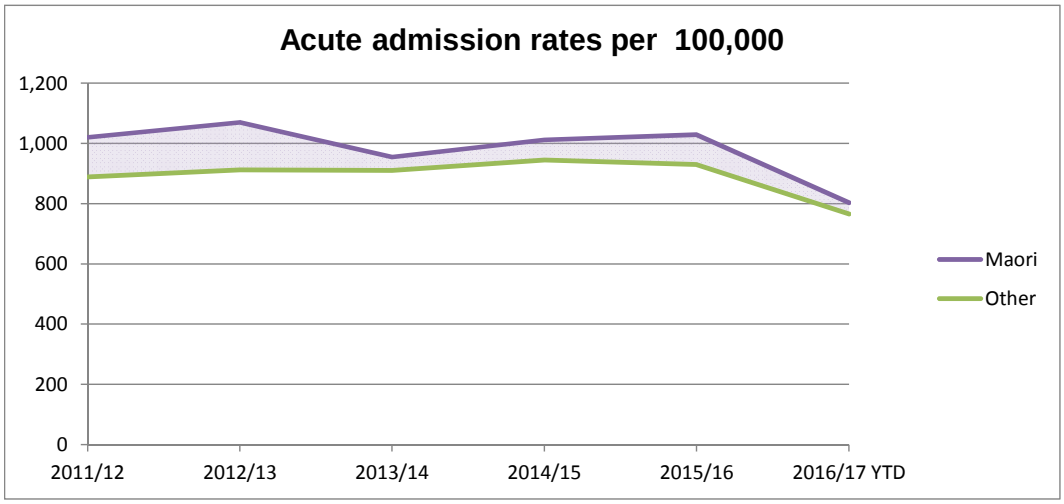
Population Estimates

Fiscal year	Maori	Other	Pacific	Total
2011/12	42,825	87,345	4,535	134,705
2012/13	42,995	87,450	4,585	135,030
2013/14	45,460	86,550	5,200	137,210
2014/15	46,300	87,280	5,360	138,940
2015/16	47,110	88,160	5,520	140,790
2016/17	47,920	88,900	5,690	142,510

Crude Rates per 10,000

Cal Year	Maori	Other	Pacific	Total	Equity Gap %
2011/12	1,021	889	1,069	937	14.9%
2012/13	1,070	913	1,230	974	17.3%
2013/14	955	911	992	929	4.9%
2014/15	1,012	945	1,065	972	7.1%
2015/16	1,029	930	971	965	10.7%
2016/17 YTD	804	766	754	778	5.0%

^Maori compared to Other



Note : 2016/17 YTD figure appears low as it only includes part of the year

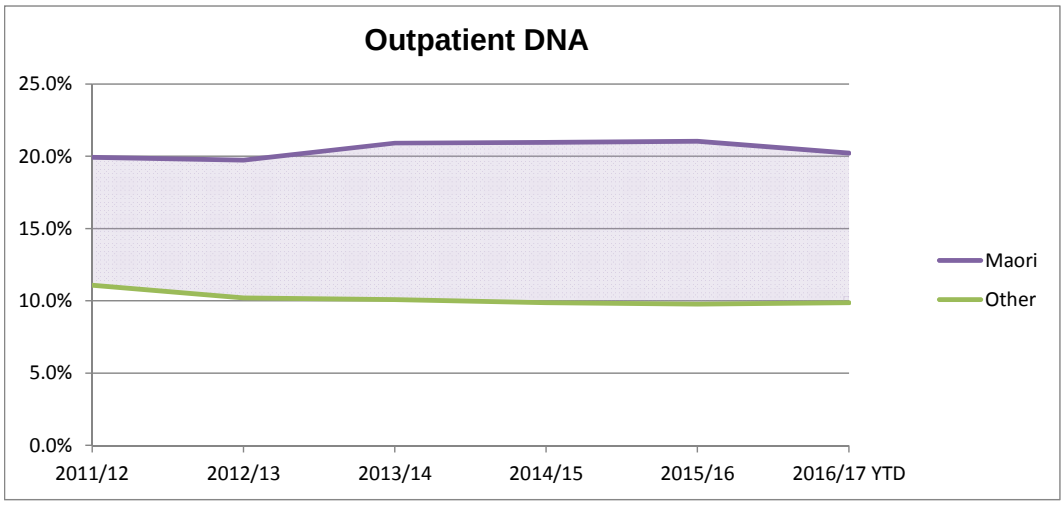
Outpatient DNA Rates - Waikato domiciled 0-24 years of age

Source: CostproBI (vwEpisodes)
Report Run Date: 2 August 2017

DNA Rate 0 -24 age group - by Ethnicity Group

Fiscal year	Maori	Other	Pacific	Grand Total	Equity Gap %
2011/12	19.9%	11.1%	19.2%	14.0%	8.9%
2012/13	19.7%	10.2%	19.0%	13.5%	9.5%
2013/14	20.9%	10.1%	17.0%	13.6%	10.8%
2014/15	21.0%	9.9%	17.0%	13.5%	11.1%
2015/16	21.0%	9.8%	19.1%	13.7%	11.3%
2016/17	20.2%	9.9%	16.8%	13.4%	10.3%

^Maori compared to Other



Full immmunisation at 6 months

Note: data is the full 12 months

Immunisations complete

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	1,062	2,339	147	3,548	29.9%
2013/14	1,140	2,381	150	3,671	31.1%
2014/15	1,265	2,514	167	3,946	32.1%
2015/16	1,148	2,511	141	3,800	30.2%
2016/17	1,296	2,610	159	4,065	31.9%

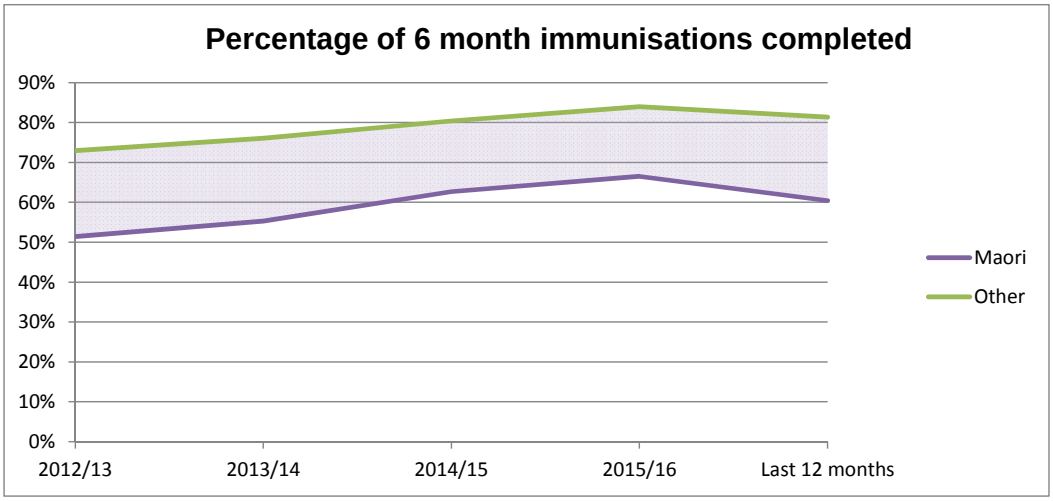
Eligible

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	2,066	3,206	224	5,496	37.6%
2013/14	2,061	3,131	207	5,399	38.2%
2014/15	2,018	3,125	232	5,375	37.5%
2015/16	1,725	2,991	187	4,903	35.2%
2016/17	2,145	3,208	209	5,562	38.6%

Coverage achieved

Cal Year	Maori	Other	Pacific	Total	Equity Gap %pts
2012/13	51.4%	73.0%	65.6%	64.6%	21.6%
2013/14	55.3%	76.0%	72.5%	68.0%	20.7%
2014/15	62.7%	80.4%	72.0%	73.4%	17.8%
2015/16	66.6%	84.0%	75.4%	77.5%	17.4%
2016/17	60.4%	81.4%	76.1%	73.1%	20.9%

^Maori compared to Other



Full immmunisation at 8 months

Note: Data is the full 12 months (HT uses 3mth rolling)

Immunisations complete

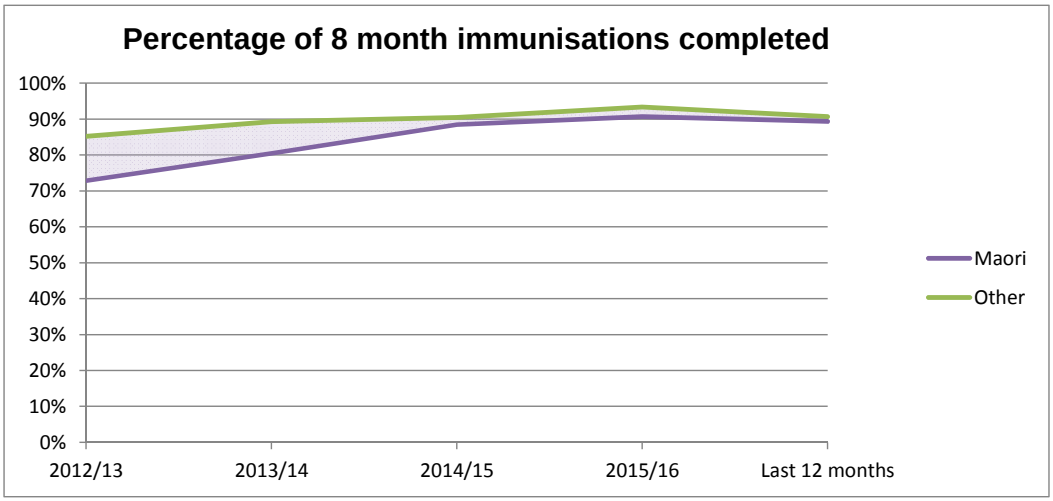
Fin Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	1,504	2,759	181	4,444	33.8%
2013/14	1,672	2,746	198	4,616	36.2%
2014/15	1,791	2,837	216	4,844	37.0%
2015/16	1,637	2,832	190	4,659	35.1%
2016/17	1,899	2,898	199	4,996	38.0%

Eligible

Fin Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	2,064	3,238	224	5,526	37.4%
2013/14	2,077	3,076	213	5,366	38.7%
2014/15	2,024	3,137	228	5,389	37.6%
2015/16	1,805	3,032	199	5,036	35.8%
2016/17	2,125	3,194	210	5,529	38.4%

Coverage achieved

Fin Year	Maori	Other	Pacific	Total	Equity Gap %pts
2012/13	72.9%	85.2%	80.8%	80.4%	12.3%
2013/14	80.5%	89.3%	93.0%	86.0%	8.8%
2014/15	88.5%	90.4%	94.7%	89.9%	1.9%
2015/16	90.7%	93.4%	95.5%	92.5%	2.7%
2016/17	89.4%	90.7%	94.8%	90.4%	1.4%
Target	95.0%	95.0%	95.0%	95.0%	*^Maori compared to Other*
National Rate Q3 16/17				92%	
Waikato Rate Q3 16/17				90%	



Full immmunisation at 2 years

Note: data is the full 12 months

Immunisations complete

Fin Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	1,805	2,939	214	4,958	36.4%
2013/14	1,806	2,831	200	4,837	37.3%
2014/15	1,910	2,928	232	5,070	37.7%
2015/16	1,761	2,748	193	4,702	37.5%
2016/17	1,899	2,971	216	5,086	37.3%

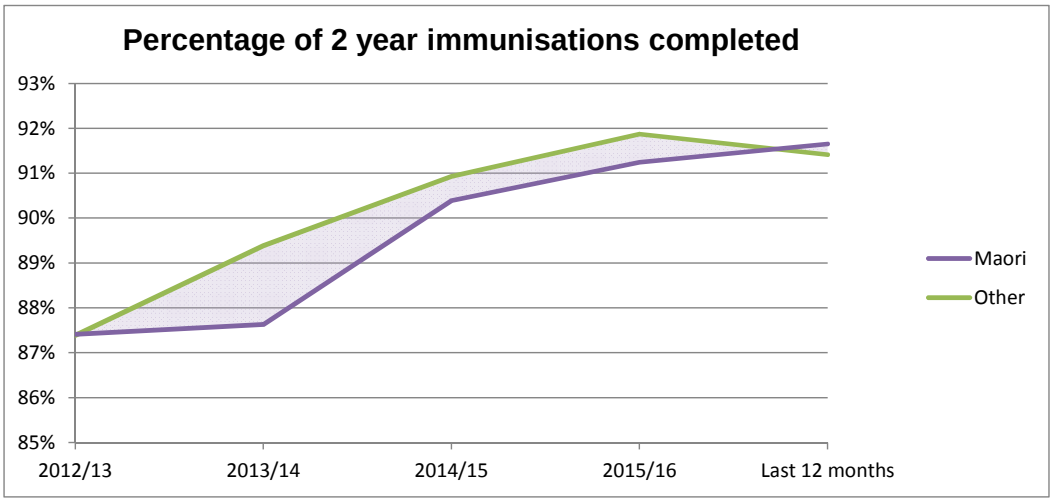
Eligible

Fin Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	2,065	3,363	232	5,660	36.5%
2013/14	2,061	3,167	218	5,446	37.8%
2014/15	2,113	3,220	243	5,576	37.9%
2015/16	1,930	2,991	203	5,124	37.7%
2016/17	2,072	3,250	232	5,554	37.3%

Coverage achieved

Fin Year	Maori	Other	Pacific	Total	Equity Gap %pts
2012/13	87.4%	87.4%	92.2%	87.6%	0.0%
2013/14	87.6%	89.4%	91.7%	88.8%	1.8%
2014/15	90.4%	90.9%	95.5%	90.9%	0.5%
2015/16	91.2%	91.9%	95.1%	91.8%	0.6%
2016/17	91.7%	91.4%	93.1%	91.6%	0.2%
Target	95.0%	95.0%	95.0%	95.0%	

^Maori compared to Other



Full immmunisation at 5 years

Note: data is the full 12 months

Immunisations complete

Fin Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	1,551	2,718	164	4,433	35.0%
2013/14	1,425	2,620	169	4,214	33.8%
2014/15	1,565	2,669	194	4,428	35.3%
2015/16	1,643	2,672	201	4,516	36.4%
2016/17	1,886	2,985	237	5,108	36.9%

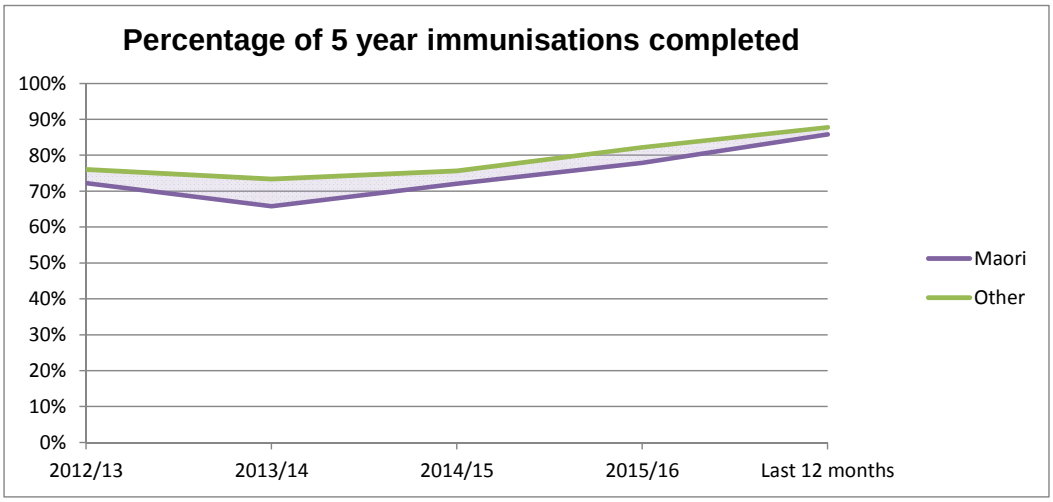
Eligible

Fin Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	2,146	3,574	217	5,937	36.1%
2013/14	2,164	3,573	241	5,978	36.2%
2014/15	2,171	3,529	247	5,947	36.5%
2015/16	2,109	3,248	230	5,587	37.7%
2016/17	2,197	3,401	268	5,866	37.5%

Coverage achieved

Fin Year	Maori	Other	Pacific	Total	Equity Gap %pts
2012/13	72.3%	76.0%	75.6%	74.7%	3.8%
2013/14	65.9%	73.3%	70.1%	70.5%	7.5%
2014/15	72.1%	75.6%	78.5%	74.5%	3.5%
2015/16	77.9%	82.3%	87.4%	80.8%	4.4%
2016/17	85.8%	87.8%	88.4%	87.1%	1.9%
Target	95.0%	95.0%	95.0%	95.0%	

^Maori compared to Other



Raising Healthy Kids

MOH published data - SI1 2016Q4

Total Cases Referred & Acknowledged

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2015/16	51	57	11	119	42.9%
2016/17	155	159	25	339	45.7%

Eligible cases identified

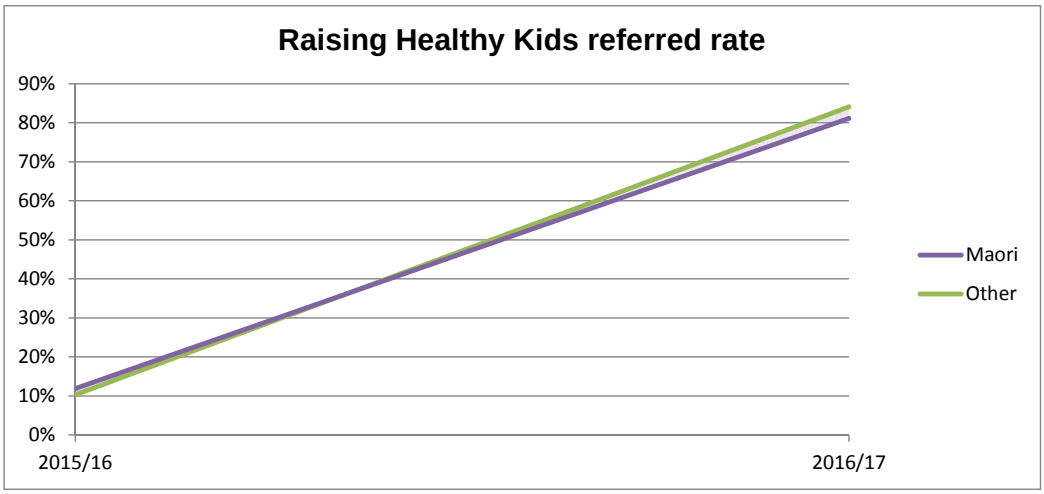
Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2015/16	428	550	82	1,060	40.4%
2016/17	191	189	33	413	46.2%

Percentage of cases referred & acknowledged

Cal Year	Maori	Other	Pacific	Total	Equity Gap %
2015/16	12%	10%	13%	11%	1.6%
2016/17	81%	84%	76%	82%	3.0%

^Maori compared to Other

Target	95%
Q3 16/17 Waikato total	84%
Q3 16/17 National result	86%



Live births to mothers under 20 years of age

Source : MoH

Number of Teen Births

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	289	120	13	422	68.5%
2012	304	122	18	444	68.5%
2013	231	107	14	352	65.6%
2014	246	91	10	347	70.9%
2015	224	61	7	292	76.7%

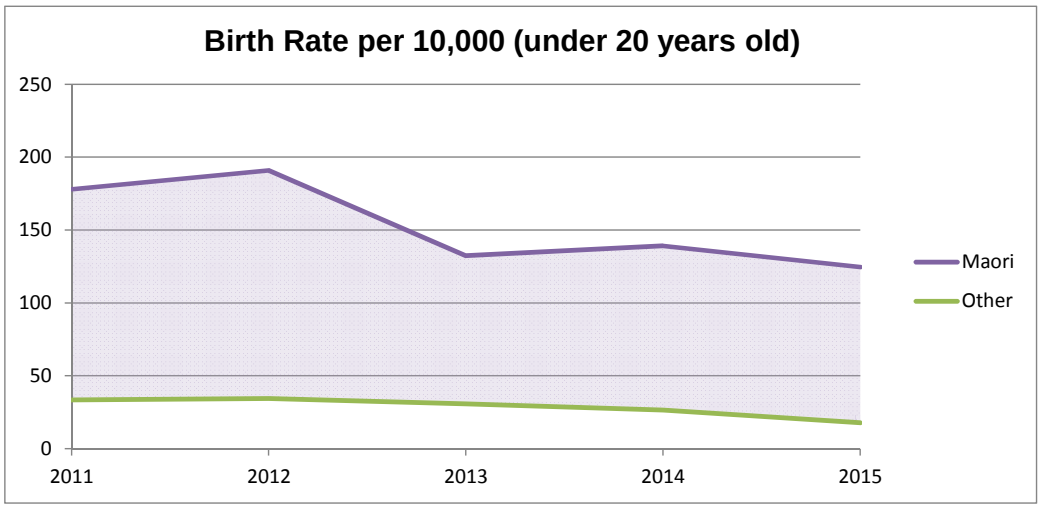
Population Estimates

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	16,240	35,960	1,770	53,970	30.1%
2012	15,920	35,430	1,780	53,130	30.0%
2013	17,440	34,700	1,990	54,130	32.2%
2014	17,680	34,360	2,000	54,040	32.7%
2015	17,960	34,310	2,010	54,280	33.1%

Crude Rates per 10,000

Cal Year	Maori	Other	Pacific	Total	Equity Gap %
2011	178	33	73	78	433.3%
2012	191	34	101	84	454.6%
2013	132	31	70	65	329.5%
2014	139	26	50	64	425.4%
2015	125	18	35	54	601.5%

^Maori compared to Other



Number of pregancies terminated (ToPs) for women under 20 years of age

Raw Volumes of Teen ToPs

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	384	684	61	1,129	34.0%
2012	389	689	46	1,124	34.6%
2013	353	651	44	1,048	33.7%
2014	313	589	34	936	33.4%
2015	341	581	43	965	35.3%
2016	306	575	49	930	32.9%

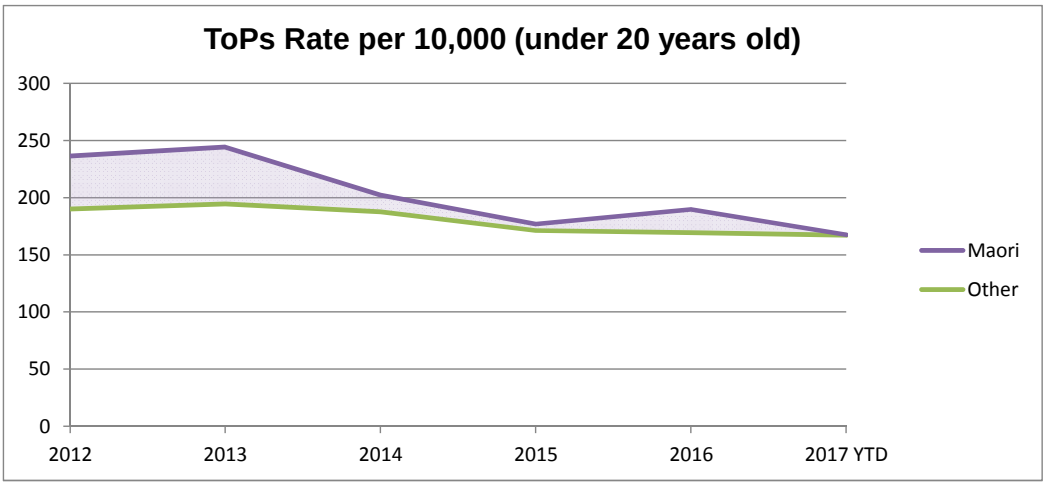
Population Estimates

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	16,240	35,960	1,770	53,970	30.1%
2012	15,920	35,430	1,780	53,130	30.0%
2013	17,440	34,700	1,990	54,130	32.2%
2014	17,680	34,360	2,000	54,040	32.7%
2015	17,960	34,310	2,010	54,280	33.1%
2016	18,260	34,410	2,060	54,730	33.4%

Crude Rates per 10,000

Cal Year	Maori	Other	Pacific	Total	Equity Gap %
2011	236	190	345	209	24.3%
2012	244	194	258	212	25.6%
2013	202	188	221	194	7.9%
2014	177	171	170	173	3.3%
2015	190	169	214	178	12.1%
2016	168	167	238	170	0.3%

^Maori compared to Other



Recorded as smoking at first registration with their primary maternity care provider
Data source : MoH

Raw Volumes of Smokers in pregnancy

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	342	133	7	482	71.0%
2012	387	114	10	511	75.7%
2013	358	114	9	481	74.4%
2014	337	104	6	447	75.4%
2015	355	80	3	438	81.1%

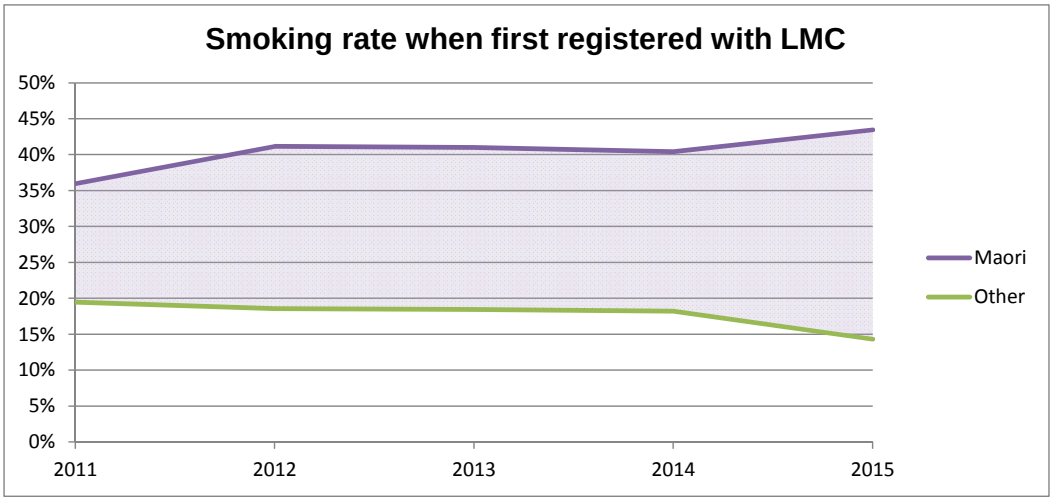
Population of pregnant women

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	951	683	56	1,690	56.3%
2012	940	614	82	1,636	57.5%
2013	873	618	69	1,560	56.0%
2014	834	571	57	1,462	57.0%
2015	817	558	45	1,420	57.5%

Smoking rate

Cal Year	Maori	Other	Pacific	Total	Equity Gap %pts
2011	36.0%	19.5%	12.5%	28.5%	16.5%
2012	41.2%	18.6%	12.2%	31.2%	22.6%
2013	41.0%	18.4%	13.0%	30.8%	22.6%
2014	40.4%	18.2%	10.5%	30.6%	22.2%
2015	43.5%	14.3%	6.7%	30.8%	29.1%

^Maori compared to Other



B4 School checks completed

Checks completed

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	1,190	3,316	174	4,680	25.4%
2013/14	1,434	3,567	175	5,176	27.7%
2014/15	1,506	3,514	207	5,227	28.8%
2015/16	1,497	3,554	173	5,224	28.7%
2016/17	1,784	3,087	224	5,095	35.0%

Eligible Population

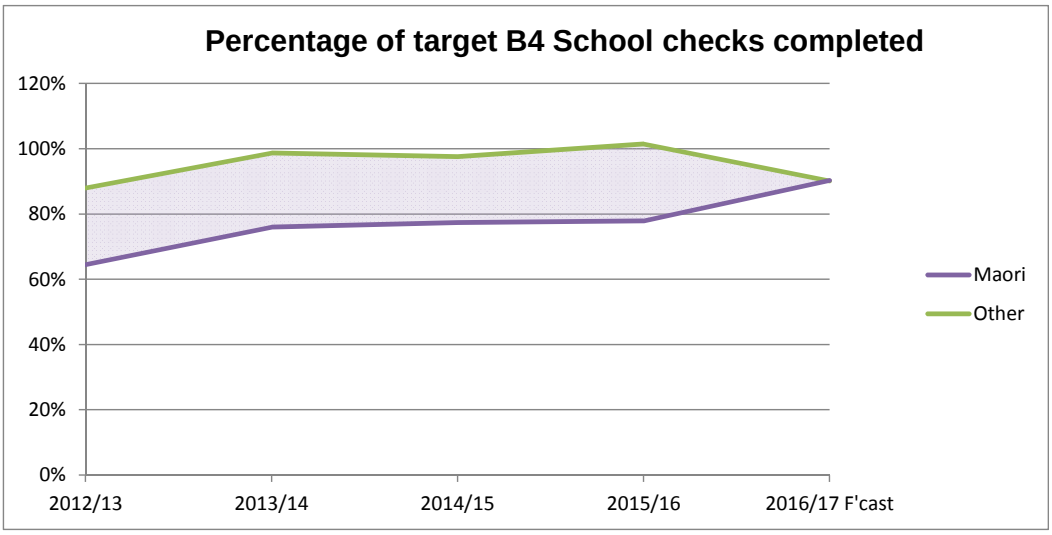
Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	1,844	3,767	233	5,844	31.6%
2013/14	1,886	3,614	222	5,722	33.0%
2014/15	1,946	3,600	249	5,795	33.6%
2015/16	1,922	3,501	227	5,650	34.0%
2016/17	1,975	3,423	242	5,640	35.0%

Percentage achieved

Cal Year	Maori	Other	Pacific	Total	Equity Gap %pts
2012/13	64.5%	88.0%	74.7%	80.1%	23.5%
2013/14	76.0%	98.7%	78.8%	90.5%	22.7%
2014/15	77.4%	97.6%	83.1%	90.2%	20.2%
2015/16	77.9%	101.5%	76.2%	92.5%	23.6%
2016/17	90.3%	90.2%	92.6%	90.3%	0.1%

^Maori compared to Other

Target	90.0%
National 16/17	93.7%
National Maori 16/17	95.1%



Percentage of children that received all five of WCTO contacts 1-5

MOH published data

Checks completed

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2014	568	1,935	90	2,593	21.9%
2015	691	2,552	86	3,329	20.8%

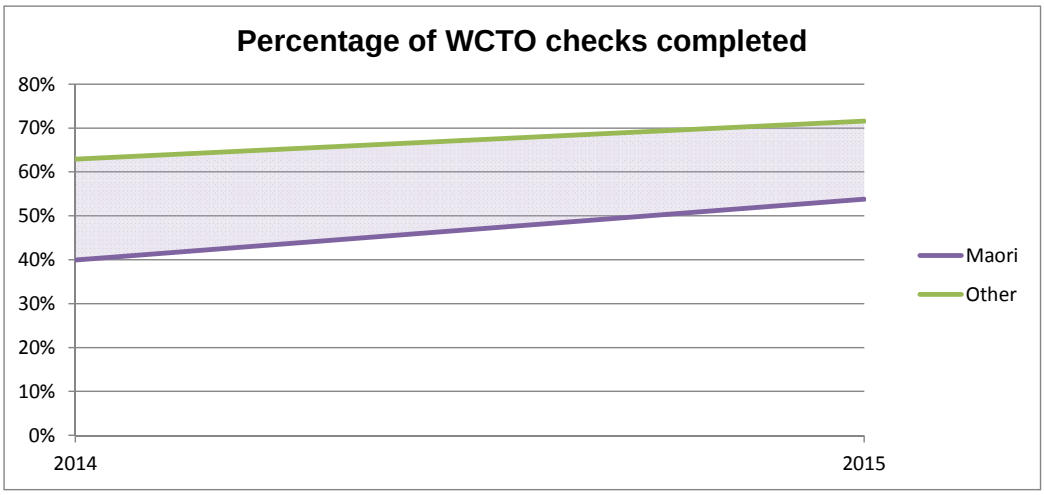
Eligible population

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2014	1,422	3,075	181	4,678	30.4%
2015	1,284	3,566	163	5,013	25.6%

Percentage receiving all 5 Core checks

Cal Year	Maori	Other	Pacific	Total	Equity Gap %
2014	40%	63%	50%	55%	36.5%
2015	54%	72%	53%	66%	24.8%

^Maori compared to Other



Registration with a Primary Maternity Carer in first Trimester of pregnancy (0-24 age)

Source: Ministry of Health

Number of first trimester registrations

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	415	448	13	876	47.4%
2012	427	393	18	838	51.0%
2013	419	424	14	857	48.9%
2014	426	403	10	839	50.8%
2015	463	408	7	878	52.7%

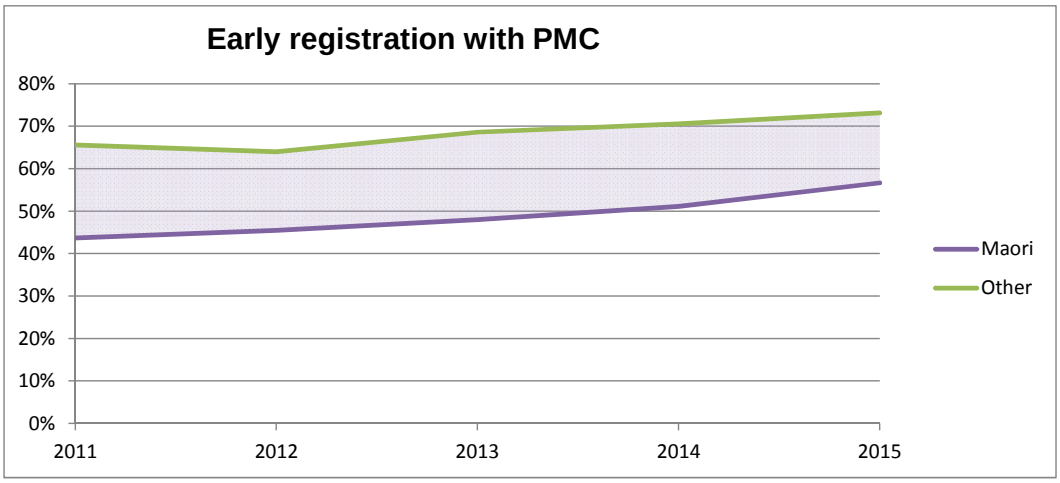
Population of pregnant women

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	951	683	27	1,661	57.3%
2012	940	614	32	1,586	59.3%
2013	873	618	28	1,519	57.5%
2014	834	571	26	1,431	58.3%
2015	817	558	19	1,394	58.6%

Early registration rate

Cal Year	Maori	Other	Pacific	Total	Equity Gap %pts
2011	43.6%	65.6%	48.1%	52.7%	22.0%
2012	45.4%	64.0%	56.3%	52.8%	18.6%
2013	48.0%	68.6%	50.0%	56.4%	20.6%
2014	51.1%	70.6%	38.5%	58.6%	19.5%
2015	56.7%	73.1%	36.8%	63.0%	16.4%

^Maori compared to Other



PHO enrolment 0-24 years old

Enrolled

Fin Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	41,235	86,996	4,690	132,921	31.0%
2013/14	40,064	86,057	4,731	130,852	30.6%
2014/15	40,717	85,543	4,842	131,102	31.1%
2015/16	41,903	85,293	4,918	132,114	31.7%
2016/17	42,883	85,081	5,421	133,385	32.1%

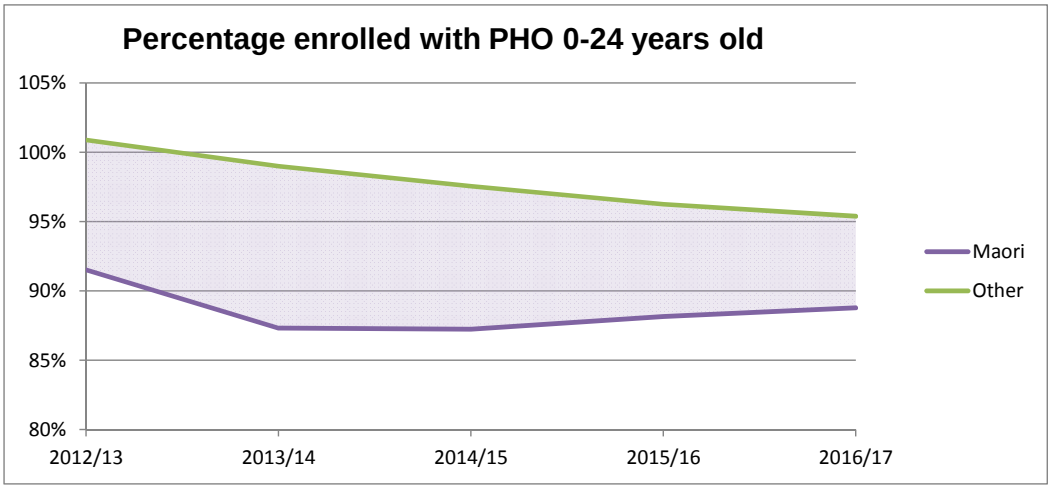
Population Estimates

Fin Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	45,060	86,230	5,130	136,420	33.0%
2013/14	45,890	86,920	5,280	138,090	33.2%
2014/15	46,680	87,690	5,440	139,810	33.4%
2015/16	47,540	88,620	5,620	141,780	33.5%
2016/17	48,300	89,200	5,760	143,260	33.7%

Percentage enrolled

Fin Year	Maori	Other	Pacific	Total	Equity Gap %pts
2012/13	91.5%	100.9%	91.4%	97.4%	9.4%
2013/14	87.3%	99.0%	89.6%	94.8%	11.7%
2014/15	87.2%	97.6%	89.0%	93.8%	10.3%
2015/16	88.1%	96.2%	87.5%	93.2%	8.1%
2016/17	88.8%	95.4%	94.1%	93.1%	6.6%

^Maori compared to Other



PHO enrolment under 1 years old

Enrolled children under 1 in June quarter

Fin Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	1,315	2,614	181	4,110	32.0%
2013/14	1,266	2,573	155	3,994	31.7%
2014/15	1,404	2,647	153	4,204	33.4%
2015/16	1,409	2,660	158	4,227	33.3%
2016/17	1,472	2,714	157	4,343	33.9%

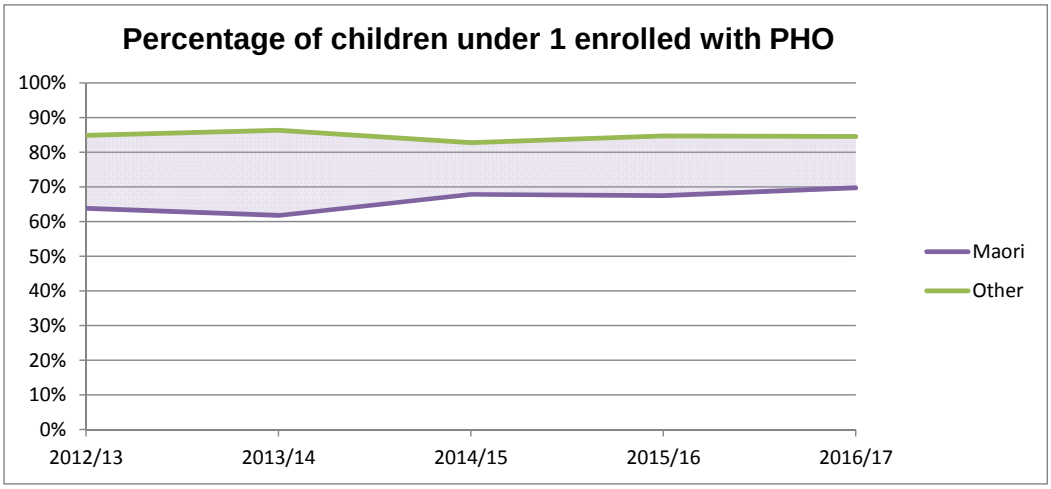
Population Estimates

Fin Year	Maori	Other	Pacific	Total	Maori % of Total
2012/13	2,060	3,080	230	5,370	38.4%
2013/14	2,050	2,980	220	5,250	39.0%
2014/15	2,070	3,200	220	5,490	37.7%
2015/16	2,090	3,140	220	5,450	38.3%
2016/17	2,110	3,210	220	5,540	38.1%

Percentage enrolled

Fin Year	Maori	Other	Pacific	Total	Equity Gap %pts
2012/13	63.8%	84.9%	78.7%	76.5%	21.0%
2013/14	61.8%	86.3%	70.5%	76.1%	24.6%
2014/15	67.8%	82.7%	69.5%	76.6%	14.9%
2015/16	67.4%	84.7%	71.8%	77.6%	17.3%
2016/17	69.8%	84.5%	71.4%	78.4%	14.8%

^Maori compared to Other



Population estimates based on Statistics NZ projects of under 1 year olds at 30 June
From base data of 2013
Medium Projection : Assuming Medium Fertility, Medium Mortality, Medium Inter-Ethnic Mobility, and Medium Migration

Caries free at Age 5

Source:

Caries free at Age 5

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	492	1,715	39	2,246	21.9%
2012	554	1,858	30	2,442	22.7%
2013	439	1,767	51	2,257	19.5%
2014	458	1,714	36	2,208	20.7%
2015	483	2,015	37	2,535	19.1%
2016	530	1,723	37	2,290	23.1%

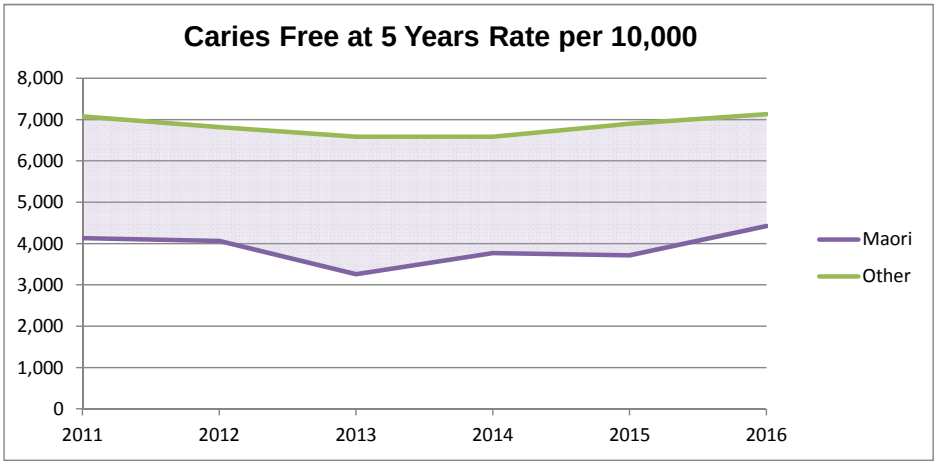
Population Examined

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	1,190	2,423	76	3,689	32.3%
2012	1,362	2,725	92	4,179	32.6%
2013	1,347	2,681	99	4,127	32.6%
2014	1,213	2,600	88	3,901	31.1%
2015	1,300	2,920	98	4,318	30.1%
2016	1,197	2,414	91	3,702	32.3%

Crude Rates per 10,000

Cal Year	Maori	Other	Pacific	Total	Equity Gap %
2011	4,134	7,078	5,132	6,088	71.2%
2012	4,068	6,818	3,261	5,844	67.6%
2013	3,259	6,591	5,152	5,469	102.2%
2014	3,776	6,592	4,091	5,660	74.6%
2015	3,715	6,901	3,776	5,871	85.7%
2016	4,428	7,138	4,066	6,186	61.2%

^Maori compared to Other



Mean DMFT at Year 8

Source:

Mean DMFT at Year 8

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	487	1,909	40	2,436	20.0%
2012	637	2,149	39	2,825	22.5%
2013	649	1,650	46	2,345	27.7%
2014	536	1,607	34	2,177	24.6%
2015	700	2,109	53	2,862	24.5%
2016	726	2,235	75	3,036	23.9%

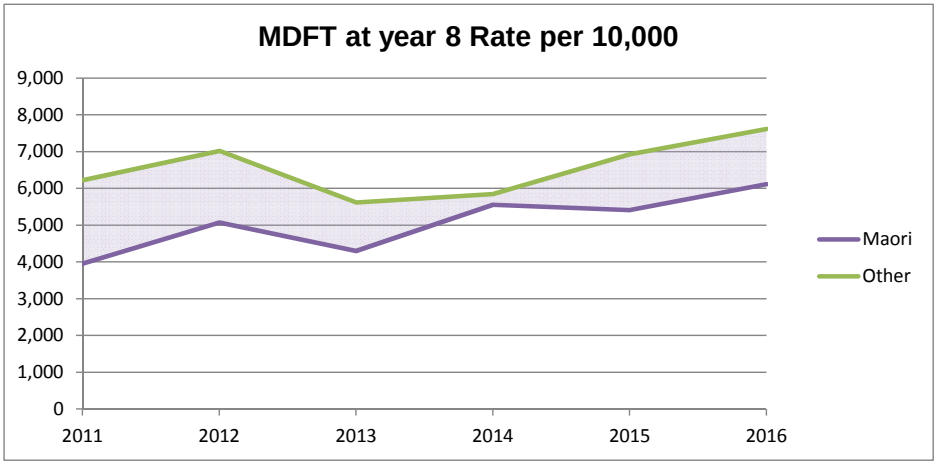
Population Examined

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	1,231	3,066	121	4,418	27.9%
2012	1,256	3,060	101	4,417	28.4%
2013	1,508	2,936	107	4,551	33.1%
2014	965	2,746	87	3,798	25.4%
2015	1,294	3,042	86	4,422	29.3%
2016	1,187	2,933	94	4,214	28.2%

Crude Rates per 10,000

Cal Year	Maori	Other	Pacific	Total	Equity Gap %^
2011	3,956	6,226	3,306	5,514	57.4%
2012	5,072	7,023	3,861	6,396	38.5%
2013	4,304	5,620	4,299	5,153	30.6%
2014	5,554	5,852	3,908	5,732	5.4%
2015	5,410	6,933	6,163	6,472	28.2%
2016	6,116	7,620	7,979	7,205	24.6%

^Maori compared to Other



Access to Mental Health Services (age 0-19 years)

Source: Ministry of Health

Patients

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2013	941	1,759	282	2,982	31.6%
2014	1,023	1,774	332	3,129	32.7%
2015	1,332	2,199	397	3,928	33.9%
2016	1,431	2,545	397	4,373	32.7%

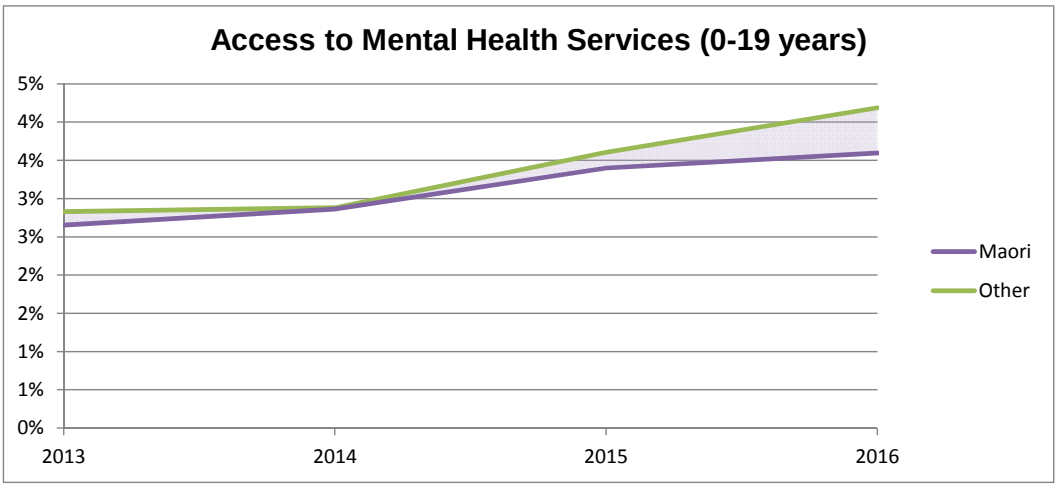
Population Estimates

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2013	35,480	62,130	9,480	107,090	33.1%
2014	35,740	61,550	9,690	106,980	33.4%
2015	39,160	60,960	11,420	111,540	35.1%
2016	39,800	60,760	11,800	112,360	35.4%

Crude Rates per 10,000

Cal Year	Maori	Other	Pacific	Total	Equity Gap %pts
2013	2.7%	2.8%	3.0%	2.8%	0.2%
2014	2.9%	2.9%	3.4%	2.9%	0.0%
2015	3.4%	3.6%	3.5%	3.5%	0.2%
2016	3.6%	4.2%	3.4%	3.9%	0.6%

^Maori compared to Other



Note: this is a measure of population access, not access based on prevalence

Population Estimates - 00 - 24 years

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	42,780	87,320	4,510	134,610	31.8%
2012	42,870	87,370	4,560	134,800	31.8%
2013	45,060	86,230	5,130	136,420	33.0%
2014	45,890	86,920	5,280	138,090	33.2%
2015	46,680	87,690	5,440	139,810	33.4%
2016	47,540	88,620	5,620	141,780	33.5%
2017	48,300	89,200	5,760	143,260	33.7%

Population Estimates - 00 - Age 12

Cal Year	Maori	Other	Pacific	Total	Maori % of Total
2011	24,852	43,191	2,522	70,565	35.2%
2012	25,190	43,235	2,600	71,025	35.5%
2013	25,494	43,170	2,710	71,374	35.7%
2014	25,936	42,826	2,866	71,628	36.2%
2015	26,382	42,910	3,034	72,326	36.5%
2016	26,810	43,390	3,180	73,380	36.5%
2017	27,246	43,798	3,320	74,364	36.6%

Population Estimates - 00 - 24 years

Financial Year	Maori	Other	Pacific	Total	Maori % of Total
2011/12	42,825	87,345	4,535	134,705	31.8%
2012/13	42,995	87,450	4,585	135,030	31.8%
2013/14	45,460	86,550	5,200	137,210	33.1%
2014/15	46,300	87,280	5,360	138,940	33.3%
2015/16	47,110	88,160	5,520	140,790	33.5%
2016/17	47,920	88,900	5,690	142,510	33.6%

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 7.2

ALLIANCES

Purpose	1) For assessment and input

BACKGROUND
The DHB has recently been in discussions with local PHOs, our regional DHB partners and the Ministry of Health in relation to our Alliancing arrangements.

Currently the Waikato DHB is engaged in four alliances:
1. The Midland Region United Inter Alliance Leadership – (MURIAL) a cross DHB and PHO grouping focussed on integration opportunities between services across the region.
2. The Midlands Alliance
3. The Hauraki Alliance
4. The National Hauora Alliance

The DHB also engages in a regular Inter-Alliance meeting where each of the parties attend and discuss items of mutual interest.

From the DHB's perspective, the current Alliance structures are fragmented and don't effectively support a Waikato system of integration and population health improvement. The DHB has therefore signalled to its partners that it wishes to consider continuing with the MURIAL alliance (to explore where opportunities exist to work regionally together to improve system sustainability), but exiting other alliance arrangements and redeveloping a new single Alliance with all PHOs and other key parties.

The intention of a new Waikato alliance would be to be more population focussed with the key goals of eliminating equalities and improving service sustainability. Should the proposal progress it would have a new and jointly developed memorandum of understanding, a focus on integration and be intended to foster greater collaboration amongst each of the Alliance members. The Alliance would be the vehicle for identifying opportunities for services to work more closely together, to develop integrated models of care in communities of interest, and to develop Waikato focussed investment and delivery approaches to reduce the inequalities that exist.

FEEDBACK THAT HAS BEEN SOUGHT
Letters have been sent to our existing Alliance partners (attached) seeking feedback on this proposal. The document has also been circulated to the Waikato District Health Board Iwi Maori Council for their input. We have been actively engaged with the Ministry in respect of this proposal and our rationale of wanting a district-focussed

alliance. It has been important to work with the Ministry, as the Director General will need to sign-off any change to Alliancing arrangements.

Feedback received through this process will be developed into a discussion document for Board consideration. Should this process result in a proposal for change which is supported by the Board, another stage would commence to identify the appropriate design of a Waikato alliance. This would be expected to occur with significant input from both Alliance partners and the broader community.

Feedback from the Health Strategy Committee is requested in relation to the discussion document, and possible areas requiring exploration that may enhance the proposal or reduce risks associated with the proposal.

Recommendation
THAT
The Committee provides comment on the attached report.

JULIE WILSON
EXECUTIVE DIRECTOR, STRATEGY AND FUNDING

17 July 2017

Dear

Waikato DHB is currently considering opportunities to improve the effectiveness of alliance arrangements for the Waikato population. Our intention is to ensure that we have an alliance approach that:

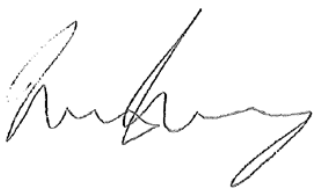
- includes broader representation across the Waikato including service providers, clinicians, consumers and Iwi;
- supports enhanced integration across PHOs, other primary care providers, and secondary services across the Waikato;
- supports and provides input into the implementation of the DHB strategy with respect to developing people-centred services, addressing inequities and supporting people to stay healthy and fit within their communities.

Waikato DHB is seeking your feedback on a proposal for the DHB to transform existing arrangements (membership of the Midlands Health Regional Network, Hauraki PHO Alliance, National Hauora Coalition Alliance and the Waikato Inter-alliance Forum) and move to an inclusive Waikato DHB Alliance arrangement focussed on improving the outcomes of the Waikato population.

This proposal is attached for your consideration. Feedback is sought by 17 August 2017 and will form part of a discussion document at a future Waikato DHB board meeting.

If, following discussion by the Waikato DHB board, there is a desire to proceed with the proposal, a workplan would then be developed to ensure transition from existing arrangements occurs in a considered way and that the development of a new Alliance occurs with the input of all parties.

Yours sincerely



Nigel Murray
Chief Executive

Encl

Waikato DHB Alliancing Review

Introduction
Alliance arrangements between the Waikato District Health Board and external organisations are a key opportunity for:

- the development of clinical leadership
- focussed service design
- approaches for enhancing services
- service integration for local populations.

Waikato DHB has identified that there is a need to change, redesign and transform our alliances as over time they have become unwieldly and unfocussed. This is not because of a lack of goodwill, but because we are splitting our efforts across three separate mechanisms diluting our attention on the specific needs of the population in the Waikato district. This brief paper outlines the rationale for change and potential future approaches.

Current State
The Waikato DHB is currently engaged in four alliances in respect to primary care:

1. The Midland Region United Inter Alliance – (MURIAL) this alliance includes all DHBs and Primary Health Organisations (PHOs) in the Midland region and is focussed on integration opportunities across the region
2. The Midlands Health Network Alliance
3. The Hauraki Alliance
4. The National Hauora Coalition Alliance

The DHB has also established a Waikato district Inter-Alliance meeting where each of the PHOs attend and discuss items of mutual interest alongside a representative from the Midland Community Pharmacy Group.

Problem Statement
From the DHB's perspective, the current alliance arrangements are fragmented, have not supported broad clinical or community input and do not support a Waikato system view. Because of the number of alliance meetings it has been unrealistic to get appropriate numbers of clinicians to attend or ensure appropriate levels of Iwi, consumer or other service providers input.

The development of MURIAL has created the opportunity for good regional collaboration across all Midland DHBs and PHOs. We intend continuing our involvement in MURIAL as a vehicle to explore future integration and sustainability work across the Midland region. It has been useful to date and we believe it will continue to develop over time.

The other alliance arrangements, while they have provided a base from which to work, are not currently able to drive a district wide integrated approach to care or a system view of delivery, nor do they support true cross sectoral collaboration around improving health outcomes and reducing disparities. The Midlands Health Network Alliance and National Hauora Coalition are also complicated by the fact that they work across other DHB districts, which we believe splits focus away from local engagement and achieving optimal outcomes for the people of the Waikato.

To address the population disparities within our own district and to improve the sustainability of our local services, a new approach to alliancing is required. One that brings multiple service delivery parties to the table, and has the focus to drive the strategic system and investment decisions we make across the Waikato health system.

Proposed Structure
The DHB is proposing that we replace our involvement in the Midlands Health Network Alliance, the Hauraki Alliance and the NHC Alliance with a district wide Waikato Alliance. The separate Care Alliance documents would move to a single alliance agreement with multiple parties. Contracts with each of the PHOs that sit under the existing alliance agreements would change to PHO contract agreements sitting under the Waikato Alliance agreement. For MHN and NHC this would mean separating these agreements from the current regional agreements.

Our intention would be to establish together a new alliance with a mutually developed constitution/ charter and work plan that would bring together the DHB, the PHOs and other critical service providers and community/consumer representatives. The focus of the alliance will align with the DHB strategy, along with a commitment to service integration in the Waikato and improving the health of the population.

We are proposing that the other members in the Waikato Alliance would include representatives from the DHB provider arm (secondary and community), Pharmacy, St John, Aged Residential Care, Home Based Support Services, and Community Mental Health. The alliance would also include representation from Maori and the consumer forums.

The new Waikato Alliance would be the vehicle for identifying opportunities for services to work more closely together, to develop integrated models of care in communities of interest, and to develop Waikato focussed investment and delivery approaches to reduce the inequalities that exist.

Moving Forward
Feedback on the proposed development of a district wide alliance to replace Waikato DHB's involvement in existing alliances is sought from all PHOs, Midland DHBs, Iwi Maori Council and the committees of the Board by:

5pm 17 August 2017

This will inform discussion at a future Waikato District Health Board meeting. Waikato DHB representatives are happy to discuss this proposal with management teams or Boards over the next month. Similarly any questions can be emailed to:
Support@waikatodhb.health.nz

Following on from these considerations we will communicate the proposed approach. If there is a decision to develop a Waikato district alliance we would wish to actively engage key parties as we work through this process.

A workshop will be held with existing partners to explain what the DHB is looking for and to secure their input into the new design.

A working group will also be established to ensure there is broad input into the design of the new arrangements and define the parameters, goals and reporting structure of the new Waikato Alliance.

Changes to existing alliances will be timed to coincide with the establishment of the new alliance and reflecting the notice periods within the agreements.

Dr Damian Tomic
Clinical Director
Primary and Integrated Care

Julie Wilson
Executive Director
Strategy and Funding

Papers for Information

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 8.1

PACIFIC ISLAND PROFILE

Purpose	1) For information

Introduction
Talofa lava, Kia orana, Malo e lelei, Bula vinaka,

The Public Health Advisory and Development (PHAD) team have worked alongside local Pacific providers *K'aute Pasifika* and *South Waikato Pacific Islands Community Services (*SWPICS) to develop a Waikato region Pacific Health profile. This has been a collaborative piece of work and one which has been thoughtfully developed with the Pasifika Fanau Ola framework guiding the structure of the profile. The Pacific proverbs introducing each section which were provided by both SWPICS and K'aute Pasifika.

The intention of this profile is to:

- provide access to up to date key demographic and health statistics of our Pacific peoples through an innovative resource utilising infographics
- initiate discussion and thus support future planning across health and other key sectors that will contribute to the health and wellbeing of Pacific peoples within the Waikato region.

Throughout the profile a conscious effort had been made to provide an overview of the health and wellbeing of the Pacific population in our region, taking a strengths based approach and highlighting improvements in Pacific health indicators that have been achieved over time.

Recommendation
THAT
The Committee notes the report.

MARK SPITTAL
EXECUTIVE DIRECTOR, COMMUNITY & CLINICAL SUPPORT SERVICES

Pacific Health Profiles - Waikato

Acknowledgements

We would like to extend our grateful thanks to all who contributed to the development of this Pacific Health profile, particularly our local Pacific Health providers South Waikato Pacific Islands Community Services (SWPICS), K'aute Pasifika Trust and some members from the Waikato Pacific community. Your support and views into the design, appropriate health model and framework to work with, time and insights into translations, provision of the Pacific proverbs and support with accessing key primary health data is acknowledged and much appreciated. We also acknowledge the Pacific Team at the Ministry of Health and at Counties Manukau Health for some initial support advice and in providing some review of the drafts. To the working group (Public Health Advisory and Development Team) who developed and designed this profile, thank you for your passion and dedication to producing such an informative and high quality document.

Finally we would like to acknowledge our Senior management, Pacific peoples, both past and present, who have inspired us to develop this Health Profile and allow us to join other key stakeholders in our region and nationally to work towards improved health outcomes and reduced inequalities for Pacific peoples.

South Waikato Pacific Islands Community Services Trust

K'aute Pasifika Services

Contents

"Talofa lava, Kia orana, Malo e lelei, Fakaalofa lahi atu, Taloha ni, Bula vinaka, Kam na Mauri, Halo Olketa"

Pacific Health Profiles – Waikato

Addressing health equity is fundamental to an overarching approach of Population Health and the wider Waikato District Health Board. The primary goal of Population Health is: ***to promote, improve and protect health with a focus on achieving health equity for people living in the Waikato DHB area.*** This aligns to the strategic imperative of the Waikato DHB, ***Oranga – Health equity for high need populations*** aimed to eliminate health inequities between segments of the population (Waikato DHB, 2016).

This Pacific Health Profile is designed to inform and further enhance Population Health's approach with key strategic partners to accelerate Pacific health gains, envisioned in the New Zealand Health Strategy (2016-2026) and 'Ala Mo'ui – the Ministry of Health's Pacific Health and Wellbeing Plan (2014 – 2018).

The specific objectives of this Pacific Health Profile are to:

- provide access to Pacific Health data for the Waikato DHB region, and
- innovatively communicate Pacific people's health status and progress through key health and social determinant indicators.

We need to work on all New Zealanders achieving equitable health outcomes, and we will target and tailor services for those groups who have poorer health and social outcomes than the population on average, for example Pacific peoples, people with disabilities and people with mental health conditions *(Hon Dr Jonathan Coleman, Minister of Health, New Zealand Health Strategy, 2016).*

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018 is driven by the Government's long term vision of achieving health equity for all Pacific peoples in New Zealand that:

"Pacific 'aiga, kaiga, magafaoa, kopu tangata, vuvale and family experience equitable health outcomes and lead independent lives."

Pacific concepts of health particularly the 'Fono Fale' model of Health (Pulotu-Endemann, 2009) were used to guide the development of this profile report. All data is organised under the relevant domains of the Pasifika Fanau Ola[1] framework. The five main domains in this Health Profile report connect with the 'life-course approach' intended in the New Zealand Health Strategy and key determinants of health indicators highlighted for monitoring in the 'Ala Mo'ui' Plan.

[1] Pasifika Fanau Ola builds on the principles of Whanau Ora (for Maori) which is an innovative whanau-centred approach to empowering whānau to achieve better health, education, housing, skills development and economic outcomes (www.tpk.govt.nz). In terms of healthcare, it works by putting patients and their 'aiga/family at the centre of care.

Layout of the Profile

The Pasifika Fanau Ola framework:

Pasifika Fanau Ola is a comprehensive strength-based approach to understanding family health and wellbeing that acknowledges the spirit, heart, mana and inherent dignity of Pacific families and communities. The Fanau Ola concept contextualises the lives of Pacific peoples who have travelled to New Zealand over the past several decades and have settled in the different regions of New Zealand including the Waikato DHB region. Social determinants such as income, employment, housing quality and education have been known to contribute substantially to the relatively poor health status of Pacific peoples *(Tukuitonga 2012; Ministry of Health 2013).* The Fanau Ola framework[2] is holistic, encompassing multiple elements of fanau life often influenced by socio-environmental determinants of health, experienced at different life-course stages. The elements/ dimensions include: goals, family and social relationships, cultures and languages, physical, mental and emotional health, education, economic contexts and their unique circumstances *(Counties Manukau Health 2013; K'aute Pasifika 2013).*

[2] The Pasifika Fanau Ola framework was adapted from Counties Manukau DHB (Counties Manukau Health) Fanau Ola approach which has been built on the 'Fonofale Model of Health' (Pulotu-Endemann, 2009) and similar Pacific models of health. The Fonofale model was created by Fuimaono Karl Pulotu-Endemann as a Pacific Island model of health for use in the New Zealand context. The early development of the Fanau Ola approach and framework came about from implementation of the 'Pacific family wellbeing/Fanau Ola' pilot project (an initiative of K'aute Pasifika Trust, Hamilton and the Aere Tai Pacific Midlands Collective Network).

Counties Manukau Health, serving approx. 112,768 Pacific people (21.5% compared to 6.5% nationally, www.health.govt.nz) has implemented the Fanau Ola approach since 2013 as part of its Pacific health services to achieve better health and wellbeing for Pacific families through tailored pathways for Pacific patients and their fanau (www.countiesmanukau.health.nz).

The Fanau Ola approach has been widely adopted by the Aere Tai Network (Pacific Midland Collective of Pacific providers) working together to serve Pacific communities in the midland region of the North Island, with some of the poorest health, education and social outcomes in the country. The Aere Tai Network implements the Fanau Ola approach through its whanau ora navigation service to families with high needs, empowering them to reach their full potential through providing services and enabling opportunities (www.aeretai.nz).

The health profile is organised into five core domains of the Fanau Ola framework:

Āiga ma le aganu'u | Family & Culture

- This domain sets the scene through shared national visions for Pacific families/population, demographics, family dynamics and health services, culture through identity, cultural values and practices such as language and spirituality.

Yago | Body

- Relates to biological or physical wellbeing and includes the physical health status of 'aiga/family, risk factors and health conditions prevalent to the Pacific population, and access to health services such as clinical health assessments.

Manako e te Pukuatu | Mind & Heart

- Relates to mental wellbeing which involves emotion, love, support and behaviours expressed.

Ako Faka'atamai | Intellect & Learning

- Relates to raising intellect /learning/education achievements and skills across the Pacific population age groups.

Buoka ao Kairiri | Resources & Leadership

- Relates to resources (such as employment, income, housing and access to health services) and leadership (such as the Pacific professional workforce) that the Pacific community require to enable them achieve their goals of aspired states of health and wellbeing.

Other notes in reading the Profile:

- All ethnicities other than Pacific and Māori were initially classified as 'non-Pacific non-Māori' and now simplified as *'other.'* When European is used it refers to that ethnic group only.

- Where regional Pacific data is not available, national data/information is used given characteristics and trends are usually similar across Pacific health indicators nationally. National data is identified throughout the profile. Primary Care data utilised in this profile has been obtained from Hauraki and South Waikato Primary Health Organisations (PHOs).

- Only selected key data are highlighted in the report while details for similar data can be found in the tables (back of the report/appendices).

- Pacific languages used for:
  - Introductory greetings - Samoan, Cook Is, Tongan, Niuean, Tokelauan, Fijian, Kiribati, Solomon Is
  - Translations and proverbs throughout the report (in order of appearance) – Samoan, Fijian, Cook Is, Tongan, and Kiribati.

- The term "Pacific peoples"[3] used throughout the report, is a broad term encompassing a wide variety of people from the Pacific Islands who have made New Zealand their home or who identify with the Pacific Islands because of ancestry or heritage. The term encompasses a range of ethnic, national, language and cultural groupings.

- Sources of information used in this report are detailed with tables and in the reference list.

[3] As described in
- Public Health Commission, 1994. Bathgate M; Alexander D; Mitukulena A; Borman B; Roberts A; Grigg M:The Health of Pacific Islands People in New Zealand. Wellington, New Zealand.
- Ministry of Pacific Island Affairs (2001). Pacific Consultation Guidelines. Ministry of Pacific Island Affairs, Wellington.

Āiga ma le aganu'u
Family & Culture

"Ua se afa e tasi"

"We were all made from the same mesh-sticks"

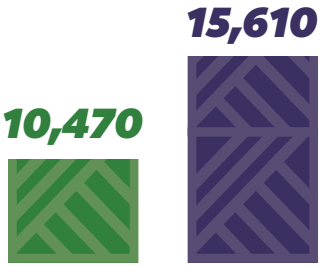
When a fish net is made, the mesh-sticks are measured and made equal so that they are of the same size. Culturally, we are identified by the same values, beliefs, and customs which are guided by our innate spiritual beliefs to promote success, prosperity, and social harmony.

(Samoan proverb)

Āiga ma le aganu'u | Family & Culture

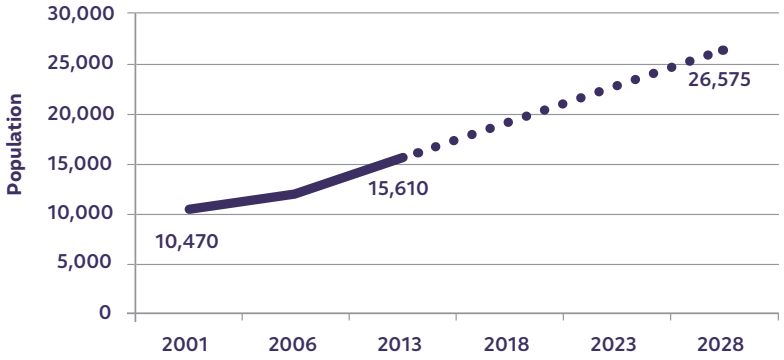
Setting the scene

5% (15,610)
of New Zealand's
Pacific population
live in Waikato DHB and make up 4% of the DHB population (2013)

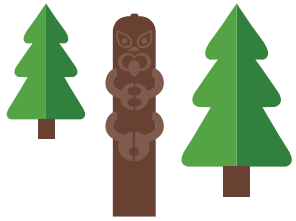


The
Pacific population in Waikato DHB is growing
by 49% 2001-2013

The
Pacific population in Waikato DHB is estimated to increase by 70% by 2028
(2013-2028)



Most
Pacific peoples live in Hamilton City
(8,010, 51%) and
South Waikato
(2,920, 19%)



The highest concentration of
Pacific peoples live in South Waikato
(13% of the population of South Waikato) (5%, Hamilton City)

Āiga ma le aganu'u | Family & Culture

Setting the scene

Pacific population in Waikato DHB is youthful

15% under 5 years old

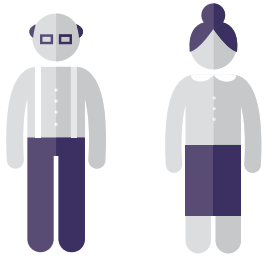
(1,630 in 2001, 2,355 in 2013)

(Māori 12%, Other 6%)

58% under 25 years old

(6,205 in 2001, 9,705 in 2013)

(Māori 53%, Other 30%)



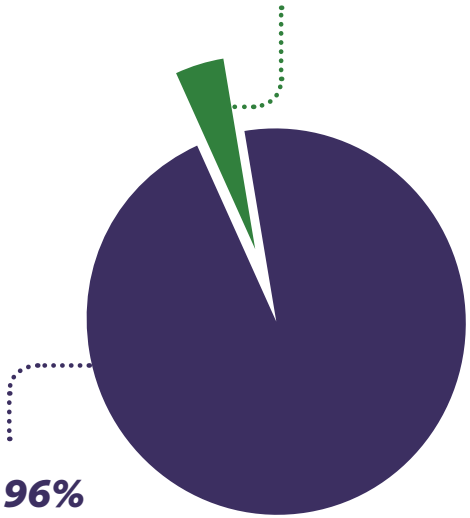
2% 65 years and over

(185 in 2001, 375 in 2013)

(Māori 5%, Other 18%)

Births in Waikato DHB, 2015

187 babies were born into Pacific fanau, 4% of all new borns in Waikato DHB



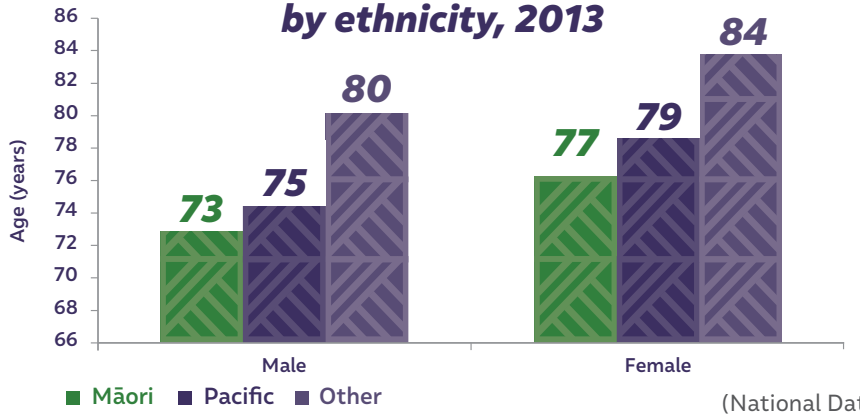
Non-Pacific babies, 5101, 96%

Āiga ma le aganu'u | Family & Culture

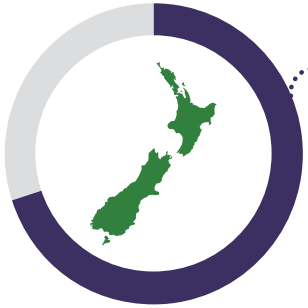
Setting the scene

Pacific peoples are living longer

Life expectancy in New Zealand, by ethnicity, 2013

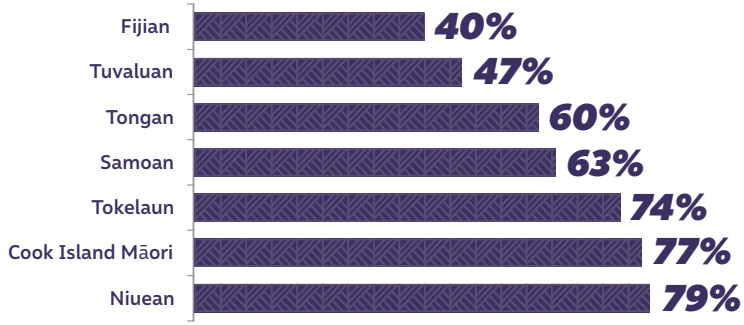


(National Data)



In the Waikato 70% of all Pacific peoples were born in New Zealand

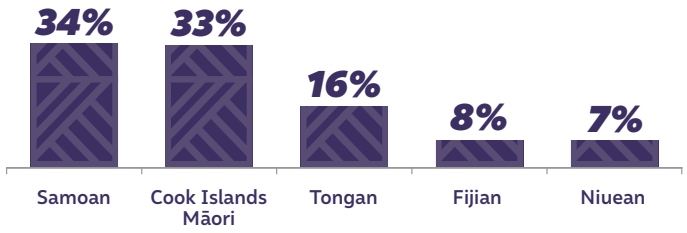
Proportion of Pacific peoples living in New Zealand born in New Zealand, 2013



(National data)

Āiga ma le aganu'u | Family & Culture

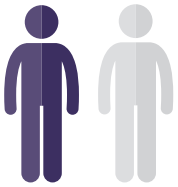
The largest Pacific ethnic groups in the Waikato are:



1 in 3 Pacific peoples speak two or more languages

(33%, 2013)

(Pacific peoples in New Zealand 44%)

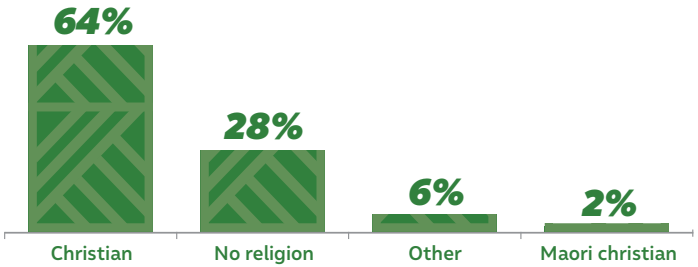


Over half of Pacific peoples also identify with another ethnicity that is not Pacific

(54%, 2013)

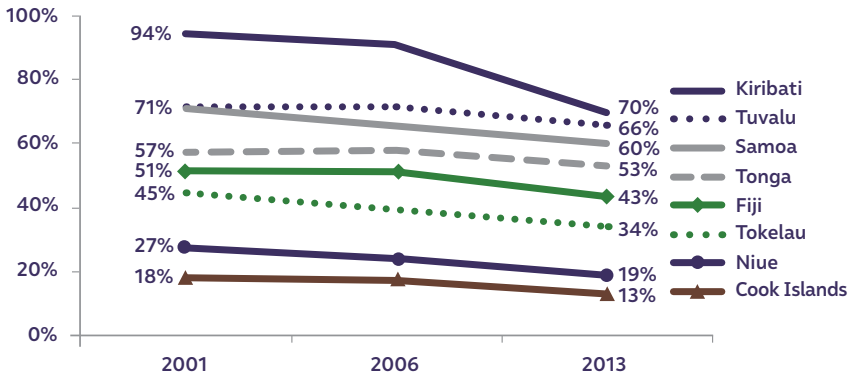
The majority of Pacific peoples are Christian

(64%, 2013)

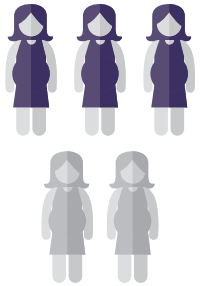


The proportion who speak a Pacific language are decreasing

(National data)



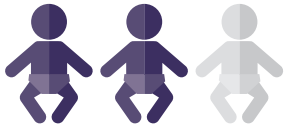
Āiga ma le aganu'u | Family & Culture



3 in 5 Pacific women register with a Lead Maternity Carer in the first trimester of pregnancy

(59%, 2015) ⬆ from 51% in 2011

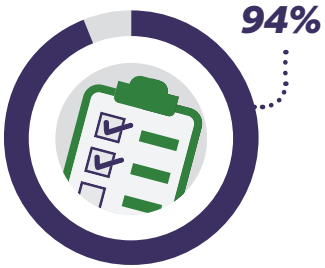
(Māori 58%, Other 78%)



2 in 3 Pacific new-borns are enrolled with a GP by three months

(68%, 2015) ⬆ from 60% in 2014

(Māori 74%, total DHB 70%)



Most Pacific peoples are enrolled with a Primary Health Organisation

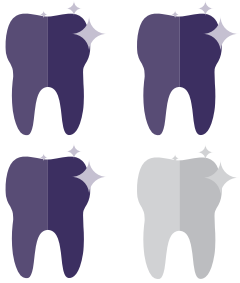
(94%, 2016)

(Māori 92%, Other 96%)

2 in 10 Pacific primary care patients visit their GP each year

(21%, 2015/16)

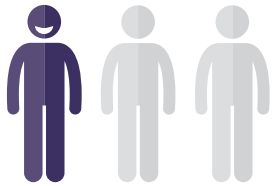
(Māori 30%, Other 17%)
(Hauraki PHO)



3 in 4 Pacific children aged 5 and under are enrolled with community oral services

(75%, 2015) ⬆ from 68% in 2013

(Māori 61%, Other 72%)
(National Data)



1 in 3 Pacific adults has visited a dental care clinic in the last 12 months

(31%, 2014/15) ⬇ from 35% in 2006/07

(Māori 38%, Other 53%)
(National Data)

Āiga ma le aganu'u | Family & Culture

1 in 2 Pacific women are exclusively and fully breastfeeding at 3 months

(50%, 2015) ↓ from 57% in 2013

(Māori 43%, total DHB 54%)

Almost all Pacific women are smoke free during pregnancy

(94%, 2015) ↑ from 91% in 2011

(Māori 65%, Other 92%)

2 in 3 Pacific women (50-69 years) go for their breast screening

(63%, 2016) Stable since 2014

(Māori 59%, Other 68%)

78% of Pacific women (25-69 years) go for their cervical screening

(2016) ↑ from 76% in 2014

(Māori 65%, Other 81%)

2 in 3 Pacific 4-year olds receive a before school check

(66%, 2015) ↓ from 77% in 2014

(Māori 77%, total DHB 92%)

9 in 1,000 Pacific Primary care patients access podiatry services each year

(2015/16)

(Māori 9, Other 7)
(Hauraki PHO)

Yago
Body

"Tu i kete na tata – Ni sa tawa na kete sa qai rawa ni qaravi na itavi se cakacaka
Ni sa qaravi vinaka na bula ni dua na tamata, na bula vakayago, nai tuvaki ni bula e loma, na tiko bulabula kei na kena veiqaravi salavata, sa na basika na bula vinaka e taucoko"

Tu i – The pivotal point or space for interaction
Kete – means the stomach
Na tata – the actual activity/actual cutting

This proverb literally means that when the physical need of a person is nourished well the other aspects of his or her life continue to develop and grow. In this contextual Fijian perspective, the garden and its harvest are important for the physical wellbeing of the community. The "Tata" – symbolises the collective activity in the garden (were) such as cleaning, maintaining, and gathering the harvest for the good nourishment of the 'kete' (stomach) and for people to have good health and wellbeing.

(Fijian proverb)

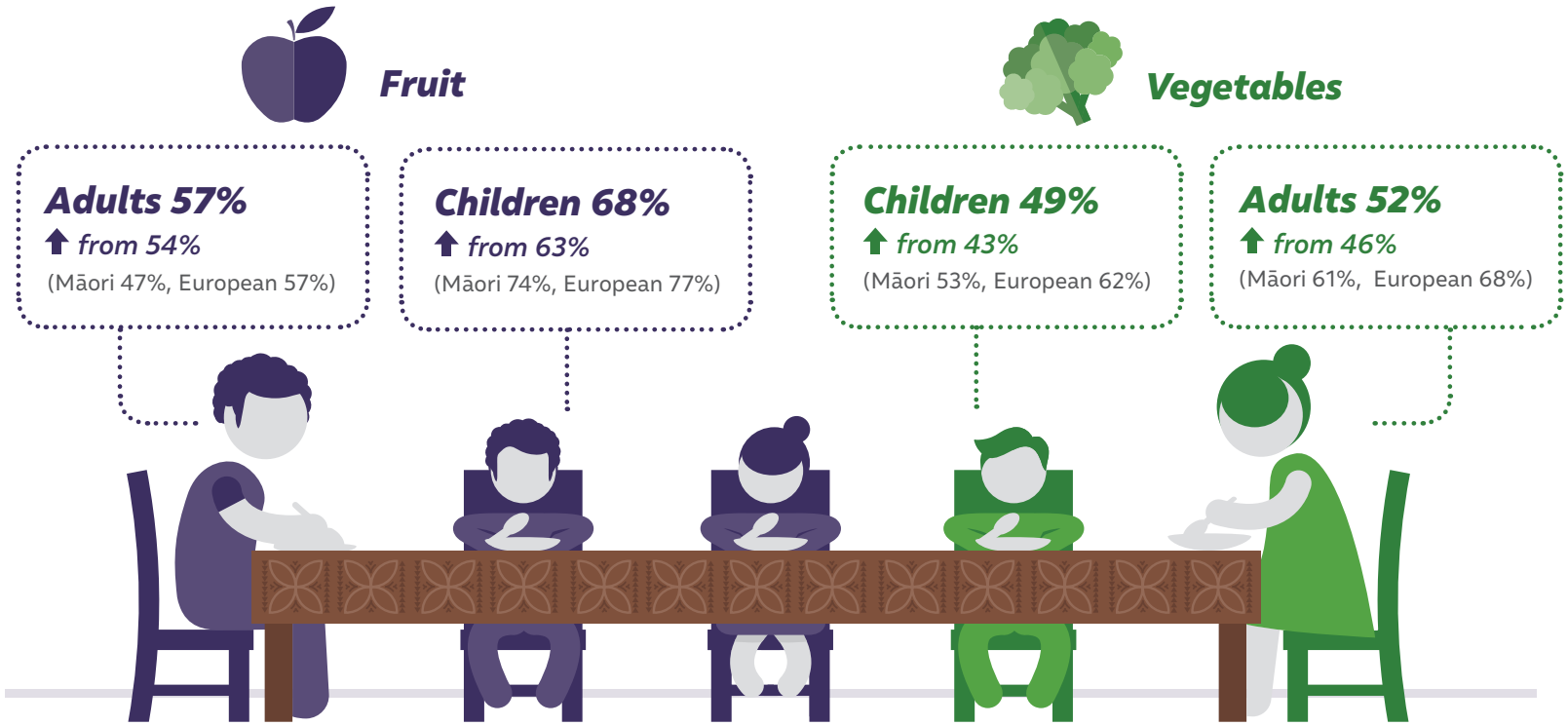
13

Yago | Body

Nutrition

More Pacific peoples meet the recommended fruit and vegetable intake guidelines

2011/12 - 2014/15



(National data)

Yago | Body

Many adults are physically active

(2014/15, national data)

Body size

2006/07-2014/15

Healthy weight

(BMI 24 and under)

Children 36%
↓ *from 44%*
(Māori 56%, European 67%)

Adults 10%
↓ *from 11%*
(Māori 22%, European 33%)

Overweight

(BMI 25-29)

Children 33%
↑ *from 31%*
(Māori 27%, European 20%)

Adults 23%
↓ *from 25%*
(Māori 30%, European 36%)

Obese

(BMI 30 and over)

Children 30%
↑ *from 23%*
(Māori 15%, European 8%)

Adults 66%
↑ *from 63%*
(Māori 47%, European 29%)

Note: Māori and Pacific-specific BMI limits have not been utilised.
Adults = 15 years and over, Children = 2-14 years, BMI for children is an equivalent of adult BMI

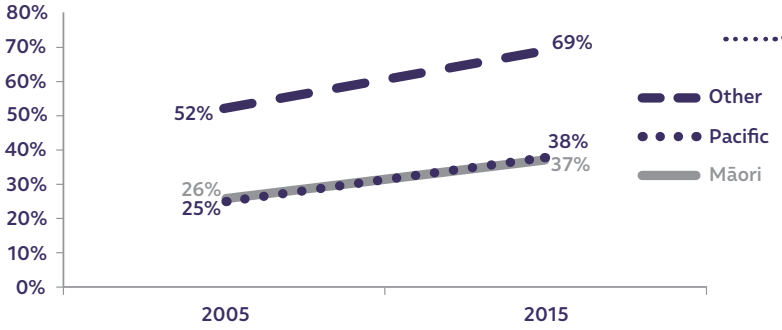
(National data)

Yago Body

Children

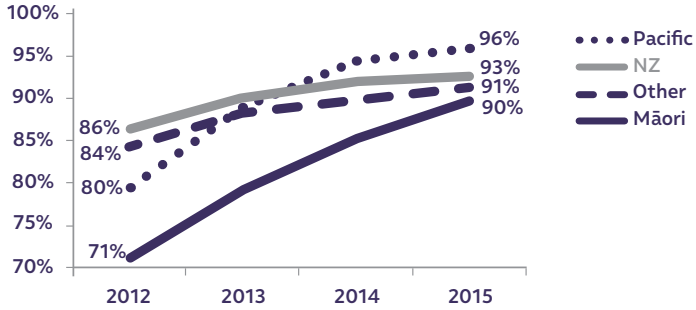
More Pacific 5-year olds are free of tooth cavities

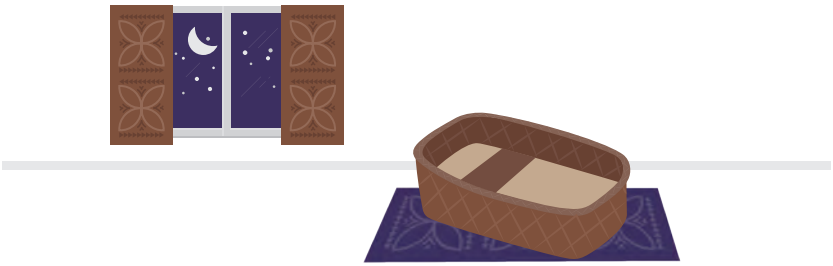
Percentage of five-year-olds free of tooth cavities, Waikato DHB, 2005-2015



The immunisation coverage among Pacific children is high

Immunisation coverage at 8 months of age, by ethnicity, Waikato DHB, 2012-2015





Sudden unexpected death in infancy (SUDI) for Pacific children is declining

⬇ *from 1.0 to 0.9 per 1,000 live births 2000-2011*

(Māori 2.1, Other 0.4)
(National data)

Yago | Body

Smoking, Alcohol and Drugs

Fewer Pacific smoke in 2013 than in 2006

30% 2006

23% 2013

Female Adults 23%

(Māori 37%, Other 12%)

31% 2006

20% 2013

Female Youth 20%

(Māori 32%, Other 10%)

30% 2006

25% 2013

Male Adults 25%

(Māori 32%, Other 14%)

27% 2006

21% 2013

Male Youth 21%

(Māori 29%, Other 14%)

Pacific peoples use less cannabis (2%) and amphetamine (0.2%) compared to other ethnic groups

(Māori 11%, 3%, European 4%, 1%)
(National Data)

Males 35%

Females 14%

Hazardous drinking: more common in men *(2014/15)*

(Māori males 38%, Other males 26%)
(National Data)

* Regular kava drinking for recreational use is increasing among Pacific communities in New Zealand

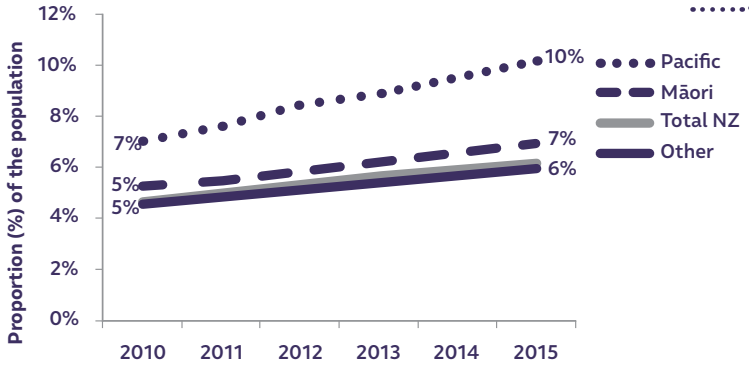
(Adults: 15 years and over. Youth: 15-24 years)

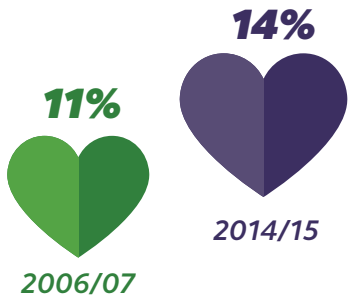
Yago | Body

1 in 10 Pacific adults have diabetes (type 1 & 2)

(2015)

Estimated diabetes prevalence, Waikato DHB, 2010-2015





More Pacific adults are medicated for high blood pressure

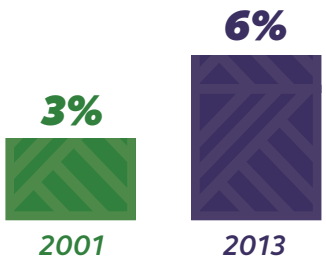
(14%, 2014/15)

(Māori 13%, European 17%)
(National data)

20% of Pacific patients in primary care have asthma

(2016)

(South Waikato HPO, Tokoroa)



6% of Pacific adults are diagnosed with gout

(2014/15)

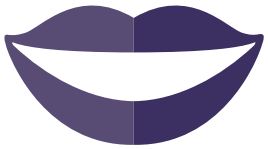
(Māori 5%, European 3%)

Yago | Body

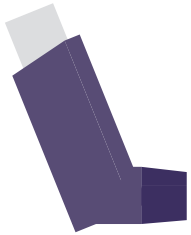
Hospital Admissions

For every 1,000 Pacific children (0-14 years) each year:

34 are admitted for respiratory infections
(Māori 28, Other 16)



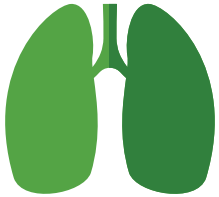
15 are admitted for tooth and gum disease
(Māori 13, Other 10)



7 are admitted for asthma
(Māori 6, Other 3)

(2013/15)

For every 1,000 Pacific adults (45 years and over) each year:



11 are admitted for chronic obstructive pulmonary disease
(Māori 17, Other 6)

10 are admitted for ischaemic heart disease
(Māori 7, Other 9)

7 are admitted for type 2 diabetes
(Māori 9, Other 3)

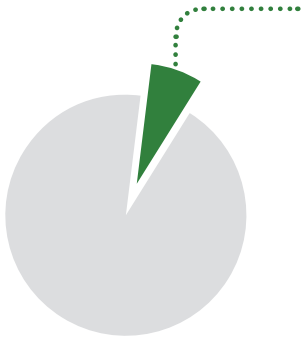
(2013/15)

Yago Body

Hospital Admissions

ASH* events 2015/16:

11% of Pacific children (0-4 years) admitted each year



7% of Pacific adults (45-64 years) admitted each year

* ASH (Ambulatory Sensitive Hospital Admissions) are mostly acute admissions that are considered potentially reducible through interventions delivered in primary care. E.g. COPD, respiratory infections, dental conditions.

Hospital admissions for acute rheumatic fever:

⬆ *from 21 to 28 per 100,000 2004/06-2013/15*

(Māori 14, Other 0.2)

Manako e te Pukuatu
Mind & Heart

"Kia pukuru O vaevae,
kia mokora O kaki
E tiro te mata ia O Rongo"

"With a strong mind
A searching heart
Look ahead to God"

This Cook Islands proverb is used in all settings and highlights the fundamentals of wellbeing – in that if your heart, mind and soul are one with your environment, then you are cognisant of the values that shape us into the people that we are. Our village life is built upon these foundational elements that are entrenched in our cultural practices, and customs. Our central belief is based on our spirituality and encompasses both traditional and contemporary. We are encouraged to hold on to those things that were intended for us, but also to look forward to those things that will ensure our prosperity and quality of life.

(Cook Islands proverb)

Manako e te Pukuatu | Mind & Heart

1 in 10 Pacific peoples report pyschological distress

(10%, 2014/15) ⬇ from 13% in 2006/07

(Māori 10%, European 6%)
(National data)

During a year 2 in 1,000 Pacific adults (15-44 years) are hospitalised for schizophrenia (2013/15)

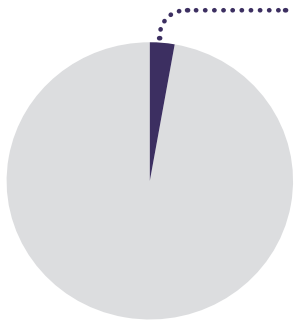
⬇ *from 3 in 2008/2010*

(Māori 5, Other 1)

2% of Pacific children (2-14 years) are diagnosed with emotional or behavioural problems (2014/15)

(Māori 5%, European 5%)
(National data)

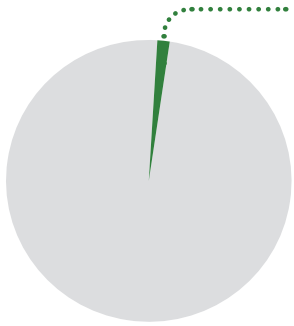
Service access among Pacific peoples:



3.48% access DHB mental health services (2015)

⬆ *from 1.54% in 2005/06*

(total NZ 3.48%)



1.4% access DHB alcohol and drug services (2015)

⬆ *from 1% in 2012/13*

(Total NZ 1%)

Ako Faka'atamai
Intellect & Learning

"Filihia mo e 'elili"
"Fishing beyond the rough seas with perseverance"

The theme "Filihia moe 'elili" is an old Tongan proverb that depicts the story of the fishing trail for a particular sea snail called "elili" known as "common periwinkle".

Periwrinkle is known for its delightful and its endorsed flavour. These tasty edible sea snails unfortunately are found on rocky shores in the higher intertidal zone, an environment of harsh extremes and tidal excursion.

Filihia conveys the challenges one faces against the rough waves to get to the periwinkles and to ensure they return with it safely to shore.

The theme metaphorically encapsulates our journey through intellectual and learning pursuits and reminds us to handle with "perseverance" the rough seas, trials, tribulations and our sacrifices towards a worthwhile end. Ke tau "kataki" pea mei he kataki, 'a e lava 'o e 'ahi'ahi; pea mei he lava 'o e 'ahi'ahi 'a e fakatu'amelie moe ikuna.

(Tongan proverb)

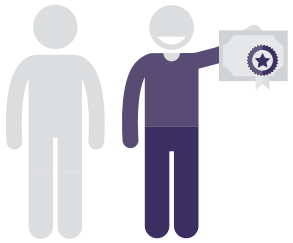
Ako Faka'atamai | Intellect & Learning

More Pacific peoples with qualifications

64% 2006

70% 2013

(Māori 64%, Other 78%)



1 in 2 Pacific peoples with a level 2 certificate or higher

(55%, 2013) Up from 49% in 2006

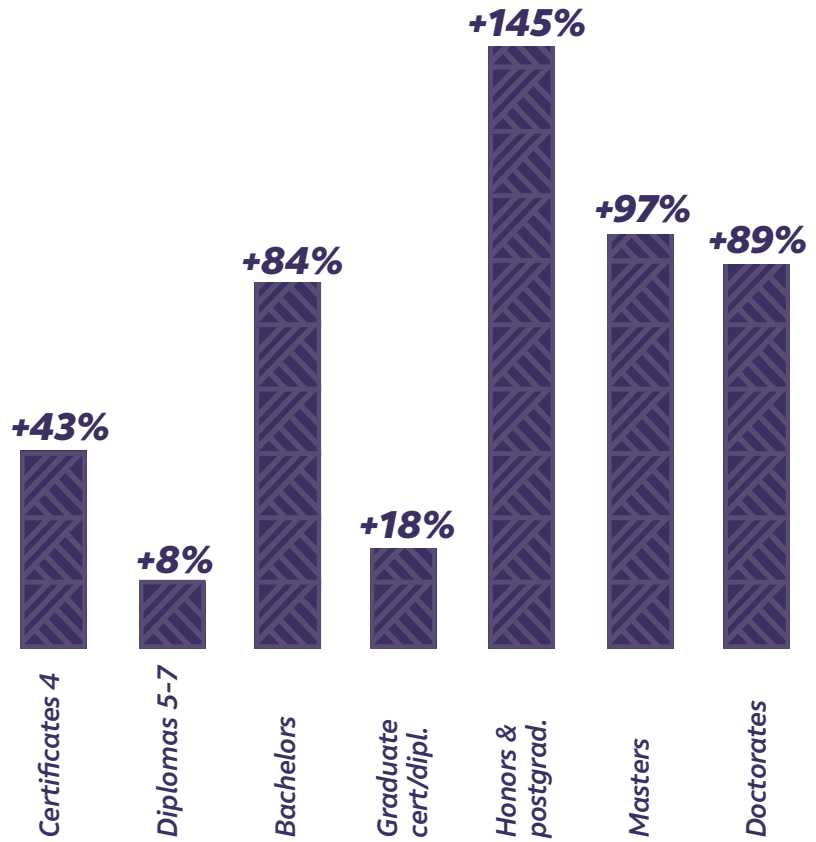
(Māori 48%, Other 65%)

More Pacific students are enrolled in tertiary education

⬆ *by 27% 2005-2015*

(National data)

Increase in tertiary education enrolment 2005-2015



8.1

Buoka ao Kairiri
Resources & Leadership

"E mwaiti kanana te ben"
"One who has eaten many coconuts"

A Kiribati proverb often used in formal and informal gatherings, to remind the community about the value of leadership and drawing on the wisdom of elders of the village, who understood life in its totality *(eaten many coconuts)* and are as resilient as *'te ben'* itself.

It takes proper care and the right resources to let the coconut fruit reach maturity. *Te ben (mature coconut fruit)*, has multiple uses: as a domestic resource (providing food, livestock feed, ingredient for cooking, firewood, sennet, *te kora* and oil for the body), a source of revenue and a source of new life (when it germinates into a young coconut tree), thus a vital resource for the community.

The theme metaphorically describes the importance of cultural values, environmental consciousness, and working together effectively with leaders in our communities and key partners, in achieving self-reliance *(toronibwai)* and wellbeing *(maiu raoi)*.

(Kiribati proverb)

Buoka ao Kairiri | Resources & Leadership

$390

$485

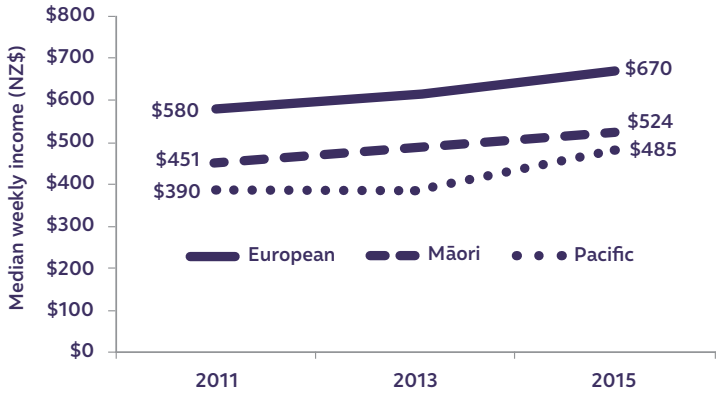
2011 2015

Median weekly income for Pacific peoples $485

⬆ *by 24% since 2011*

(Māori $524, Other $670)
(National data)

Median weekly income by ethnic group, New Zealand, 2011-2015



69%

Proportion of Pacific adults active in the labour market

⬆ *from 67% in 2008*

(Māori 64%, European 69%)

The Pacific unemployment rate:

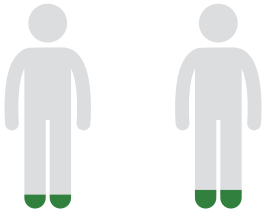
16% 21%

2008 2015

Youth (15-24 years) 21%

(Māori 22%, European 11%)

6% 8%



2008 2015

Adults (15 years and over) 8%

(Māori 13%, European 4%)

Buoka ao Kairiri | Resources & Leadership

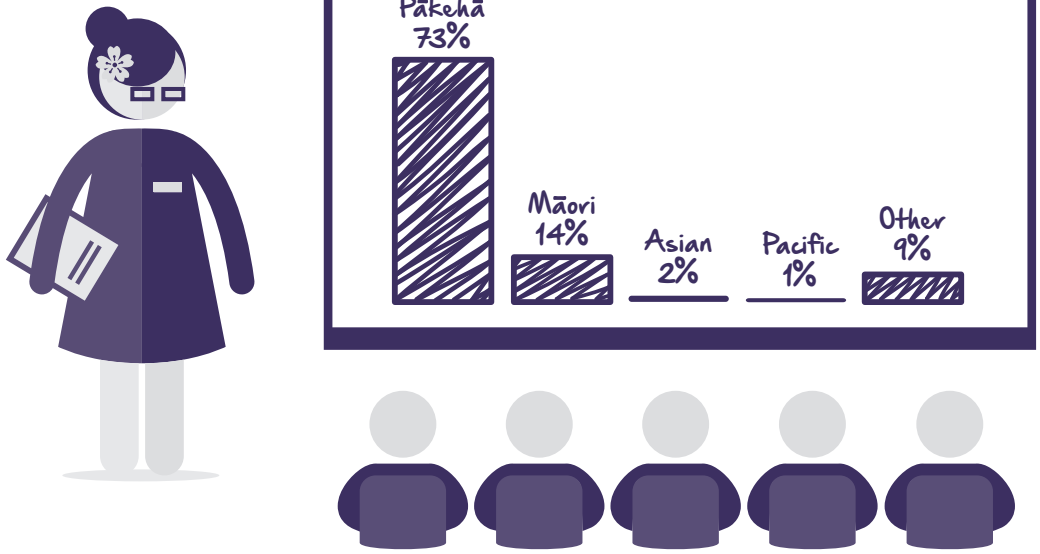
Pacific peoples in the New Zealand health workforce:

2%
Nursing
(2015)

1%
Dentist
(2012)

2%
Midwife
(2015)

3%
Doctor
(2014)



Teachers who are Pacific make up 1% of Waikato region's teachers
(in state or stated integrated schools) (2015)
(3% in New Zealand)

Buoka ao Kairiri | Resources & Leadership

8.1

Pacific peoples and housing:

20%

Tenure holders who own their house

(Māori 26%, Other 56%)
(National data)

40%

Households who live in crowded housing

(Māori 20%, Other 6%)
(National data)

49%

People who live in an area of high deprivation

(NZDep 9-10)

(Māori 44%, Other 20%)

Buoka ao Kairiri | Resources & Leadership

Barriers to accessing health services

Report not going to GP due to costs:

Children

2006/07 — 2014/15

(Māori 8%, European 6%)

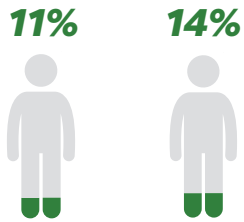
Adults

2006/07 — 2014/15

(Māori 20%, European 13%)

Avoid filling a prescription due to costs:

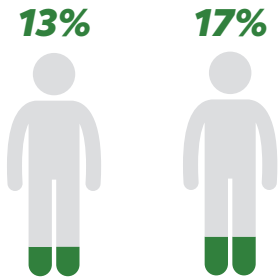
Children



2006/07 — 2014/15

(Māori 8%, European 4%)

Adults



2006/07 — 2014/15

(Māori 15%, European 5%)

Children = 2-14 years, Adults = 15 years and over

Tables

Tables

Āiga ma le aganu'u | Family & Culture

Population demographic statistics for Pacific peoples, Māori and Other adults in Waikato DHB.

Setting the scene	Pacific peoples				Māori	Other	NZ	Pacific vs. Other	
	Past	Recent	Trend	Change in %	Recent	Recent	Recent	Rate ratio	Difference in %
Population (*n*) 2001-2013[1]	10,470	15,610	↑	49%	84,960	277,370	4,442,100	0.1	-94%
New babies born (number) 2011-2015[2]	207	187	↓	-10%	1,858	3,243	58,954	0.1	-94%
Under 5 years old (%) 2001-2013[1]	16%	15%	↓	-3%	12%	6%	7%	2.7	171%
Under 15 years old (%) 2001-2013[1]	41%	39%	↓	-6%	34%	17%	20%	2.3	129%
Under 25 years old (%) 2001-2013[1]	59%	58%	↓	-2%	53%	30%	35%	2.0	96%
Over 65 years old (%) 2001-2013[1]	2%	2%	=	0%	5%	18%	14%	0.1	-87%
Male life expectancy at birth (years) 1996-2013[3]	71.8	74.5	↑	4%	73.0	80.3	79.5	0.9	-7%
Female life expectancy at birth (years) 1996-2013[3]	77.0	78.7	↑	2%	77.1	83.9	83.2	0.9	-6%
New Zealand born 2001-2013[4]	71%	70%	↓	-1%	98%	78%	75%	0.9	-10%

Notes: Other = non-Māori and non-Pacific. [1]Statisitcs NZ, Estimated resident population (ERP), subnational population by ethnic group, age, and sex. [2]Ministry of Health: National Maternity Collection [3]Statistics NZ, Infoshare, Life Expectancy at Birth, Maori Ethnic Group Population by Sex (Annual-Dec). National data. [4]Statistics NZ, 2013 Census data. **Trend:** direction of change over the time period (↑/↓/ = increase/decrease/no change). **Change in %**: change in percent for the most recent rates compared to the past. **Rate ratio:** Other (=non-Maori/Pacific) is held as reference category. A rate ratio of 2 means the Pacific rate is 2 times higher than the Other rate. **Difference in %**: shows how much bigger/smaller in percent the Pacific rate is compared to Others. **NZ:** rate for total NZ (all ethnic groups).

Āiga ma le aganu'u | Family & Culture

Ethnic group belonging for Pacific peoples in Waikato DHB and New Zealand, 2001-2013.

Ethnic group belonging[1]	Waikato DHB					New Zealand				
	Pacific peoples					Pacific peoples				
	2001		2013		2001-2013	2001		2013		2001-2013
	No.	%	No.	%	Trend	No.	%	No.	%	Trend
Samoan	2,793	30%	4,389	34%	↑	115,017	50%	144,141	49%	↑
Cook Islands Māori	3,978	42%	4,314	33%	↑	51,486	22%	61,077	21%	↑
Tongan	1,305	14%	2,142	16%	↑	40,719	18%	60,333	20%	↑
Fijian	408	4%	978	8%	↑	7,041	3%	14,445	5%	↑
Niuean	732	8%	903	7%	↑	20,148	9%	23,883	8%	↑
Other Pacific peoples	480	5%	501	4%	↑	4,218	2%	4,866	2%	↑
Kiribati	69	1%	324	2%	↑	648	0%	2,115	1%	↑
Tokelauan	90	1%	141	1%	↑	6,204	3%	7,173	2%	↑
Tahitian	66	1%	81	1%	↑	1,200	1%	1,407	0%	↑
Pacific peoples	33	0%	81	1%	↑	678	0%	1,026	0%	↑
Tuvaluan	30	0%	66	1%	↑	1,965	1%	3,537	1%	↑
Total Pacific peoples	9,372	100%	13,038	100%	↑	231,798	100%	295,944	100%	↑

Notes: [1]Statistics NZ, 2013 Census data: Dataset: Ethnic group (total responses), for the census usually resident population count, 2001, 2006, and 2013 Censuses (RC, TA, AU) Waikato DHB includes all of Waikato District and Ruapehu District (due to otherwise missing data because of small numbers) **No.** Number of people who belong that ethnic group. **%:** Proportion of Pacific people who belong to that ethnic group.

Āiga ma le aganu'u | Family & Culture

Number of languages spoken by Pacific peoples in Waikato DHB compared to New Zealand, 2001-2013.

Number of languages spoken by Pacific peoples[2] (% of total Pacific population)	Waikato DHB			New Zealand		
	Pacific people			Pacific people		
	2001	2013	2001-2013	2001	2013	2001-2013
	%	%	Trend	%	%	Trend
One	61%	63%	↑	48%	52%	↑
Two	27%	30%	↑	42%	41%	↓
Three or more	7%	3%	↓	6%	3%	↓

Notes: [2]Statistics NZ, dataset: Ethnic group (grouped total responses) by number of languages spoken, for the census usually resident population count, 2001, 2006, and 2013 (RC, TA, AU). Waikato DHB includes all of Waikato District and Ruapehu District (due to missing data because of small numbers)

The number and proportion of fluent Pacific language speakers, New Zealand, 2001-2013.

Fluent Pacific language speakers[3]	New Zealand					
	Pacific peoples					
	2001		2013		2001-2013	
	No.	%	No.	%	Trend no.	Trend %
Samoa	81,036	71%	86,403	60%	↑	↓
Cook Islands	9,372	18%	8,121	13%	↓	↓
Tonga	23,046	57%	31,839	53%	↑	↓
Niue	5,478	27%	4,545	19%	↓	↓
Fiji	3,588	51%	6,273	43%	↑	↓
Tokelau	2,808	45%	2,469	34%	↓	↓
Tuvalu	1,398	71%	2,349	66%	↑	↓
Kiribati	609	94%	1,476	70%	↑	↓

Notes: [3]National data. Statistics NZ, dataset: 'Languages spoken (detailed total responses) For the census usually resident population count '2001, 2006, and 2013. **No.** number of people who speak that language. **%:** Proportion of people within that ethnic group who speak that language.

Āiga ma le aganu'u | Family & Culture

Health indicator statistics for Pacific peoples, Māori and Other adults in Waikato DHB.

Family indicators	Pacific peoples				Māori	Other	NZ	Pacific vs. Other	
	Past	Recent	Trend	Change in %	Recent	Recent	Recent	Rate ratio	Difference in %
Birth rate (per 1,000 population), 2011-2015[1]	15.6	14.1	↓	-10%	25.2	14.7	13.9	1.0	-5%
Registration with LMC in 1st trimester 2011-2015[1]	51%	59%	↑	15%	58%	78%	65%	0.8	-25%
PHO enrolment 2015-2016[2]	89%	94%	↑	6%	92%	96%	95%	1.0	-2%
PHO enrolled patients with a GP visit each year, 2014/15-2015/16[3]	14%	21%	↑	50%	30%	17%	-	1.2	24%
PHO enrolled patients who access podiatry each year, 2014/15-2015/16[3]	1%	1%	↓	0%	1%	1%	-	1.0	0%
New-borns enrolled with a GP by 3 months, 2014-2015[4]	60%	68%	↑	14%	74%	70%	70%	1.0	-2%
Children participate in early childhood education (ECE), 2014-2015[4]	96%	96%	↓	0%	95%	97%	96%	1.0	-1%
Four-year-olds receive a B4 School Check, 2014-2015[4]	77%	66%	↓	-15%	77%	92%	93%	0.7	-29%
Under five-year-olds enrolled in community oral services, 2013-2015[4,4b]	68%	75%	↑	10%	61%	72%	76%	1.0	4%
Breastfeeding exclusive and full at 3 months 2013-2015[4]	57%	50%	↓	-12%	43%	54%	55%	0.9	-7%
Breastfeeding (any) at 6 months 2013-2015[4]	70%	57%	↓	-19%	50%	60%	66%	1.0	-5%
Smoke free in pregnancy 2011-2015[1]	91%	94%	↑	3%	65%	92%	86%	1.0	2%
Dental care visit in the last 12 month (15+ years), 2006/07-2014/15[5]	35%	31%	↓	-10%	38%	53%	48%	0.6	-41%
Breast screening (50-69 years), 2014-2016[6]	64%	63%	↓	-2%	59%	68%	71%	0.9	-8%
Cervical screening (25-69 years), 2014-2016[7]	76%	78%	↑	3%	65%	81%	76%	1.0	-4%

Notes: Other = non-Māori and non-Pacific. [1]Ministry of Health: National Maternity Collection. LMC= Lead Maternity Carer. [2]Ministry of Health: Enrolment in a primary health organisation (PHO): Access to primary care. [3]Hauraki PHO, primary care data. Proportion of enrolled patients. [4]Ministry of Health: Well Child Tamariki Ora (WCTO) quality improvement framework. GP= General Practitioner. National data for Pacific and Maori. Other = Total Waikato DHB. [4b]National data. [5]Ministry of Health: NZ Health Survey. National data. Ethnicity group "Other" = Europeans/Other (Asians not included).[6]Ministry of Health. July 2016. BSA District Health Board Coverage Report: period ending 30 June 2016. Wellington: Ministry of Health. [7]Ministry of Health. October 2016. NCSP New Zealand District Health Board Coverage Report: period ending 30 September 2016. Wellington: Ministry of Health. Other = excluding Asians. **Trend:** direction of change over the time period (↑/↓/ = increase/decrease/no change). **Change in %**: change in percent for the most recent rates compared to the past. **Rate ratio:** Other (=non-Maori/Pacific) is held as reference category. A rate ratio of 2 means the Pacific rate is 2 times higher than the Other rate. **Difference in %:** shows how much bigger/smaller in percent the Pacific rate is compared to Others. **NZ:** rate for total NZ (all ethnic groups).

Āiga ma le aganu'u | Family & Culture

Religious affiliation by Pacific peoples in Waikato DHB compared to New Zealand, 2001-2013.

Religious affiliation[4] (% of total stated Pacific population)	Waikato DHB					New Zealand			
	Pacific peoples			Māori	Other	Pacific peoples			Total people
	2001	2013	2001-2013	2013	2013	2001	2013	2001-2013	2013
	%	%	Trend	%	%	%	%	Trend	%
Christian	71%	64%	↓	38%	48%	82%	77%	↓	48%
Māori christian*	2%	2%	↓	7%	0%	1%	1%	↓	1%
Other	8%	6%	↓	6%	9%	5%	4%	↓	9%
No religion	20%	28%	↑	49%	43%	12%	17%	↑	42%

Notes: [4]Statistics NZ, 2013 Census data: Dataset: Selected ethnic groups (total responses) by religious affiliation (total responses), for the census usually resident population count, 2001, 2006, and 2013 Censuses (RC, TA, AU) Waikato DHB includes all of Waikato District and Ruapehu District (due to missing data because of small numbers).

*Includes Ratana and Ringatū. People who did not want to answer this question are not included in this table, thus the percentage does not add up to 100.

Yago | Body

Nutrition and physical activity statistics for Pacific children and adults in Waikato DHB, 2006-2015.

Nutrition and physical activity	Pacific peoples				Māori	Europeans	NZ	Pacific vs. Europeans	
Children 2-14 years	Past	Recent	Trend	Change in %	Recent	Recent	Recent	Rate ratio	Difference in %
Meet fruit intake guidelines, 2011/12-2014/15[1]	63%	68%	↑	8%	74%	77%	75%	0.9	-12%
Meet vegetable intake guidelines, 2011/12-2014/15[1]	43%	49%	↑	15%	53%	62%	57%	0.8	-20%
Healthy weight at 4 years, 2014-2015[2]	63%	53%	↓	-16%	59%	68%	70%	0.8	-23%
Healthy weight, 2006/07-2014/15[1]	44%	36%	↓	-19%	56%	67%	63%	0.5	-47%
Overweight (but not obese), 2006/07-2014/15[1]	31%	33%	↑	4%	27%	20%	22%	1.6	63%
Obese (class 1, 2,3), 2006/07-2014/15[1]	23%	30%	↑	29%	15%	8%	11%	3.9	286%
Obese class 2-3, 2006/07-2014/15[1]	11%	14%	↑	26%	6%	3%	4%	5.5	454%
Active transport to school (walk, bike, etc.) 2006/07-2014/15[1]	54%	44%	↓	-18%	43%	41%	41%	1.1	8%
Adults 15 years and over									
Meet fruit intake guidelines, 2011/12-2014/15[1]	54%	57%	↑	6%	47%	57%	55%	1.0	1%
Meet vegetable intake guidelines, 2011/12-2014/15[1]	46%	52%	↑	15%	61%	68%	65%	0.8	-24%
Physically active (30 min/day), 2006/07-2014/15[1]	49%	54%	↑	11%	53%	52%	51%	1.1	5%
Healthy weight (BMI 18.5-24.9), 2006/07-2014/15[1]	11%	10%	↓	-10%	22%	33%	33%	0.3	-69%
Overweight (but not obese) (BMI 25-29), 2006/07-2014/15[1]	25%	23%	↓	-7%	30%	36%	35%	0.6	-37%
Obese (class 1-3) (BMI 30+), 2006/07-2014/15[1]	63%	66%	↑	4%	47%	29%	31%	2.3	127%
Obese (class 3) (BMI 40+), 2006/07-2014/15[1]	16%	20%	↑	26%	10%	4%	5%	4.6	357%

Notes: [1]Ministry of Health: NZ Health Survey. National data. Child weight is classified as the equivalent of adult BMI: healthy weight (18.5-24.9), Overweight but not obese (25-29.9), Obese (30 or greater), Obesity class 1 (30-34.9), class 2-3 (35 or greater). [2]Ministry of Health: Well Child Tamariki Ora (WCTO) quality improvement framework. 2015 = Jul-Dec. Data for Europeans not available, data presented is for total Waikato DHB. **Trend:** direction of change over the time period (↑/↓/ = increase/decrease/no change). **Change in %**: change in percent for the most recent rates compared to the past. **Rate ratio**: Other (=non-Maori/Pacific) is held as reference category. A rate ratio of 2 means the Pacific rate is 2 times higher than the Other rate. **Difference in %**: shows how much bigger/smaller in percent the Pacific rate is compared to Others. **NZ:** rate for total NZ (all ethnic groups).

Yago | Body

Health indicator statistics for Pacific children and adults in Waikato DHB.

Health indicators	Pacific peoples				Māori	Other	NZ	Pacific vs. Other	
Children 0-14 years	Past	Recent	Trend	Change in %	Recent	Recent	Recent	Rate ratio	Difference in %
Immunisation at 8 months, 2012-2015[1]	80%	96%	↑	20%	90%	91%	93%	1.1	5%
SUDI per 1,000 live births per year, 2000-2011[2]	1.0	0.9	↓	-10%	2.1	0.4	1.0	2.3	125%
Caries free at age 5, 2005-2015[3]	25%	38%	↑	52%	37%	69%	59%	0.6	-45%
Mean DMFT at age 5, 2005-2015[3]	4.4	3.1	↓	-30%	2.9	1.3	1.8	2.4	138%
Adults 15 years and over									
Diabetes prevalence, total population, 2010-2015[4]	7%	10%	↑	45%	7%	6%	6%	1.7	67%
Medicated for high blood pressure, 15+, 2006/07-2014/15[5]	11%	14%	↑	36%	13%	17%	16%	0.8	-17%
Arthritis (diagnosed), 2006/07-2014/15[5]	8%	14%	↑	72%	14%	19%	17%	0.7	-28%
Gout (diagnosed), 2006/07-2014/15[5]	3%	6%	↑	133%	5%	3%	1%	2.4	142%
Regular smoking, males, 2006-2013[6]	30%	25%	↓	-17%	32%	14%	16%	1.7	72%
Regular smoking, females, 2006-2013[6]	30%	23%	↓	-25%	37%	12%	14%	2.0	99%
Youth smoking, males, 15-24 years, 2006-2013[6]	27%	21%	↓	-22%	29%	14%	17%	1.5	48%
Youth smoking, females, 15-24 years, 2006-2013[6]	31%	20%	↓	-37%	32%	10%	15%	1.9	93%
Hazardous drinking, males, 2006/07-2014/15[5]	34%	35%	↑	3%	38%	26%	25%	1.3	35%
Hazardous drinking, females, 2006/07-2014/15[5]	14%	14%	↓	-2%	27%	11%	11%	1.3	30%
Amphetamine use*, 15-64 years, 2013/14-2015/16[7]	0.5%	1.2%	↑	140%	2.9%	1.3%	1.1%	0.9	-8%
Cannabis use at least weekly, 15-64 years, 2014/15[8]	-	2%	-	-	11%	4%	4%	0.7	-33%

Notes: Other = non-Māori and non-Pacific. [1]Ministry of Health: National Immunisation Register (NIR). [2]Ministry of Health: National Mortality Collection, foetal and infant deaths. Average annual national rate, 2001-2005, 2006-2011. SUDI = sudden unexpected death in infancy. [3]Ministry of Health: Oral health data and statistics. DMFT = decayed, missing and filled teeth. [4]Ministry of Health: Virtual Diabetes Register. Type 1& 2 diabetes. [5]Ministry of Health: NZ Health Survey. National data. Ethnicity group "Other"= European. [6]Statisitcs NZ, 2013 census data. [7]Ministry of Health: Amphetamine Use 2015/16: New Zealand Health Survey. *Use in the last year. [8]Ministry of Health: Cannabis Use 2012/13: New Zealand Health Survey.

Yago | Body

Average annual number and age- and ethnicity-specific hospital admission rates (per 100,000 people) for (selected) common diseases in the Waikato DHB Pacific population, children and adults, 2004-2015.

Hospital admission rates per 100,000 population[1]	Pacific peoples					Māori		Other		Other vs. Pacific	
	2004-2006		2013-2015		2004-2015	2013-2015		2013-2015		2013-2015	
	Annual average					Annual average		Annual average		Annual average	
Infants & children 0-14 years	No.	Rate	No.	Rate	Trend	No.	Rate	No.	Rate	Rate ratio	Difference in %
Respiratory infections	36	1475.4	110	3363.9	↑	840	2843.6	812	1644.7	2.0	105%
Tooth and gum disease	21	847.0	48	1478.1	↑	390	1321.4	495	1003.3	1.5	47%
Asthma	15	601.1	24	733.9	↑	175	593.5	164	331.5	2.2	121%
Gastroenteritis	7	300.5	18	550.5	↑	103	349.8	272	550.3	1.0	0%
Adults 45 years and over											
COPD	11	719.0	27	1088.7	↑	339	1689.1	830	642.7	1.7	69%
Type 2 diabetes	16	1067.5	19	752.7	↓	177	880.3	384	297.0	2.5	153%
Heart failure	8	501.1	14	564.5	↑	170	845.4	541	418.8	1.3	35%
Ischaemic heart disease	10	675.4	26	1034.9	↑	137	684.3	1169	904.9	1.1	14%
Stroke	6	413.9	13	537.6	↑	102	508.2	581	450.0	1.2	19%
Breast cancer (women)	2	307.0	6	491.8	↑	41	375.2	172	255.6	1.9	92%
Acute rheumatic fever, total population	2	21.4	3	27.8	↑	14	13.8	1	0.2	120.3	11928%

Notes: Other = non-Māori and non-Pacific. [1]Hospital admission data from Waikato DHB hospital register Costpro 2004/06-2013/15 for the Waikato DHB resident population aged 0-14 years and 45 years and over. The denominator for the rates is the projected estimated resident population 2005 and 2014. **No.:** Average number of admissions per year 2004-2006 and 2013-2015. **Rate:** Average annual age-and ethnicity specific rate per 100,000 population (based on Census 2006 and 2013). **Trend**: direction of change between 2004-2006 and 2013-2015 (↑/↓ increase/decrease). **Rate ratio**: Other is held as reference category. A rate ratio of 2 means the Pacific rate is 2 times higher than the Other rate. **Difference in %**: shows how much bigger/smaller in percent the Pacific rate is compared to Other. **Classification of disease (ICD10 codes)**: respiratory infections J00-22, tooth and gum disease K00-08, asthma J55-46, gastroenteritis A00-09, Chronic Obstructive Pulmonary Disease (COPD) J40-44, J47, type 2 diabetes E11, heart failure I50, ischaemic heart disease I20-25, stroke I60-69, breast cancer C50 and acute rheumatic fever I00-02 (crude rate).

8.1

Yago | Body

The most common (selected) ambulatory sensitive hospitalisations (ASH) rates per 100,000 population, children aged 0-4 years, and adults aged 45-64 years, by ethnicity, Waikato DHB, 2012-2016

	Pacific peoples					Māori		Other		NZ	Pacific vs. Other	
	2012-2013		2015-2016		2012-2016	2015-2016		2015-2016		2015-2016	2012-2016	
ASH* rates per 100,000 population[1]	Annual average					Annual average		Annual average				
Children 0-4 years	**No.**	**Rate**	**No.**	**Rate**	**Trend**	**No.**	**Rate**	**No.**	**Rate**	**Rate**	**Rate ratio**	**Difference in %**
ASH rates, all conditions[2]	117	11554.5	141	11176.9	↓	960	9112.5	1064	6678.9	6942.3	1.7	67%
Dental conditions	25	2469.4	33	2609.6	↑	206	1955.4	162	1016.9	967.4	2.6	157%
Respiratory infections	32	3114.6	40	3164.1	↑	254	2411.1	302	1896.8	1844.2	1.7	67%
Gastroenteritis/dehydration	20	1923.3	19	1468.0	↓	115	1086.7	261	1633.8	1268.4	0.9	-10%
Asthma	20	1979.0	18	1430.2	↓	196	1860.5	140	878.6	1334.0	1.6	63%
Cellulitis/dermatitis/eczema	9	889.2	15	1154.2	↑	90	849.6	50	310.9	654.8	3.7	271%
Adults 45-64 years												
ASH rates, all conditions[2]	108	6800.0	145	7293.2	↑	1231	7716.6	2570	3239.4	3716.2	2.3	125%
Angina and chest pain	33	2054.9	42	2103.2	↑	278	1741.9	790	995.5	1062.8	2.1	111%
Pneumonia	11	699.7	13	649.5	↓	81	504.3	126	158.7	230.8	4.1	309%
COPD	7	439.2	12	577.5	↑	166	1037.3	184	231.4	256.2	2.5	150%
Myocardial infarction	7	408.1	7	321.7	↓	43	266.5	171	214.9	308.8	1.5	50%
Stroke	5	285.0	6	272.7	↓	43	270.4	91	114.0	122.8	2.4	139%

Notes: Other = non-Māori and non-Pacific. *ASH rates are seen as avoidable hospital admissions in the sense that they could often have been prevented by treatment in primary care. [1]Ministry of Health: National Minimum Dataset (NMDS), Statistics New Zealand Population Projections.[2] "All conditions" include more than displayed in this table, for a list of all conditions, see http://nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive. ICD 10 codes: Dental conditions (K02, K04, K05). Upper, ENT (ear/nose/throat.) and lower respiratory infections (J00-06, H65-67, J22). Gastroenteritis and dehydration (A02-09, R11, K529). Asthma (J45-46, R062). Cellulitis (L01-04, L08, H000, H010, J340, L980), dermatitis and eczema (L20-30). Angina and chest pain (R072-074, I200). Pneumonia (J13-16, J18). Chronic Obstructive Pulmonary Disease (COPD) (J44). Myocardial infarction (I21-24.1). Stroke (I61-66) **No.:** Average annual number of admissions 2012-2013 and 2015-2016. **Rate:** Average annual age-and ethnicity specific rate per 100,000 population. **Trend:** direction of change 2004-2006 and 2013-2015 (↑/↓ increase/decrease). **Rate ratio:** Other = reference category. A rate ratio of 2 means the Pacific rate is 2 times higher than the Other rate. **Difference in %:** shows how much bigger/smaller in percent the Pacific rate is compared to Other.

Manako e te Pukuatu | Mind & Heart

Average annual number and age- and ethnicity-specific admission rates for (selected) mental disorders (per 100,000 population) in the Waikato DHB Pacific, Māori and Other population, 2004-2015.

Mental health and wellbeing	Pacific peoples					Māori		Other		Pacific vs. Other	
	2004-2006		2013-2015		2004-2015	2013-2015		2013-2015		2013-2015	
	Annual average					Annual average		Annual average			
Hospital admission rates per 100,000 population, 15-44 years [1]	No.	Rate	No.	Rate	Trend	No.	Rate	No.	Rate	Rate ratio	Difference in %
Schizophrenia	12	317.5	11	224.0	↓	175	471.2	121	112.6	2.0	99%
Intentional self-harm[1b]	3	75.6	7	131.8	↑	111	298.9	346	321.6	1.9	92%
Mood disorders	5	132.3	2	39.5	↓	56	149.9	150	139.5	0.3	-72%
Psychoactive substance use disorders	3	79.4	4	72.5	↓	71	191.2	163	151.3	0.5	-52%
Community mental health	Past		Recent		Trend	Recent		Recent		Recent	
Psychological distress, 15+ years, 2006/07-2014/15[2]	13%		10%		↓	10%		6%		1.8	79%
Children diagnosed with emotional or behavioural problems, 2-14 years, 2011/12-2014/15[3]	2%		2%		↓	5%		5%		0.5	-53%
Access to DHB mental health services, 2005/06-2015[4]	1.5%		3.5%		↓	-		3%		1.0	0%
Access to DHB alcohol and drug services, 2012/13-2015[4]	1.0%		1.4%		↓	-		1%		1.4	36%

Notes: Other = non-Māori and non-Pacific.[1]Hospital admission data from Waikato DHB hospital register Costpro 2004/06-2013/15 for the Waikato DHB resident population aged 15-44 years. Denominator = projected estimated resident population 2005 and 2014. [1b]Years 2008-2010 (denominator = projected estimated resident population 2009) and 2013-2015. [2]Ministry of Health: NZ Health Survey. Psychological distress (high or very high probability of anxiety or depressive disorder, K10 score ≥12). Other= European. National data. [3]Ministry of Health: NZ Health Survey 2011/12 & 2014/15. Includes depression, anxiety disorder, ADD and/or ADHD. National data. [4]PRIMHD, in: Ministry of Health: 'Ala Mo'ui Progress Report: June 2016. Wellington. % of the total population. Data for Maori was not available. Other = national data (local data not available), total NZ (all ethnic groups). **No.:** Average annual number of admissions. **Rate:** Average annual age-and ethnicity specific rate per 100,000 population (based on Census 2006 and 2013). **Trend**: direction of change between 2004-2006 and 2013-2015 (↑/↓ increase/decrease). **Rate ratio**: Other is held as reference category. A rate ratio of 2 means the Pacific rate is 2 times higher than the Other rate. **Difference in %**: shows how much bigger/smaller in percent the Pacific rate is compared to Other. **Classification of disease (ICD10 codes)**: schizophrenia (F20-29), intentional self-harm (X60-84), mood disorder (F30-39), disorders due to psychoactive substance use (F10-19).

Ako Faka'atamai | Intellect & Learning

Qualification statistics for Pacific peoples, Māori and Others in Waikato DHB.

Qualifications	Pacific peoples				Māori	Other	NZ	Pacific vs. Other	
	Past	Recent	Trend	Change in %	Recent	Recent	Recent	Rate ratio	Difference in %
Qualifications, 15+ years, 2006-2013[1]	64%	70%	↑	10%	64%	78%	79%	0.9	-10%
Education: Level 2 certificate or higher, 15+, 2006-2013[1]	49%	55%	↑	12%	48%	65%	66%	0.9	-14%
Tertiary education enrolment (number), 2005-2015 [2]	28,105	35,615	↑	27%	81,805	358,305	-	0.1	-90%

Notes: Other = non-Māori and non-Pacific.[1]Statisitcs NZ census data.[2]National data from Education Counts, data from 2015, updated October 2016. "Other" = All domestic students.

8.1

Buoka ao Kairiri | Resources & Leadership

Socioeconomic statistics for Pacific peoples, Māori and Others in Waikato DHB.

Socioeconomic indicators	Pacific peoples				Māori	Other	NZ	Pacific vs. Other	
	Past	Recent	Trend	Change in %	Recent	Recent	Recent	Rate ratio	Difference in %
Median weekly income (NZ$), 2011-2015[1]	$390	$485	↑	24%	$524	$670	$621	0.7	-28%
Labour force participation rate, 2008-2015[2]	67%	69%	↑	4%	64%	69%	69%	1.0	0%
Unemployment rate, 15+ years, 2008-2015[2]	6%	8%	↑	50%	13%	4%	6%	2.3	127%
Youth unemployment rate, 15-24 years, 2008-2015[2,2b]	16%	21%	↑	33%	22%	11%	-	1.9	88%
Tenure holders who own usual residence, 2001- 2013[3]	29%	20%	↑	-31%	26%	56%	61%	0.4	-65%
Households in crowded housing (national), 2013[4]	-	40%	-	-	20%	6%	10%	6.4	542%
Living in high deprivation areas (NZDep 9-10) 2001 -2013[5]	55%	49%	↓	-11%	44%	20%	20%	2.5	149%
Unmet need for GP due to cost, adults 2011/12-2014/15[6]	16%	20%	↑	23%	20%	13%	14%	1.5	52%
Unmet need for GP due to cost, children 2011/12-2014/15[6]	6%	7%	↑	7%	8%	6%	6%	1.2	16%
Unfilled prescription due to cost, adults 2011/12-2014/15[6]	13%	17%	↑	33%	15%	5%	7%	3.4	242%
Unfilled prescription due to cost, children 2011/12-2014/15[6]	11%	14%	↑	27%	9%	4%	5%	4.0	298%

Notes: Other = non-Māori and non-Pacific.[1]New Zealand Income Survey: June 2015 quarter. Published by Statistics NZ. National data. Other= Europeans.[2]Household Labour Force Survey released quarterly by Statistics NZ, annual average rate for Waikato Region. [2b]National data. [3]Statisitcs NZ census data. % of tenure holders who own or partly own usual residence. [4]Ministry of Health: 2014 report: "Analysis of Household Crowding based on Census 2013 data". Measure of crowding: one or more bedrooms are required in a household, according to the Canadian National Occupancy Standard (CNOS). [5]Statistics NZ, 2013 Census data: Estimated resident population matched with census area unit NZDep score from the University of Otago.[6]Ministry of Health: NZ Health Survey 2011/12 & 2014/15. National data. Ethnicity group "Other" = Europeans/Other (Asians not included). Adults 15+ years, children 2-14 years.

Buoka ao Kairiri | Resources & Leadership

Workforce statistics for Pacific peoples, New Zealand.

Workforce indicators	Pacific peoples			
	Past	Recent	Trend	Change in %
Pacific teachers in state and state integrated schools, 2004-2015[1]	0.9%	1.2%	↑	33%
Pacific in the medical workforce (doctors) 2008-2014[2]	1.8%	2%	↑	11%
Pacific in the nursing workforce 2010-2015[3]	2%	3%	↑	50%
Pacific nursing force working for DHB, 2015[3,3b]	-	61%	-	-
Pacific nursing force working for Pacific Health Service Provider, 2015[3,3b]	-	3%	-	-
Pacific in the midwife workforce, 2011-2015[4]	2.1%	2.4%	↑	14%
Pacific in the dentist workforce, 2007-2012[5]	0.7%	0.9%	↑	29%
Pacific in the dental therapist workforce, 2007-2012[5]	1.8%	2.3%	↑	28%

Notes: [1]Waikato Region. Data source: Information from the Ministry of Education's teacher payroll data warehouse, available at https://www.educationcounts.govt.nz/statistics/schooling/teaching_staff. [2]National data. New Zealand Medical Council: The New Zealand Medical Workforce 2013-2014. [3]Waikato DHB data. The Nursing Council of New Zealand: The New Zealand Nursing Workforce. A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2010 & 2014 – 2015. [3b]National data. [4]National data. Midwifery Council of New Zealand: 2011 & 2015 Midwifery Workforce Survey. [5]National data. Dental Council of New Zealand: Workforce Analysis 2011-2012. **Trend:** direction of change over the time period (↑/↓/ = increase/decrease/no change). **Change in %**: change in percent for the most recent rates compared to the past.

List of References for Tables

List of References for Tables

Āiga ma le aganu'u | **Fanau & Culture - *Setting the scene***

1. Statistics NZ, Estimated resident population (ERP), subnational population by ethnic group, age, and sex.
2. Ministry of Health: National Maternity Collection 2011-2015.
3. Statistics NZ, Info Share, Life Expectancy at Birth, Maori Ethnic Group Population by Sex (Annual-Dec).
4. Statistics NZ, 2013 Census data: Birthplace (New Zealand or overseas) and ethnic group (grouped total responses) by languages spoken (total responses), for the census usually resident population count, 2001, 2006, and 2013 Censuses (RC, TA, AU)

Āiga ma le aganu'u | **Fanau & Culture – *Ethnicity, language & religion***

1. Statistics NZ, 2013 Census data: Dataset: Ethnic group (total responses), for the census usually resident population count, 2001, 2006, and 2013 Censuses (RC, TA, AU)
2. Statistics NZ, 2013 Census data: Ethnic group (grouped total responses) by number of languages spoken, for the census usually resident population count, 2001, 2006, and 2013 (RC, TA, AU)
3. Statistics NZ, 2013 Census data: Dataset: Selected ethnic groups (total responses) by language spoken (total responses), for the census usually resident population count, 2001, 2006, and 2013 Censuses (RC, TA, AU)
4. Statistics NZ, 2013 Census data: Dataset: Selected ethnic groups (total responses) by religious affiliation (total responses), for the census usually resident population count, 2001, 2006, and 2013 Censuses (RC, TA, AU)

Āiga ma le aganu'u | **Fanau & Culture – *Fanau indicators***

1. Ministry of Health: National Maternity Collection 2011-2015
2. Ministry of Health: Enrolment in a primary health organisation: Access to primary care, 2015-2016
3. Hauraki PHO, primary care data.
4. Ministry of Health: Well Child Tamariki Ora (WCTO) quality improvement framework indicators.
5. Ministry of Health: NZ Health Survey 2006/07 & 2014/15
6. Ministry of Health. July 2016. BSA District Health Board Coverage Report: period ending 30 June 2016. Wellington: Ministry of Health.
7. Ministry of Health. October 2016. NCSP New Zealand District Health Board Coverage Report: period ending 30 September 2016. Wellington: Ministry of Health.

Yago | **Body – *Nutrition and physical activity***

1. Ministry of Health: NZ Health Survey 2006/07, 2011/12 & 2014/15
2. Ministry of Health: Well Child Tamariki Ora (WCTO) quality improvement framework

Yago | **Body – *Health indicators***

1. Ministry of Health: National Immunisation Register (NIR) 2012 & 2015
2. Ministry of Health: National Mortality Collection, foetal and infants deaths 2000-2011
3. Ministry of Health: Oral health data and statistics 2005 & 2013
4. Ministry of Health: Virtual Diabetes Register 2010 & 2015
5. Ministry of Health: NZ Health Survey 2011/12 & 2014/15

6. Statistics NZ, 2013 Census data: Dataset: Cigarette smoking behaviour and ethnic group (detailed total responses) by age group and sex, for the census usually resident population count aged 15 years and over, 2006 and 2013 Censuses (DHB areas)
7. Ministry of Health: Amphetamine Use 2015/16: New Zealand Health Survey.
8. Ministry of Health: Cannabis Use 2012/13: New Zealand Health Survey.
9. Nosa V, Ofanoa M. The social, cultural and medicinal use of Kava for twelve Tongan-born men living in Auckland, New Zealand. Pac Health Dialog. 2009; 15(1); 96-102.

Yago | **Body – *Hospital admissions and ASH***

1. Waikato DHB hospital's register Costpro 2004/06-2013/15 for the Waikato DHB resident population.
2. Ministry of Health: National Minimum Dataset (NMDS) 2012/13 & 2015/16. Available at: http://nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive

Manako e te Pukuatu | **Mind & Heart – *Mental health and wellbeing***

1. Waikato DHB hospital's register Costpro 2004/06-2013/15 for the Waikato DHB resident population.
2. Ministry of Health: NZ Health Survey 2006/07 & 2014/15
3. Ministry of Health: NZ Health Survey 2011/12 & 2014/15
4. PRIMHD, in: Ministry of Health: 'Ala Mo'ui Progress Report: June 2016. Wellington

Ako Faka'atamai | Intellect & Learning - *Qualifications*

1. Statistics NZ, 2013 Census data: Dataset: Highest qualification and ethnic group (grouped total responses) by sex, for the census usually resident population count aged 15 years and over, 2006 and 2013 Censuses (RC, TA, AU)
2. Education counts, Dataset: Pasifika Tertiary Education Students by Gender. https://www.educationcounts.govt.nz/statistics/tertiary-education/summary_tables

Buoka ao Kairiri | Resources & Leadership – *Socioeconomic indicators*

1. New Zealand Income Survey: June 2015 quarter. Published by Statistics NZ
2. Household Labour Force Survey released quarterly by Statistics NZ, 2008 & 2015
3. Statistics NZ, 2013 Census data: Dataset: Tenure holder and ethnic group (grouped total responses) by sex, for the census usually resident population count aged 15 years and over, 2001, 2006 and 2013 Censuses (RC, TA, AU)
4. Ministry of Health: 2014 report: "Analysis of Household Crowding based on Census 2013 data"
5. Statistics NZ, 2013 Census data: Dataset: Estimated resident population (ERP), subnational population by ethnic group, age, and sex, at 30 June 1996, 2001, 2006, and 2013, matched with census area unit NZDep score from the University of Otago, available at http://www.otago.ac.nz/wellington/departments/publichealth/research/hirp/otago020194.html
6. Ministry of Health: NZ Health Survey 2011/12 & 2014/15.

Buoka ao Kairiri | **Resources & Leadership – *Workforce indicators***

1. Ministry of Education's teacher payroll data warehouse, available at https://www.educationcounts.govt.nz/statistics/schooling/teaching_staff
2. New Zealand Medical Council: The New Zealand Medical Workforce 2013-2014.
3. The Nursing Council of New Zealand: The New Zealand Nursing Workforce. A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2010 & 2014 – 2015.
4. Midwifery Council of New Zealand: 2011 & 2015 Midwifery Workforce Survey.
5. Dental Council of New Zealand: Workforce Analysis 2011-2012

Strategic Programmes Update

Next update at October meeting

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 9.2

MENTAL HEALTH AND ADDICTIONS MODEL OF CARE: CREATING OUR FUTURES PROGRAMME BUSINESS CASE

Purpose	1) For information

Content of Report
The overall aim of the Creating Our Futures programme business case is to identify the key problems and rationale for investment, outline the potential benefits of investment, and provide the strategic context and fit for future investment. Working with key stakeholders the investment objectives have been refined:

a) Transforming service delivery in order to improve safety, effectiveness and efficiency.
b) Creating safe and therapeutic environments that support holistic quality care at all times.
c) Building sustainable capacity and capability of services to meet future demand, values and need.

On behalf of the Waikato DHB, the MH&AS service submitted the Strategic Assessment to NZ Treasury and the Ministry of Health and presented to Investment Ministers for noting on the 8 June 2017. The focus of the assessment was on the development of a model of care that will inform what it is the service delivers; the acute environment/s and capital infrastructure needed [including, the impacts of NZ Corrections Programme increasing Waikeria prison capacity by 2021; and, the Substance Addiction (Compulsory Assessment and Treatment) Act]; and, the resources required to support that delivery of care across the spectrum.

The Strategic Assessment Tranche 1 has been closed, the key milestones achieved for Tranche 1 included:

Milestone	Date	Status
NZ Treasury Risk Assessment Profile	January 2017	✓ Completed
Investment drivers workshops (ILM)	January 2017	✓ Completed
Stakeholder Analysis	January – February 2017	✓ Completed/Ongoing

Milestone	Date	Status
Communication Strategy	January – February 2017	✓ Completed/ Ongoing
Model of Care – framework and consultation	January – April 2017	✓ Completed/Ongoing
Finalise project / programme approach	February 2017	✓ Completed
Project risk workshop	February 2017	✓ Completed/Ongoing
Quantitative Model: bed demand	February – March 2017	✓ Completed
Draft Strategic Assessment document	February – March 2017	✓ Completed
National facility site visits	February 2017	Partial
International facility site visits	March 2017	TBA
MH Clinical Governance Forum Strategic Assessment Endorsement	April 2017	✓ Completed
Gateway Review 0	April – June 2017	Not required
Incorporate feedback into Strategic Assessment	June 2017	✓ Completed
Finalise Strategic Assessment seek final sign off from SRO and submit for approval from Cabinet	July 2017	✓ Completed
Cabinet approval to proceed to programme Business Case	July 2017	Awaiting formal recommendations
End Stage – close Tranche 1	July 2017	✓

Tranche 2 of the Creating Our Futures Programme Business Case has commenced. The indicative timeframe for Tranche 2 is July 2017 – December 2017; with submission to Investment Ministers for approval to further develop a mix of project business cases is scheduled for early 2018

Recommendation
THAT
The Committee notes the content of the report.

DEREK WRIGHT
EXECUTIVE DIRECTOR
MENTAL HEALTH AND ADDICTIONS

IAN WOLSTENCROFT
EXECUTIVE DIRECTOR
STRATEGIC PROJECTS

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 9.3

SMARTHEALTH: VIRTUAL HEALTH ENCOMPASSING SMARTHEALTH AND TELEHEALTH

Purpose 1) For information

Virtual Health has been processing over the last period focusing on enabling the opportunity for service change. These outcomes have been reported across the Waikato DHB's Strategic Imperatives. These outcomes are in line with achieving the goals set out in the virtual care strategic business being:-

- Goal 1 Empty outpatients
- Goal 2 Triage at ED
- Goal 3 Create linkages between General Practices and SMOs
- Goal 4 Create a virtual market place for health advice, putting power in the hands of consumers
- Goal 5 Create a vehicle to drive positive health behaviours and support self-management by consumers, a key medium term goal

Health equity for high need populations / Oranga
Strategic business case Goal 4 and 5.

Nga Whanau o Mangaru whanau
The use of SmartHealth as an equaliser in the ability to access care has been recognised by Nga Whanau o Mangaru whanau who are predominantly Māori and represent a hard to reach sector of our community. An opportunity to establish a relationship with Nga Whanau o Mangaru's Whanau Development Leader (Cherie Sweeny) arose in late-2016, through an approach over the suitability of SmartHealth as a means for this group to more readily access healthcare.

In 2016 Cherie organised an event for gang 3affiliated women focused on improving health and wellbeing. This was a first in New Zealand and well received, with over 300 women attending. For 2017 Cherie is now organising a similar event named "Hearty Hauora Kaupapa". It remains health and wellbeing focused and they are seeking the opportunity for Nga Whanau o Mangaru members (men, women and children) to engage with health services in a neutral setting. The YMCA in Pembroke Street has confirmed their willingness to provide a venue and actively seek to develop positive and ongoing relationships with members of this whanau.

Waikato DHB is seeking to enable a wide range of services to participate and provide the opportunity for attendees to:

- talk to service providers
- learn about what healthcare services are available

- share the barriers they experience in accessing healthcare services
- receive some care, for example an oral check, blood pressure check
- enrol with services.

Some service areas will readily provide simple checks and other participants (including contracted PHO and Maori health providers) are being encouraged to consider how they could use the event as an opportunity to establish an ongoing relationship with members of this whanau.

The Hearty Hauora Kaupapa, in and of itself, is but a one day event. The gain to be realised comes from the demonstrable willingness of all parties to engage and develop greater understanding of each other. What is available from a service, how it can be accessed, and how best a service can establish and maintain long-term engagement is vital if services are to be delivered in a way that supports meaningful and sustainable change for this community.

Health needs of tangata whenua in rural Waikato

A small team of evaluation students from the University of Waikato have been engaged to deliver a student evaluation. The Evaluation proposal is still being drafted and negotiated with the draft aim and objectives as follows:

Aim

To evaluate, using Te Ao Māori values, how the health needs of tangata whenua in rural Waikato could be addressed using the Smart Health virtual health service.

Objectives

1. Identify the types of SmartHealth services tangata whenua want to receive and the current and potential barriers and enablers to engaging with those services
2. Identify Te Ao Māori values SmartHealth requires to align with the Māori models of health: Te Wheke, Te Whare Tapa Whā and Te Pae Mahutonga

Research Orientation

The evaluators propose to operate within a Te Ao Māori framework weaving together Te Ao Māori, Te Tiriti o Waitangi and Waikato DHB Te Iwi Ngakaunui (People at Heart) values and positioning these values as normative. The evaluators commit to operating within the DHB Te Iwi Ngakaunui (People at Heart) values:

- Whakamana – Give and earn respect
- Whakarongo – Listen to me, talk to me
- Mauri Pai – Fairplay
- Whakapakari – Growing the good
- Kotahitanga – Stronger together

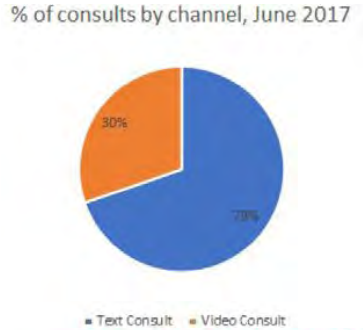
Other Te Ao Māori values involved in the way the evaluators will work are:

- Te Whakapono – The basis of our beliefs and the confidence of what we are doing is right
- Ngā Ture – The knowledge that our actions are honourable, ethical, and moral (tikanga)
- Koha – We provide meaningful contributions
- Ahūrutanga – Respect the physical, spiritual and intellectual safety of everyone

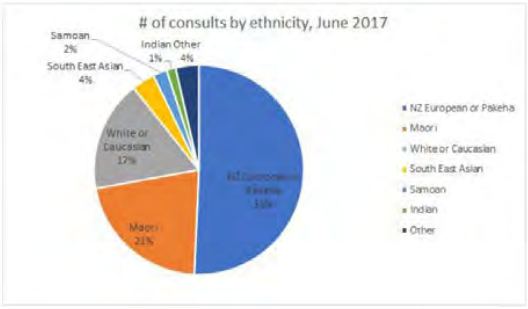
Safe, quality health services for all / Haumaru
Strategic business case Goal 1, 2, 4 and 5

Urgent After hours care
The urgent care virtual after hours service is growing in use with a uptake of actual consultation largely in line with our population demographics. Characteristic of the service are highlighted below.

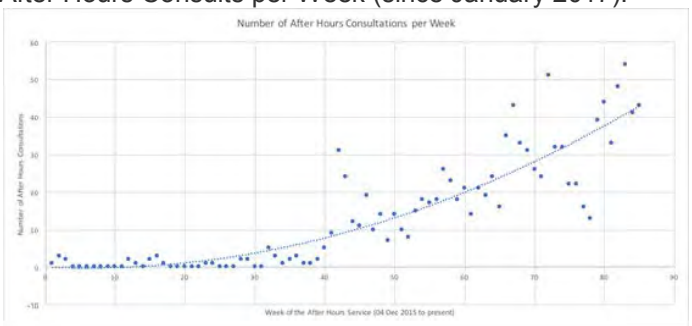
The use of the service has seen a predominance of consultation via the use of text consults.



The mix of patients utilising the service is largely in line with population demographics. Whilst this at present has not created a significantly better service for our Maori and high needs patients it has not seen the creation of greater inequalities as the service is deployed.



After Hours Consults per Week (since January 2017):



There has been a steady increase with use of the afterhours service with a overall rating of 4.74 stars out of 5 stars. What has been seen is that word of mouth, social media seem to be the most effective form of notifying patients. This will mean the service will likely see exponential growth over the next 6 months in line with experience with other social media promoted services.

Tokoroa SmartHealth Booth was launched, now in post implementation review stage prior to looking at next locations for SmartHealth booth implementation. This booth utilises the urgent care virtual after hour's service to divert patients from emergency department presentation. The report is attached for you information as Appendix A.

Healthline Integration
The integration of the SmartHealth service has been completed and is in operation with Home Care medical the service providers of the Healthline number. The way that is operates is that a nurse leading the triage of the caller on Healthline will, if it is clinically appropriate, offer anyone from the Waikato the opportunity to do a virtual consult with a afterhours urgent care doctor.

This means the redirection service to SmartHealth runs in the same hours as the urgent after hours care doctors service. This integration is based on the SOS SmartHealth service. Over the time this has been active we have had 18 SOS accounts created and 7 consults. To ensure continuum of care the SOAP notes form these consults were delivered within the 24 hour period to the GP of the patient.

St John Ambulance service
The next stage of service integration is to enable St John ambulances to contact the urgent care virtual after hours service when they have been called to transport a patient who they believe does not need transportation. The ambulance service will access the urgent care virtual after hours service to receive clinical advice on the best way to manage and care for the patient.

As part of the process the patient will be offered access to SmartHealth to enable them to receive care remotely. The intent is that where there is a patient with a condition that requires long term clinical support rather than episodic emergency department access they will be provided more appropriate care.

People centred services / Manaaki
Strategic business case Goal 3 and 4

Virtual Care Symposium
In working to empower people to take much more control over their own care and treatment we are holding a Virtual Care Symposium at Claudelands event centre on the 5 August 2017. The intent with the Symposium is to make more use of the opportunities digital technologies offer and strengthen our virtual care approach by directly engaging health care providers on the move to Virtualisation.

The focus is on the on the need for change & innovation in health care and the integration between primary/secondary and tertiary health care. The topics will cover current activity and areas of concern such as the medico legal status of providing virtual care.

Service Redesign for service closer to home
Virtual Health and REACH
The REACH team have embraced virtual health. It is a totally paperless service and uses technology to work from any location. The team will see clients in their own home, at the library, community centre, any venue of the client's choice. They are delivering service on the client's terms, and improving access and outcomes as a result.

Using technology and the mobile nature of the service has created efficiencies. The success of the services means that it has grown from a small trial to Waikato wide coverage. The key workers (Registered Health Professionals) in the team are able to do virtual consults on a regular basis. This saves on travel, keeps connected with clients, and helps juggle what is a very busy and varied case-load. Investigation are underway to involve the Living Well Coaches in Smart Health, they are a unregulated workforce, to enable them the same ability to do virtual consults further supporting the service.

There are also significant opportunities with other services (Disability Support Link, START) that will see operational efficiencies from Virtualisation. For example, with Disability Support Link the service currently uses space in Te Awamutu, Te Aroha, Matamata, Whitianga and other DHB sites. All of this could be vacated by using virtualisation as REACH has done which will create savings whilst at the same time supporting a more efficient locality based service.

Please see attached memo outlining opportunities – Appendix B, C, and D.

Effective and efficient care and services / Ratonga a iwi
Strategic business case Goal 1

The programme to deploy SmartHealth and Virtual Health has been progressing with the following highlights:

Deployment Numbers
Clinical staff
- 523 Doctors
- 2306 Nursing and Allied health

Patients
- 7803

Devices to enable mobility platform for SmartHealth, Telehealth, Chrome web based Clinical Workstation and other systems

- Monitors 213
- iPads 605
- iPhones 182

Mental Health

- 18 MH consults were completed in June.
- Planning is underway with all MH services
- Southern Rural and Community Alcohol & Drug Service have had training and are looking to plan how to use SmartHealth in their normal business

Allied Health

- Work is continuing with the two groups to rollout SmartHealth. There is the potential to increase number of groups.
- Training planned for some Allied Health staff in Thames

Renal

- Service continues to enrol patient in Nephrology outpatient service.
- Service commenced enrolling Specialist Nurses in Bay of Plenty DHB as clinicians on SmartHealth
- Virtual care is moving to a business as usual state

Waikato Hospital Services

Vascular Surgery

- Patient selection continues, however lead-in times for these patients is 3-6 months
- Draft selection criteria circulated amongst clinical team for review this awaiting response

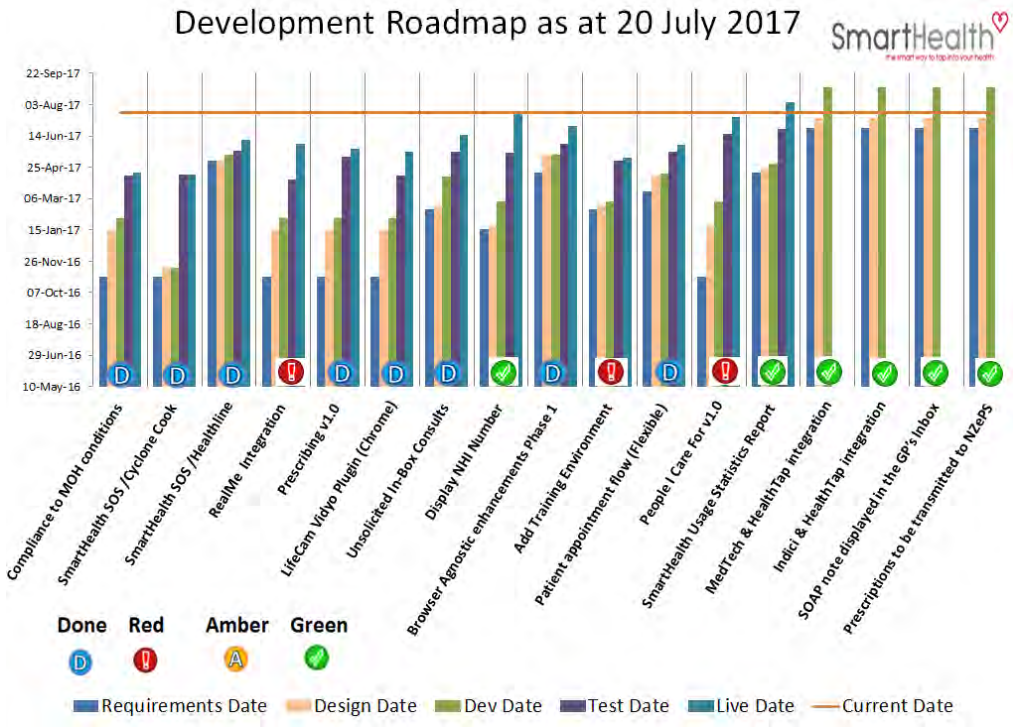
Other Services

- Services now identifying clinical champions to lead out activities as the way forward with Waikato Hospital implementation, this will be done with separate projects in each directorate area. This will allow the uniqueness that is in each area to be accommodated whilst ensuring speed of deployment with the direct oversight of each director.

- This approach will require running four parallel programs with the target being that 40% of the services running out of the Meade clinical Centre will be conducting virtual consults by the end of this calendar year.

Development Roadmap

The ongoing work to New Zealand'ise the product is outline in the development Roadmap below.



Of the 3 red items:

- The real me integration has been completed and is now awaiting sign off from the ministry of health.

- The training environment has been re-scoped with HealthTap and a deployment of the environment in the next 4 weeks is scheduled.

- People I care for module is running late due to difficulty with defining the required need and translating that to a actionable set of requirements.

Key issues for programme

- As the key influence for patient signup to SmartHealth is a positive Doctor/Clinician recommendation not having clinical champions in each area is a risk. The appointment of clinical champions to continue to promote and encourage clinical staff to use virtualisation has not been achieved across all service areas.

- Whilst a series of technical challenges have been met the rollout of SmartHealth and virtualisation has placed an increasing load on the IT infrastructure that supports the clinical work areas. The main area of concern currently is that several older section of the network may not have the processing capacity to contend with the demands of real time video conferencing.

Telehealth

- Engagement with the New Zealand Prison services has seen Oncology, Respiratory and Renal clinics delivered to prisoners on site. To being this has been a Spark/ Waikato DHB supported pilot initiative however the Prison

service is now building a business case to move to a business as usual state. As part of this engagement we are working with the prison to enable prisoners who will be leaving the Prison service to enrol in SmartHealth so that they will be able to transition from site based Telehealth to mobile access via SmartHealth.

- Number of services providing Telehealth clinics into Midland DHBs and rural hospitals has increased although we have seen a drop in overall consultations this past month. We are surveying all jabber account holders (technology used to support Telehealth clinics) to look at usage. Anecdotally we have seen an increase in videoconference meetings and Thames has been able to reduce their vehicle pool as a result. We have recently also been trailing an electronic stethoscope allowing for clinicians at either end of a Telehealth consult to be able to hear heart and lung sounds. The first pre-anaesthetic clinic via Telehealth using this technology is planned for the 14th of August.

A centre of excellence in learning, training, research and innovation / Pae traumata
Strategic business case Goal 4 and 5

To create a proactive focus for Virtual Health, encompassing SmartHealth, we have been working with WINTEC on a research project using the new Design Thinking process. WINTEC are leading this initiative in New Zealand as part of the global movement of Design Factories. Design factors are education facilities that look to undertake active research with industry partners to solve “wicked problems”.

The problem that was undertaken with the team was a challenge to come up with new approaches that can bring greater wellbeing and interconnectedness in the Waikato. The work that was undertaken redefined the problem statement to “How might we design an intergenerational education experience that promotes interconnectedness and a better understanding of wellbeing?” The innovation focus of SmartHealth and Virtual Health is the key focus rather than the technical delivery.

From this work the concept of *Wiser Generations* was created.

> The intent with Wiser Generations is to provide secondary students with an insight to well-being through social interaction, lifestyle learning and activities. Students will also learn about illnesses and early prevention.

How Wiser Generations works:

> Over six weeks, students will participate in an educational program twice a week, which will teach them about lifestyle and wellbeing choices also working with the elderly to learn new skills and to teach new skills.
>
> The initial concept uses a research assignment based on a L3 credit module (New Zealand Qualifications Authority [NZQA], 2012a). Other credits could also be granted via the Wiser Generations programme, such as credit for a public music performance (NZQA, 2012b).

The next phase is to undertake the following steps with WINTEC to develop the program into a framework ready for implementation:

- Step 1: Validation from High Schools
  - What school systems are best catered for this program?
- Step 2: Refine Program Framework and Test with Students
- After processing the findings from step 1, refine the program framework accordingly and test with a small group of 5-10 students.
- Step 3: Establish Connections with Partner Organisations to create a sustainable programme
  - This would include schools, rest homes and aged care organisations.
- Step 4: Pilot Programme

The report is attached for you information as Appendix E.

Productive partnerships / Whanaketanga
Strategic business case Goal 3 and 5

Hauraki PHO
Hauraki PHO has engaged enthusiastically with a detailed plan to have fully immersed a minimum of five Hauraki general practices by 31/12/17.

Fully immersed practices will see

- Having at least 75% of clinicians in the practice actively using Smart health
- Scheduling virtual or chat appointments
- Signing patients up to HealthTap
- Communicating with other services e.g. Multi disciplinary team, District Nurse, Hospice, secondary care
- "Chatting with colleagues"
- Clinicians keen to answer questions in the tool

Of the Identified practices:

- Hamilton Lake Clinic went live on the 7th of June
- Ngaruawahia Medical went live on the 16th of June
- Rototuna Family went live on the 21st of June
- Colville is scheduled to go live on the 1st August 2017. As part of this go live a new VDSL line to practice has been provided to the practice. Also there will be the installation of free WI-FI by Spark to enable SmartHealth users to access SmartHealth functionality for free. This free access will be live on 7 August.
- Te Korowai booked to go live after 14 August
- Putararu is scheduled to go live on 1 August – 1 GP
- Five Cross Roads Medical has confirmed and is to be scheduled

There is ongoing engagement work with Pinnacle PHO however most of the engagement is occurring at a practice rather than a whole of PHO view.

BUPA

The engagement with BUPA continues with New Zealand as a key minimum viable project for the global integration of BUPA into the HealthTap product.

Key points being for the Eventhorpe BUPA facility enablement:

- Process mapping completed for work flows and under review
- On boarding of residents occurring this week
- Consents forms and communication completed
- Out of hours Doctors service updated and prepared for stage one – residents connecting to the out of hours service
- Work SmartHealthop being planned to review work flows, discuss SmartHealth etc. with the team to support the next phases

Spark

Spark is working with Sports Waikato and has organised a kiosk in the Hamilton Sports Waikato office to sign up staff. Spark is also placing a kiosk into Spark Caro St for staff signup. Spark is also speaking with other organization they work with to promote and support the SmartHealth rollout.

In Colville the hot spot installed at the Health Centre for free fast Wi-Fi for Spark Mobile customer and also free Wi-Fi for non-Spark Wi-Fi (Called Colville free Wi-Fi). This has included external Access points also for users who can park their vehicles after hours outside the practice and still use the free Wi-Fi. Spark is happy to work alongside us to create publicity here for SmartHealth when appropriate.

The Spark SmartHealth team have meeting this week with the General Manager of Retail have to finalize details to get SmartHealth kiosk into retail shops on a pilot basis. The stores targeted for the Kiosk being Chartwell, The Base, Centreplace and

Thames. There is agreement in principle and the Spark SmartHealth team are now working through the next steps to make this happen.

The Spark Foundation (JUMP programme) has agreement with the local representative of Jump Programme in Hamilton to leverage heavily subsidized internet into homes of low income families for health initiatives. The intent is for Spark to leverage existing candidates and work with the community groups to get more modems out to families with Children that meet the criteria. Although the programs primary goal is around education in the home, there are synergies for the same demographics around health. Spark will be providing introductions to the SmartHealth team and are working on a plan of action.

The Spark Service desk is now also running test consults for patients who are due to have their first virtual consult with their clinical professional. This is to ensure that the first time they use the service they are familiar with it and the technology is working as it should. The intent here is to limit any technical challenges when they meet for the first time with their clinician so as to not waste patient or clinician time when the first consultation takes place.

Apple has is now using the Waikato DHB case study on SmartHealth for sales training of Apple sales people. This case study is on their training portal "Seed" for staff and partners of Apple as a example of impact of virtualisation on the care of patients using the iOS environment.

Recommendation
THAT
The Committee notes the content of the report/proposal.

DARRIN HACKETT
EXECUTIVE DIRECTOR, VIRTUAL HEALTH AND INNOVATION

Tokoroa ED - SmartHealth Booth
19 - 30 June 2017

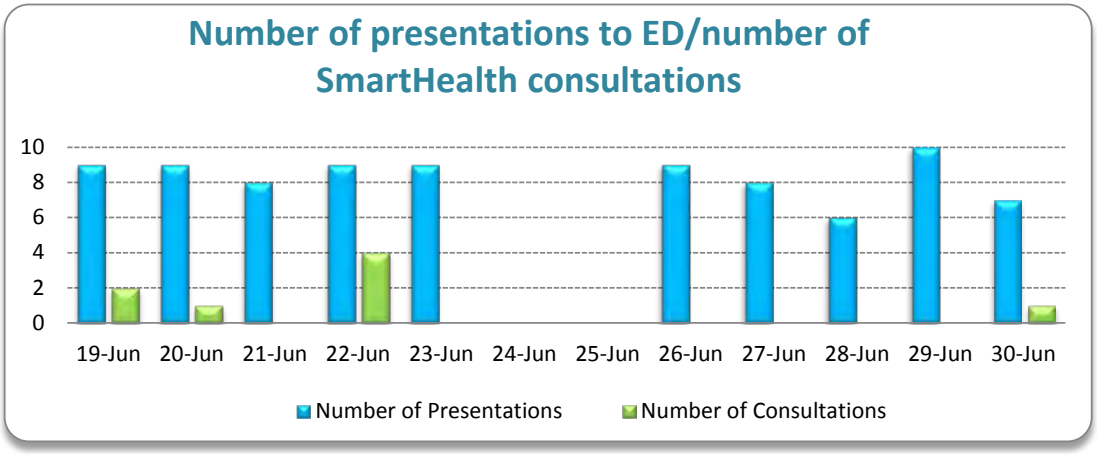
The Tokoroa ED has had increasing presentation numbers over the years. In 2008 the department had 8,682 presentations and in the 2016/17, there were 12,331 presentations. A large percentage of these presentations are triaged as 4 and 5 and should be managed by primary care. With the introduction of SmartHealth in 2016, the service has worked to get an appropriate site established in Tokoroa hospital where patients could be offered an alternative to waiting at a busy ED. The alternative would offer the patient the opportunity to be seen in a timelier manner at no extra cost to them.

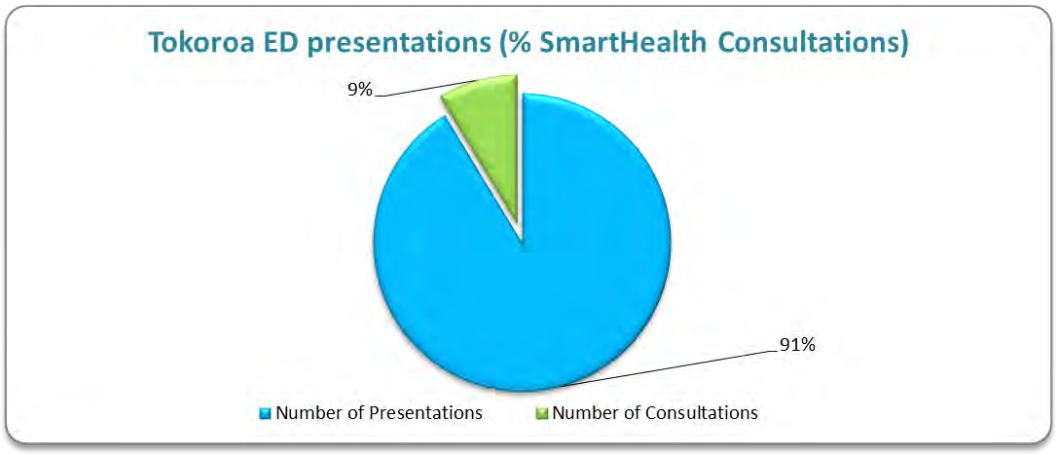
A SmartHealth booth was completed and fitted out with appropriate technology in June 2017. A pathway for redirecting suitable patients from ED to the SmartHealth booth was agreed and implemented (see attached). The service anticipated that healthcare assistants (HCA) would assist patients with registering (if required) with SmartHealth and initiating a SmartHealth consultation in the booth.

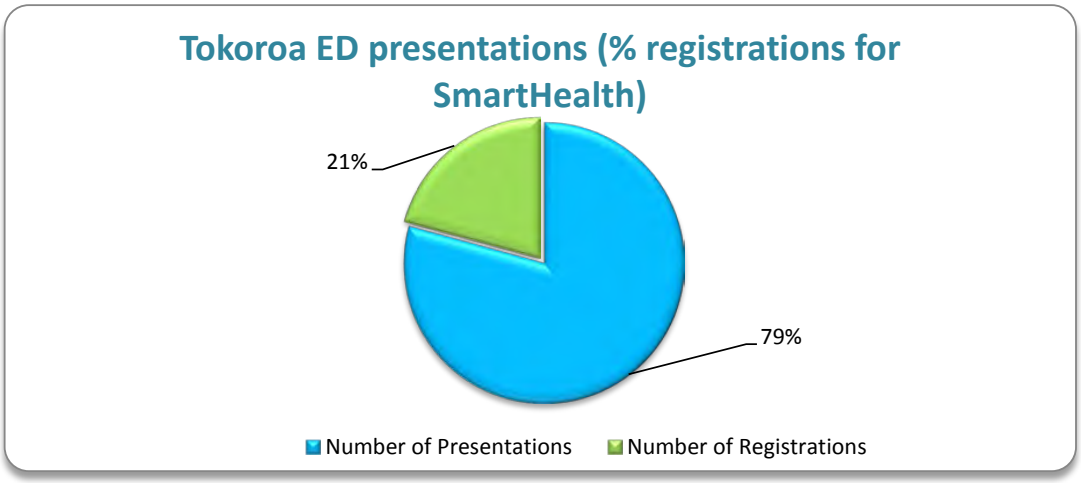
The SmartHealth booth had a go-live date of 19 June and until 30 June 2017 was initially supported by students (provided by the SmartHealth team) or by Tokoroa administration staff during the SmartHealth booth operating hours (6 - 11pm and 8am - 8pm weekends and public holidays). There was no resource support during 24 and 25 June. The total number of presentations to ED during this period was 84. The total number of SmartHealth consultations which took place was 8. Other activities related to SmartHealth included helping patients register as SmartHealth patients (22) and registration forms handed out to patients to take away to complete later (11).

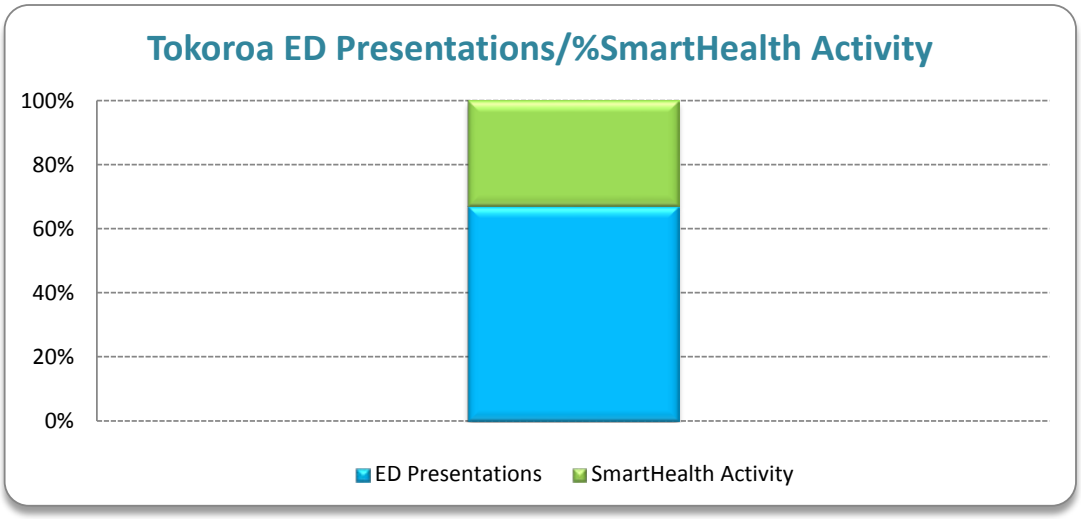
Patients who used the service reported they were happy with the outcome of their consultation and were happy to be able to use the service from their preferred location in the future. They were also happy with the timely manner in which they were seen.

Following the initial 10 day period, there has been no extra resource support dedicated to SmartHealth. This has affected the ability of the ED staff to redirect patients to the SmartHealth booth. This experience has clearly indicated to us that the service requires dedicated resource to redirect patients to SmartHealth for consultation where appropriate or to help patients sign up so that they can access SmartHealth consultations for themselves in the future.




Tokoroa ED presentations (% SmartHealth Consultations)
9%
91%
Number of Presentations
Number of Consultations


Tokoroa ED presentations (% registrations for SmartHealth)
21%
79%
Number of Presentations
Number of Registrations


Tokoroa ED Presentations/%SmartHealth Activity
100%
80%
60%
40%
20%
0%
ED Presentations
SmartHealth Activity

REDIRECTION OF ED PATIENTS TO SMARTHEALTH IN RURAL HOSPITALS

Waikato District Health Board

VERSION	DOCUMENT REFERENCE	EFFECTIVE DATE	ASSOCIATED LIPENSOFT DOCUMENTS	AUTHORISED
4.0		Jan 2017 – Jan 2020		Jill Dibble Director, Community & Southern Rural Health

RURAL & COMMUNITY CNS PATHWAYS

SMART HEALTH FOR AFTER HOURS DOCTOR CONSULTS

MON – FRI: 6:00PM – 11PM
SAT: 4:00PM – 8:00PM SUN: 8:00AM – 8:00PM

CONTRAINDICATIONS TO REDIRECT TO SMARTHEALTH:

Any patient requiring physical examination / test / x-ray.
May include:

- FAST signs of stroke
- Chest pain – cardiac related
- Moderate to severe asthma / COPD
- Testicular pain
- SOB
- Abdo pain
- Psychosis & risk of self harm
- Overdose
- Back pain with no history of trauma
- Potential dislocation
- Patient requiring controlled drugs
- Infections requiring IV antibiotics

PRINCIPLES

- All patients must be registered with iPM and willing to be / already registered with Smart Health
- All emergency symptoms / contraindications excluded prior to redirection
- Patients have the right to stay in ED without prejudice
- Patients redirected back to ED following SmartHealth consultation are to be readmitted in iPM under initial triage for further re-triage and then assessment
- Redirected patients should wherever possible, be seen as soon as possible on readmission

Memorandum

To: Darrin Hackett

From: Graham Guy, Manager DSL, START and REACH.

Date: 17 July 2017

Subject: Disability Support Link – Smart Health supporting a paperless service in the community Health

The shift to a "locality based" model in the community is making significant gains. DSL is no longer a Hamilton based service; it has staff now based throughout the Waikato. Needs Assessment and Service Coordination is almost a "co-payment", the team determine what the client and family can provide, what the community provides and then we try and provide the additional support. Solutions for these clients need to be local solutions given the diversity within our Waikato communities.

The model is demonstrating its efficiencies - it is completing 100% more interventions per month than it was in 2016. This locality based service is taking a targeted approach to support people at home and preventing unnecessary admissions.

Virtual Health and DSL

Following then implementation of the electronic evidence based assessment tool interRAI; DSL has made every effort to become as paperless as possible. The service no longer keeps any paper files, everything is stored electronically. This supports the service being locality based and closer the client, the community and local providers.

Unfortunately, Ministry of Health and other DHBs are not as paper free as us and there are two items that it still has to print off:

- InterNASC transfers – across region were another DHB or MOH are not as paperless
- For the Disability Support Services team the ability to print off a hard copy of an assessment as a client has the right to request this and physically sign this as a completed record.

Access to a mobile printer and a scanner would make the service totally paper free. Any copy the client requested to sign could be done in the person's home, it could be scanned using a phone and uploaded there and then.

For DSL this would mean it would be able to give up some office space and work as REACH does, from any environment. The needs assessor could work from home, a community centre, general practice or the client's home. This would allow DSL to vacate several of its current offices. Instead of leasing dedicated office space in the community it could take advantage of "hot-desk" options from a variety of locations when required.

The service currently uses space in Te Awamutu, Te Aroha, Matamata, Whitianga and other DHB sites. All of this could be vacated creating savings whilst at the same time supporting a more efficient locality based service.

Memorandum

To: Darrin Hackett

From: Graham Guy, Manager DSL, START and REACH.

Date: 17 July 2017

Subject: REACH and Smart Health – Access for Living Well Coaches

Waikato DHB and Ministry of Social Development have collaborated to establish a new approach to supporting clients on a return to wellness and the workplace.

An initiative helping unemployed people overcome their challenging health issues and return to work is going from strength to strength a year after it was launched as a pilot programme.

The programme, called REACH (Realising Employment through Active Co-ordinated Healthcare), is supporting clients to manage their health condition or disability so they can find suitable work. This gives them confidence and independence and improves their wellbeing.

Virtual Health and REACH

The team have embraced virtual health. It is a totally paperless service. It uses technology to work from any location. The team will see clients in their own home, at the library, community centre, any venue of the client's choice. We are delivering our service on the client's terms, and improving access and outcomes as a result.

Using technology and the mobile nature of the service has created efficiencies. The success of the services means that it has grown from a small trial to Waikato wide coverage. The key workers (Registered Health Professionals) in the team are able to do virtual consults on a regular basis. This saves on travel, keeps us connected with clients, and helps juggle what is a very busy and varied case-load. Involving the Living Well Coaches in Smart Health and giving them the same ability to do virtual consults would further support the service.

The Living Well Coaches are "rehab assistants" who have also undertaken some cognitive behavioural therapy training. They work as a coach and all of their activity with the client has a rehab focus. The engagement is initially quite intense, often seeing the client on a daily basis. As the client becomes more empowered they engage using different formats, calls and texts to ensure the client's progress is on track.

The ability to carry out virtual consults would make the service more efficient and would also support the role. It helps us make the client less dependent on us being there, empowering them to own their rehab activity but at the same time having the safety net of a face to face catch up.

The Living Well Coaches are familiar with health documentation and have training in the universally used SOAP notes. This would allow them to share their notes/updates on clients in the same shared medical record as the key workers.

Memorandum

To: Darrin Hackett

From: Graham Guy, Manager DSL, START and REACH.

Date: 17 July 2017

Subject: START and Smart Health

The now well established START service continues to go from strength to strength. It has been progressively replicated in other DHB's such as Canterbury (CREST) and Counties Manuka (ReAblement). The service has recently had enquiries from MidCentral, Bay of Plenty, Hawkes Bay and Taranaki DHB looking to replicate a similar model. Ministry of Health have directed that all District Health Boards have an admission avoidance model and supported discharge service similar to START.

Virtual Health and START

The START team work as a "virtual ward" in the person's home. The health care assistants can see the client three times per day, the OT, physio and registered nurse all see the client in their home. There is a weekly IDT that the geriatrician chairs to check on progress.

START is delivering care in an environment that makes sense to the client, delivering care on their terms and producing better outcomes. START also produces significant savings. The cost of a client in START is significantly less than that of a client in hospital, plus it is producing further savings by halving readmission rate over 90 days and 6 months.

Further efficiencies could be gained by the service embracing virtual health in the same way that the REACH service has. Currently the service completes a record in the client's home and another set of patient notes back in the office.

A shared electronic record would allow for one set of notes to be completed by all of the professions. Instead of a formal handover of information occurring in the office, the service could use technology to provide a "virtual" handover that kept all of the supports engaged with that client updated at the same time.

For a whole of team approach to this, the health care assistants would also need access to Smart Health. The Health Care Assistant have the level 1 career force training and like the REACH living well coaches are familiar with health records and the process of documenting progress notes.

Smart Health, would allow the Physio/OT/RN to carry out some virtual consults as clients improve. It would allow health care assistants to "check-in" with the health professional re updates in progress. They would be able to get client's to demonstrate how they were managing and involve them in the Geriatrician review virtually.

WISER GENERATIONS

Creating Intergenerational Connections

Studio5 Innovations Report 2017

EXECUTIVE SUMMARY

Studio5 is a dynamic interdisciplinary student team from Waikato Institute of Technology. With our various educational backgrounds, we use design processes and collaborative creativity to produce solutions to industry problems.

Our team is proud to partner with the Waikato District Health Board (DHB) to develop new approaches for greater wellbeing and interconnectedness within the Waikato Region. The Waikato DHB recognises that there needs to be a shift in how healthcare is provided and received in order to cater to the current and future needs of the Waikato people. The challenge presented to Studio5 was to come up with a solution that can engage people in their own wellbeing while reducing health inequities that disconnect people from proper healthcare.

Through our design-thinking process, we have developed a fantastic program called Wiser Generations that engages students of high school age to learn and reflect on wellbeing principles, and the impact their choices will have on their future wellbeing. The aim is to improve students' health literacy and awareness of chronic illness, while providing opportunities for intergenerational connectedness.

CONTENTS

Wicked Problem:

How might we create better interconnectedness and wellbeing throughout the Waikato Region?

A INTRODUCTION

MEET THE TEAM

About:

Studio5 Innovations is a group of students from Waikato Institute of Technology (Wintec) who came together as a team at Design Hub to create, analyse and innovate solutions for industry clients using design thinking.

Ryan Jolliffe
Information Technology

Project Manager

Ryan is in his final semester of a Bachelor of Information Technology. He has experience in programming, databases, networking, systems analysis, and project management. Ryan is currently working as a fencer, but is looking forward to moving into the IT industry after graduating.

Katie McQueen
Information Technology

Prototype & Administration

Katie is in her final year of a Bachelor of Information Technology. She has a background in communications and business administration, with skills in design, networking, prototyping and administration. Katie's interests include design, video games and socialising.

Joel Taylor
Civil Engineering

Communications Manager

Joel is in his final year of a Bachelor of Civil Engineering. He has skills in 12d 3D modeling and various field-testing techniques. Joel's interests include sports and outdoor activities such as hunting fishing and diving.

Bronson Daniels
Civil Engineering

Research Manager

Bronson is a second year student in the Bachelor of Civil Engineering Technology. He also has a diploma in Architectural Technology. Bronson was a builder for many years before deciding to venture into other areas of construction.

Cody Steens
Media Arts: Design

Archives and Design Manager

Cody is in his third year of a Bachelor of Media Arts, majoring Graphic Design. Cody's passions include user interface and experience design, branding and gaming.

INDUSTRY PARTNER

Waikato District Health Board

Key Contact: *Darrin Hackett, Executive Director of Virtual Care and Innovation*

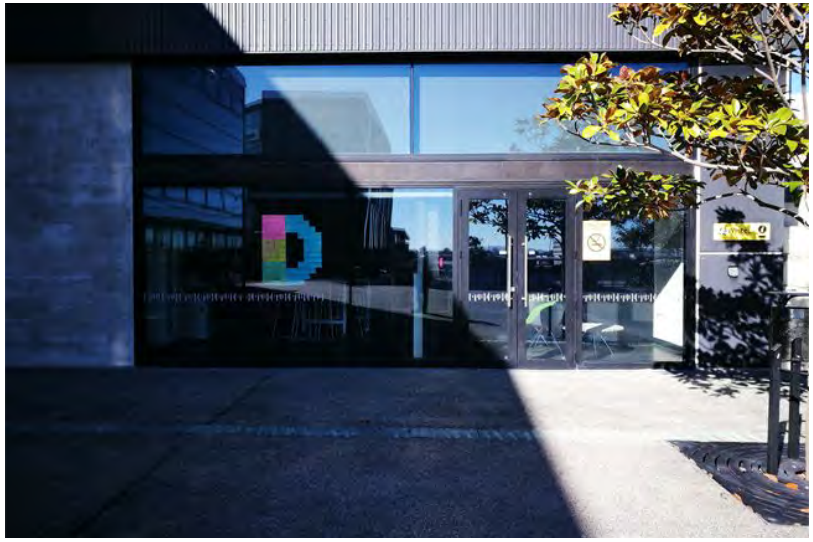
The Waikato DHB stretches from the Coromandel Peninsula in the north to Mt Ruapehu in the south, and out to Raglan in the west, over to Waihi in the east, covering a total of more than 21,000 square kilometres with a population of over 390,000. The mission that the Waikato DHB has set out to achieve is to "enable us all to manage our health and wellbeing. Provide excellent care through smarter, innovative delivery" (Waikato District Health Board [Waikato DHB], 2016a, p.2). This is where our wicked problem comes from. The problem that Studio5 was challenged with was:

How might we create better interconnectedness and wellbeing throughout the Waikato Region?

An early discussion with Darrin and his colleague Melinda Ch'Ng raised the point that, due to the increasing load that the elderly patients are placing on the health system, a major portion of the yearly budget is being spent on this area. Therefore, there is less money to spend in other areas. Darrin's challenge to Studio5 in our next meeting was to create a solution that would enable the younger generation of today's world to look after themselves and increase their self-awareness and responsibility over their own health. Ideally, this should have the long-term result of reducing the strain on the health system, so that funding can be applied to other services. Coming up with a solution that will cater for these needs would also follow another one of the DHBs approaches - a shift in focus from illness to wellness, where the younger generation will be educated around health in their future lives.

First Industry Meet and Greet with Studio5, Darrin Hackett and Melinda Ch'Ng

WINTEC DESIGN HUB



Wintec Design Hub, Wintec Campus

The Wintec Design Hub is a place to explore new ideas and possible solutions to everyday problems within a safe and supportive environment. Within the Design Hub, industries provide groups of students with a real world problem allowing them to explore solutions from many different perspectives in order to produce one conclusive resolution. These groups of students come from different disciplines such as Media Arts, Design, Information Technology and Civil Engineering, providing an in depth knowledge-base and perspectives from multiple professions enabling solutions to wicked problems. The Design Hub provides a setting where the industry partners are able to work closely with each group of students, guiding them and encouraging them.

The Design Hub facilitates a co-creation process between the Waikato District Health Board (or Industry partners) an academic supervisor, and the Studio5 team. This group combines and integrates ideas through a number of human centered tools and frameworks to achieve a greater understanding of the problem context. This process results in a more defined and effective solution, while having input from both our industry partner and academic supervisor to help guide us in the right direction throughout the journey.

"Healthcare demand is intensifying as the population ages. We propose a shift of emphasis to promote healthy life choices, early intervention to reduce disability and preventing ill health from getting worse."
(Waikato DHB, 2016a)

B

THE PROBLEM

PROBLEM BACKGROUND

Waikato's Aging Population

Older age health care has become somewhat of a double-edged sword for the Waikato District Health Board (DHB). On one side you have the needs of the elderly (65 years and older) to ensure that they age safely and with dignity through their twilight years, and on the other you have the massive costs associated with elderly care that consumes a bulk of the Waikato DHB's funding. A large number of these costs are due to chronic illnesses such as:

- Dementia
- Obesity
- Diabetes
- Ischaemic heart disease
- Heart failure
- Mental health issues like depression
- Along with long term support such as home and residential care

Due to the ageing of the 'baby boomer' generation, the population of elderly is expected to increase, as is the prevalence of chronic illness, which in turn will leave funding even more scarce for those under the age of 65. For this reason the Waikato DHB has been preparing for the future. *(D. Hackett, personal communication, March 8, 2017; Waikato DHB, 2015, 2017).*

Facts

- 2011 -2031 the number of 65+ will increase by 465,000
- By 2051 the 65+ range will make up 26% of New Zealand's projected population
- 60% of Waikato's population lives outside of Hamilton

(Waikato DHB, 2015)

The healthcare costs for those over 65 years of age is 5 times that of those under 65 years

(Waikato DHB, 2015)

The 65+ population in the Waikato is estimated to increase by 33% by 2026

(Waikato DHB, 2015)

Illness to Wellness

The Waikato DHB has identified that the best long-term solution is to promote the education and application of wellbeing principles in order to prevent illness rather then treat it. A focus on wellbeing also means focusing on a more holistic model for wellness, not only on health. The desired outcome is that through the support of whanau and community (professional and non-professional services), people can live healthier lives that are less reliant on the public health system; however, this requires accountability on the individual's part, as well as access to community and public health services. *(D. Hackett, personal communication, March 8, 2017; Waikato DHB, 2016a, 2017)*

Interconnectedness & Engagement

Interconnectedness between individuals, whanau, community and the public health system can prove particularly difficult for rural and underprivileged communities, as well as those who are experiencing disabilities. As one can understand, each of these diverse groups is faced with unique circumstances that challenge this concept of interconnectedness, resulting in health inequalities. The Waikato DHB identified these issues among their top priorities in their 2016 Strategy.

Youth are another group of particular interest as they are less inclined to take accountability for their wellbeing. Not so much because of barriers that restrict them from receiving healthcare, but rather that they are less engaged due to the reliance on parents or guardians for their wellbeing, as well as the fact that health indicators are less obvious for them. To avoid repetition of the same health and funding issues in the future, the youth must be a part of the plan. *(D. Hackett, personal communication, March 8, 2017; Waikato DHB, 2016a, 2017)*

New Approaches

The Waikato DHB challenged Studio5 to come up with new approaches that can bring greater wellbeing and interconnectedness in the Waikato. Such a broad problem can become very overwhelming, and the reality is that there is no single solution that will satisfy all of the issues involved. Our approach was to identify the many different areas of concern within the larger problem, and then eventually narrow our focus down to one or two pieces of the bigger picture.

Studio5 established core objectives that guided our concept development:

- Decrease the burden placed on the public health system
- Improve the wellbeing of the individual
- Remove barriers causing health inequities
- Community involvement
- Increase heath literacy

IDEAS & PROCESSES

C

THE DESIGN PROCESS

Design Thinking

Design Thinking is a methodology that is used to collaboratively solve wicked problems in an interdisciplinary group. This incorporates problem solving in a real world context, on a real industry problem, in a human-centered way.

The Design Thinking process is made up of five different stages: Empathise, Define, Ideate, Prototype and Test. The processes Empathise, Define and Ideate can be used parallel with another stage and repeated until an idea is formed, and then the Prototype and Test stages can begin. These stages can also be repeated until a final prototype has been created, tested and approved. So, the process is an iterative one throughout, where all stages can be repeated as well as run in sequence.

Our Process

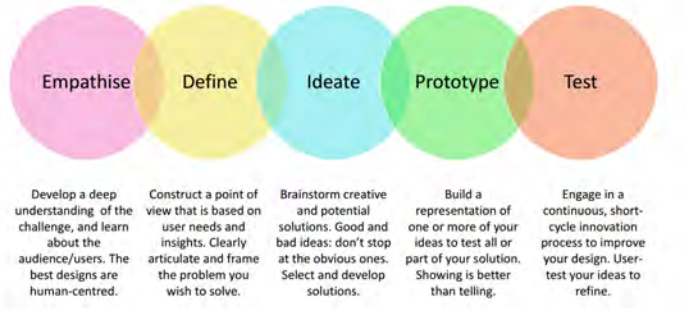
We identified potential stakeholders and users that are affected by our problem, and who we might create a solution for. This helped us create an online survey that would provide useful feedback, and also helped determine who we would like to interview first.

Through empathy interviewing we identified possible solutions which we further developed through ideation processes including various brainstorming methods, and specific techniques like the Lotus technique. From there we chose our top ten solutions that we would research further and discuss with our Industry Partner, Darrin Hackett. At our halfway point presentation with Darrin, we presented our top ten solutions that would be recorded into the Castle Method.

Using the Castle Method, our top three solutions were chosen and we continued to progress with the top-rated solutions; an Interschool Competition and an Education Programme, which has now lead to our solution, Wiser Generations.

We considered potential users of our solution, and created customer journeys for personas we developed. We tested the prototype of our solution with potential users – both for feedback, and for refinement of particular components of the solution.

The remainder of this section of the report outlines the Empathise, Define, and Ideate stages of our process in more detail. The Prototype and Test phases are discussed in more detail in Section D of this report.



(Wintec Design Hub, 2017)

RESEARCH

Primary Research

The next stage in the design thinking process was to empathise and delve deeper into our problem, in order to gather a much greater understanding of the context. Empathising can be done in a number of ways such as through the process of accumulating data and results from a survey. It can also be done through empathy interviews, through personas and by using a journey map. Our empathising process was a key part in developing ideas. Because our problem is aimed towards the public, we needed to get multiple perspectives and views from a range of age groups in order to progress through the design thinking process.

Survey

Using a survey was the first form of empathising and reaching out to receive the general public's views and perspectives towards our problem. Due to our problem statement being aimed at the Waikato DHB region, we intended on reaching out to many of the regional communities to seek their views, as well views from people in the more populated areas like Hamilton.

The survey consisted of 17 questions, some of which were very open ended and some that were quite specific. As a group we crafted and worded each of the questions so we could effectively accumulate the data that would help us narrow the scope of the problem. We created the online survey using a programme called Survey Monkey, which allowed us to send the survey line through Facebook and email. The survey was active for a total of two weeks, this allowed us time to analyse the data and identify the key findings and insights. (The survey can be found in Appendix 1)

Overall, the empathy survey helped us gain a much greater insight into the general public's feelings and beliefs about their own health and the current health systems in place. This survey also helped identify the possible pathways that we could focus our research towards: a technology solution or an education system, as these were the common themes through the survey.

Empathy Interviews

Empathy interviewing was another tool we used to gather the public's thoughts and feelings about our problem statement. Empathy interviews proved a useful tool for our situation, as these were ways of seeing what people do and don't do in regards to their wellbeing, and the wellbeing of others close to them. Empathy interviewing allowed for analysis of their thoughts and feelings around what the current health system does and does not provide/cater for the general public and all healthcare consumers.

Our empathy interviews consisted of nine questions that had lead into other related questions. These questions were a variety of personal, direct and open-ended questions, which gave the interviewee the chance to open up about their wellbeing. The people that were interviewed were from various ages and generations; this was intended, as it would provide us with a greater understanding from all aspects of our possible solutions, and what one to pursue, whether it be down the technology, educational or community pathway. (Refer to Appendix 2)

Empathy Maps

Empathy Mapping was used as a tool to help us identify some of the links and overlapping insights from the empathy interviews. This was done by taking out some of the important quotes that the interviewees said, how they felt throughout the interview, what questions they struggled with, what

things they do to help maintain a healthy lifestyle. We also considered what they thought throughout the interview. This covers the four main areas of the empathy map: Say, Think, Do and Feel.

The common themes and insights

- A considerable number of people have seen their GP in the last year. However over half of them have never had a general health check up, suggesting that they will only see their GP when they need to.
- The survey showed that people have limited knowledge on general health conditions, as knowledge about each of the stated conditions was rated well below the average.
- Over half of the survey users stated that the delivery of health education is limited in today's society. Many of these people stated that it is not taught in schools as much as it should be.
- People explained/identified areas that need to be fixed, or areas where our solution might lie, could be within the technology sector or the education sector.
- Mental health and wellbeing was important to all interviewees, as this is a large issue that has grown in recognition over the past few years as more and more people suffer from mental illness, especially in New Zealand.
- People tend to take more interest in their health as they get older.
- Most people that we interviewed were afraid of losing something; their motivation for good wellbeing was the fear of not being able to take care of themselves and not maintaining adequate health.
- Education is important. We cannot change and implement something if we don't know what we are doing wrong.
- Young adults are not ignorant to healthcare systems; it's due to the cost of booking an appointment to see a General Practitioner being so high. From a younger person's point of view, this cost can be put towards rent and food, making their health second priority.
- The underlying issue that was prominent throughout the interviews and the survey was the lack of education towards health and wellbeing throughout schools.

Further insights and common themes can be found in Appendix 3.

Empathy Interview Insight

Most people that we interviewed were afraid of losing something, their motivation is the fear of not being able anymore.

Refer to Appendix 3.

After analysing the empathy research findings, the main vision that was unmistakable was the need to better educate the younger generation on how to manage and look after their wellbeing. This confirmed to us that we had been thinking down the right path of which solution to focus on.

Taking all the key insights into consideration we had an ideation session using various ideation techniques like Brainstorming, the Lotus Method and Heuristic Ideation. During this session we came up with multiple ideas. We narrowed this down to 10 ideas of possible solutions to our problem. Some of these ideas were impractical and some were not feasible. We then pitched these ideas to our industry partner, Darrin, to receive his thoughts and ideas so we could focus our final weeks on refining or combining the ideas that had the most potential and could be developed into a working prototype.

Castle Technique

Following on from our pitch and present to our industry partner we carried out an activity in order to further define the pathway in which our solution would take, we needed to effectively rank each of our ideas. We used the Castle Technique to do this, as it was a fair and even way to rank our ideas. This technique takes into consideration the feasibility of each of the ideas and how easy implemented they were and taking the feedback that our industry partner had provided towards each of the ideas.

Once we ranked each of our original ten ideas we added up the results. The top four ideas were the ones that we took away. As a group we were happy with the outcome of this process, as it identified a pathway that was in the back of our minds, and one we were really quite passionate and proud about.

These four ideas consisted of:

- NCEA paper
- Interschool competition
- Rural nurse
- Virtual reality health experience

However, we discarded the virtual reality idea, as this solution would be unfeasible for the time frame that we were given. From the results of the castle technique we looked at ways in which we could combine two or more of ideas together or incorporate some of the ideas that one solution posed into the other solution. As they were along similar lines, we saw potential in combining the NCEA course and the Interschool competition, which focussed on students engaging with groups in the community.

D

CONCEPT & SOLUTION

Redefined Problem Statement:

How might we design an intergenerational education experience that promotes interconnectedness and a better understanding of wellbeing?

CONCEPT DEVELOPMENT & REFINEMENT

Phase One

After considering feedback from Darrin, and the feasibility of solutions through a SWOT analysis, we decided to develop our educational ideas. These ideas narrowly beat our idea of a Wellness Hub, because of the feasibility of getting multiple professionals to all meet in one place.

We took our educational ideas to a teacher at a new contemporary high school in the Waikato region, and they praised the inter-school competition. They noted that the kids there were engaged in previous community outreach work, but also noted that teachers struggled to find the time to set up connections to organise these. They gave kids a different way of learning, a new experience, and a way to give back, they would jump at the chance. The teacher also mentioned time built into their curriculum for passion projects, noting it will be easy to make time for this (see Appendix 4 for further information).

With this feedback, we decided to pursue the inter school idea further. One problem we found with the idea was the ability to measure the effectiveness of it. Our current understanding of the idea's outcomes would be to provide 'indirect' learning to the children, by putting them in places where they will interact with people in need, such as those who are retired, homeless, sick, etc. However, the idea needed to take a more active approach in facilitating learning, so we decided to integrate our second educational idea (NCEA wellness based learning). We also created a persona, Jordan Jackson, who is a male student at high school. Personas are fake stakeholders of a project, used to make and defend decisions, and to build empathy. We used this to gain an idea of a typical user of our concept.

Phase Two

We developed a basic programme for students visiting retirement homes, interacting with the retirees and teaching each other, and included a reflection session for students. This session would allow the students to think back on what they learnt during their visits. Retirees would get socialisation with youth, and learn about technology and new trends. Students would learn about lifestyle illnesses and gain valuable insights on life from retirees who have lived it. Both would be able to feel a sense of being valued, and the ability to give back. This was the first solution we had found that would fully answer our industry problem, by aiming to solve the intergenerational disconnect between the elderly and youth, and promoting wellbeing in both.

To develop this idea further, we created a customer journey map (see pg. 24-25), following the programme from the eyes of our persona Jordan. A customer journey map captures iconic experiences the user has, from their point of view, and maps what they do, think, feel, and what they interact with (Miller & Flowers, 2016). This allowed us to better plan our programme, and find gaps in what was required to allow Jordan a seamless experience.

We also created a service design blueprint in conjunction with the customer journey map. A service design blueprint documents the internal workings of how a project is run, or how the user experience is produced. (Miller & Flowers, 2016)

From this we discovered we needed to approach both schools and retirement homes, to find out what is required from both to make our programme happen. We also reworked our programme idea based on our discussion of Jordan's journey.

Phase Three

We took our revised prototype to Aged Concern, a charitable organisation that provides information and support to elderly people. They jumped at our idea, and let us know they could have the programme up and running within a day. We had a similar experience visiting Eventide Tamahere, a retirement village. We had a walkthrough of the village, the rest home, and dementia wards, and got to talk with some of the residents. They also loved our idea, and pushed for us to implement it. We gained useful feedback on the timing of the visits, to help refine our prototype.

We then took our idea back to the contemporary school teacher. They told us one teacher was needed per 25 students, as well as 2-4 parent helpers. Students also need permission from parents to leave the school. The school also needs to fill out a risk assessment management strategy. Finally, they reiterated the need within their school for a programme like this, that would set up the connections needed to allow their students to give back to the community.

Finally, we set up a meeting with a former teacher at a more traditional school within the Waikato Region. They mentioned it would be easier to start this programme at a more contemporary school, with younger students, or to implement NCEA credits into the learning. We, as a group, had already discussed this, and found it would be quite simple to record students undertaking internal assessments. There are credits within a lot of subjects that this programme could cover, such as English, music, social studies, and physical education (see examples pg. 28-29). With this feedback we refined the prototype to align in-class learning with the visits.

Phase Four

Our programme had been validated by both potential users. We now had to test part of our programme. Ethics approval limited us in what we could do, especially around kids, but we were able to organise a group of people through Aged Concern to run a couple activities, and get their opinions and criticisms.

First, we got them up and moving, performing stretches. This is an activity the students can run, to promote physical wellbeing. This also got the participants talking about physical health problems they faced, and what they had done in their past for them to occur.

Secondly, we played some conversation starter games. These were quite fun, and initiated conversations about each other's lives, past experiences, and interests. After this, we asked participants about their use of technology. There were varying answers, but we noted that they all weren't using the full potential that they had available. Youth are very adept at technology, and we are certain they could teach them anything they would like to know about it.

Finally, we talked about what they thought about the programme, what they think they could bring to the programme, and other activities they would enjoy. They had a lot of fun, and wanted it to be a recurring activity. They have a wealth of knowledge and experience, and would love to share it. They said just talking was amazing, and one even mentioned it was her longest conversation for a long time.

EARLY CONCEPT/ USER JOURNEY

Key is on the next page

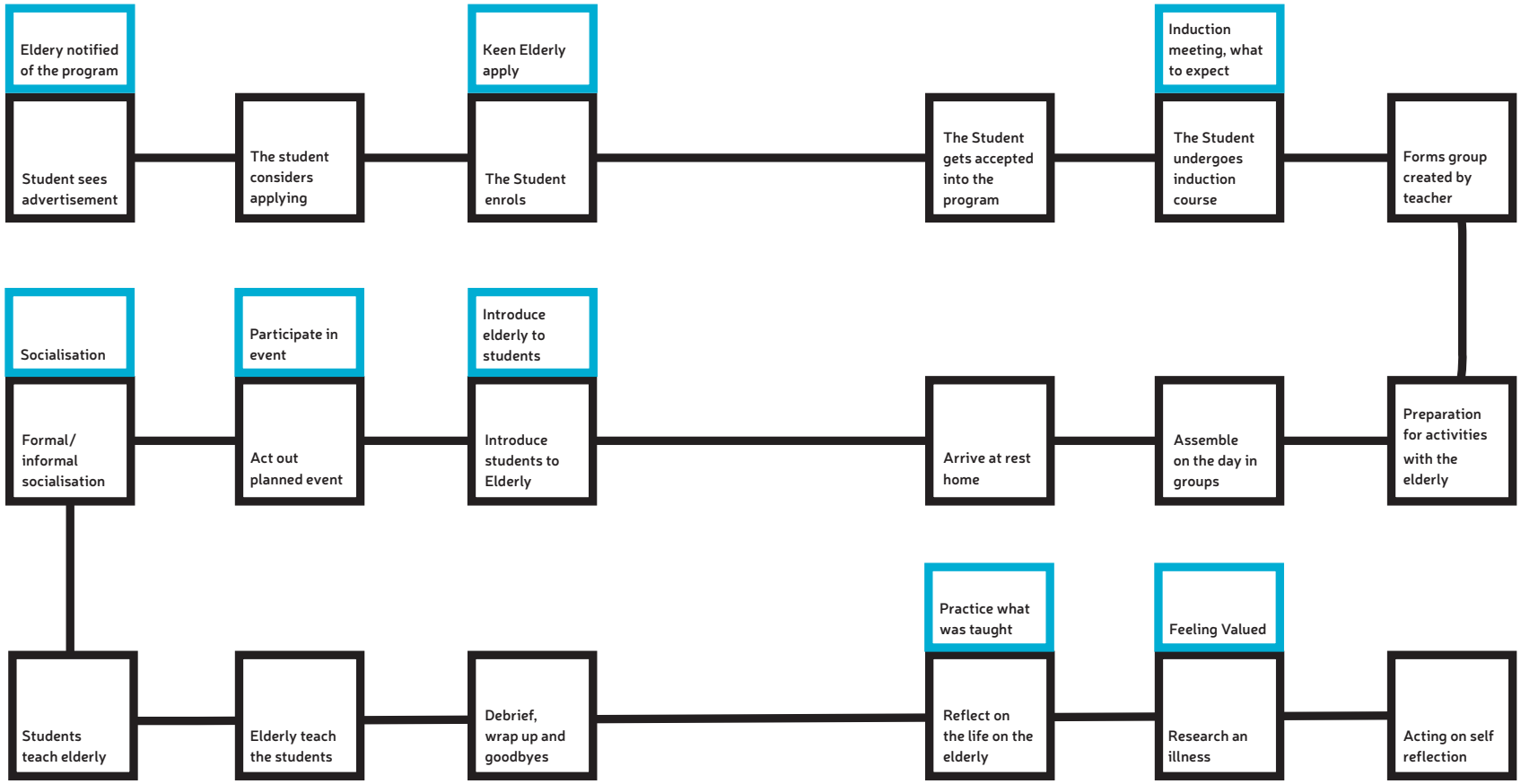
User Journey

This is one of our first concepts and user journeys, it outlines a basic journey from when a student sees the advertisement of the program, though signing up and eventually finishing the program.

We have also incorporated a parallel journey for the elderly.

Elderly journey

Student journey



FINAL CONCEPT

Wiser Generations will provide students with an insight to well-being through social interaction, lifestyle learning and activities. Students will also learn about illnesses and early prevention.

How Wiser Generations works;

Over six weeks, students will participate in an educational program twice a week, that will teach them about lifestyle and wellbeing choices also working with the eldery to learn new skills and to teach new skills.

Once a week during Week Three, Four and Five, Students will visit their organised retirement home for;

Introductions - First Visit

Ice Breaker Activities

Student-Planned Activities

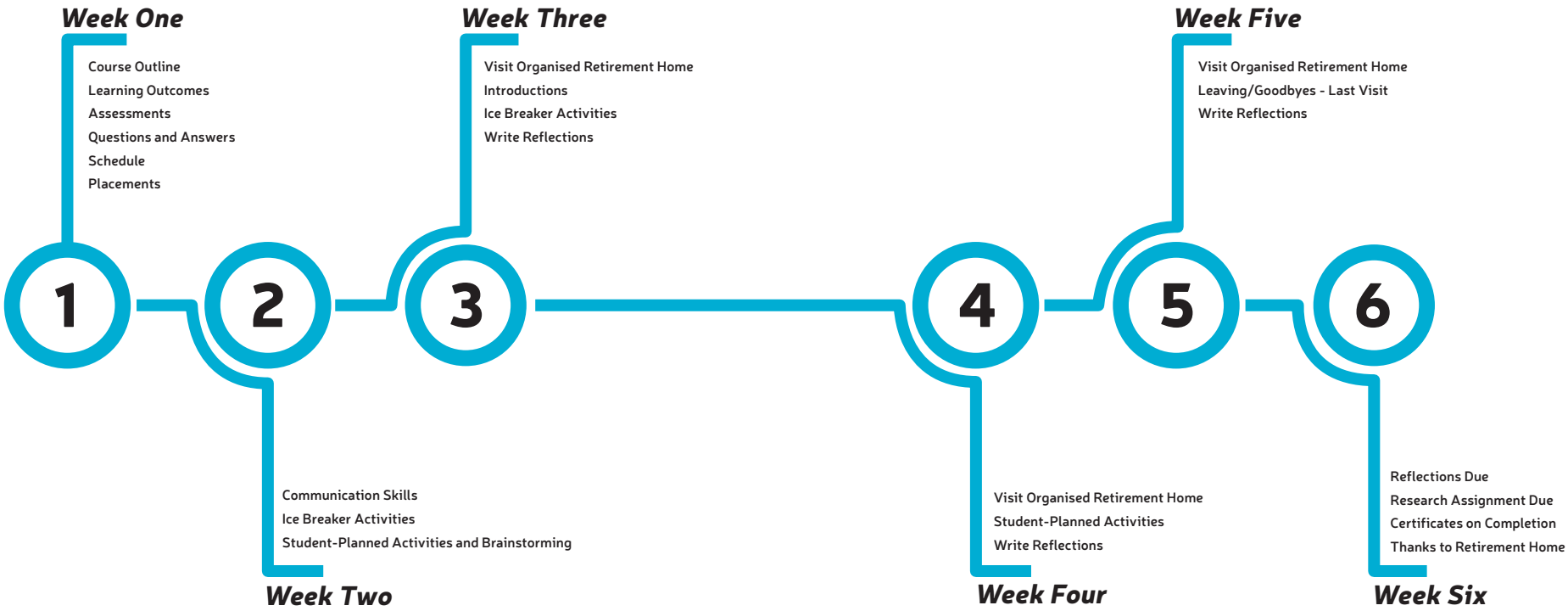
Students will work with the same retiree at each visit, where they will teach them something new in return to learn something new themselves.

Week Three, Four and Five Reflections Class:

Once a week during class time at school, students will spend their time writing reflections and researching different illness they have learnt for an assignment and answer a series of questions.

Research Assignment

Key Questions



EXAMPLES OF ASSIGNMENTS

Our initial concept uses a research assignment based on a L3 credit module (New Zealand Qualifications Authority [NZQA], 2012a). Other credits could also be granted via the Wiser Generations programme, such as credit for a public music performance (NZQA, 2012b).

Research Assignment

Administrative information
Title of the program: Analysis an international health issue
Assessment Number: AS91462
Version: 2
Credits: 5
Level: 3

Course/class description

Following the students receiving insights and life experiences into their partnered resident's lives, the students are required to carry out a research assignment about an illness that their partner may have. The aim of this assessment is to enable the students to reflect upon their visit and become educated and aware of some of the illnesses that can be prevented upon good or well-maintained health and wellbeing of our bodies throughout a person's lifetime.

The assessment will require information that they need to ask from their partner (and gain consent to use this information, as well as ensuring confidentiality of personal information) and information that will need to be researched. This must consist of different activities and habits that cause the illness that is linked to their partners and what they can be doing to help prevent and manage the effects the illness will have on their health and wellbeing.

Intended learning outcomes

- How what we do as a younger generation can affect our wellbeing and health in the later stages of life.
- How to manage the effect of the studied health issue

Structure and sequence of class activities

- The students will be handed the assessment before the commencement of their visits and activities.
- The first half of the class will consist of reflecting on the visits and preparing for the next ones.
- The last half of the class will consist of time to work on the analysis of an international health issue, and questions.

Grading procedures

The class teacher will internally mark this assessment; another colleague to ensure fairness will moderate the top two students, the average two students and the bottom two students.

Music Assignment

Administrative information
Title of the program: Perform two programs of music as a featured soloist.
Assessment Number: AS91416
Version: 2
Credits: 8
Level: 3

Course/class description

Throughout the duration of this class the music students will get an opportunity to perform two programmes of music as a featured soloist to a respectable audience in the retirement village. This NCEA paper is an internally assessed achievement standard, which students have the ability to gain 8 credits to go towards their NCEA Level 3 result. Following their performance the students will be allocated a partner based on common interests. With their partners the students will be allocated time to educate the resident in a technology sector or device, this might consist of teaching them how to use Skype or take a picture using their smart phone. The residents will also be given time to educate the student on their life experiences and how activates and habits they commenced throughout their life has influence how they live today.

By allowing the student to perform in front of the residents to gain NCEA credits, it creates self belief and confidence. This confidence can be transferred into their everyday life further increasing their wellbeing and lifestyle.

Intended learning outcomes

- Gain insight into a serious health conditions
- Students better managing their health
- Bridging the intergenerational gap

Structure and sequence of class activities

- The student or group of students will come in early to set up the stage in which they will be perform their pieces of music on.
- The students will run an Icebreaker activity to become motivated for the activities ahead.
- The music students will perform their pieces of music in front of the residents of the retirement village.
- The students will be issued a partner based on their interests and occupations and teach them how to use an aspect of technology.
- Their partners will share a life story related to their health and wellbeing
- Allocated time to reflect, gather thoughts and record them in a notebook. These thoughts will be referred back to in the reflection assessment.

Grading procedures

Careful consideration towards the marking of the student's performance from not only the presentation but also attitude and how they portray themselves during the class. Their music teacher and the course coordinator for the program will carry out the marking.

FURTHER DEVELOPMENT

Recommendations:

It is recommended that the following steps be taken to further develop the program into a framework ready for implementation:

Step 1: Validation From High Schools

There is still a need for more information and insight to answer the following:

- What school systems are best catered for this program?
- What are the processes to implement a program into a school system that involves achievement standards and field trips?
- What are the incentives to get schools and teachers on board with the program?
- What are the incentives to get students on board with the program?

It is recommended to interview school administrators, teachers and students.

Step 2: Refine Program Framework and Test with Students

After processing the findings from step 1, refine the program framework accordingly and test with a small group of 5-10 students.

Step 3: Establish Connections with Partner Organisations

Funding:

There are a number of avenues worth considering in order to get funding. Here are some recommendations:

- Seek out businesses that are ready to invest in community initiatives in order to enhance branding prestige.
- Work with existing community health programmes that may have the resources to implement the program e.g. Age Concern.
- The Waikato DHB may fund the program or provide a means of funding.

Facilitation:

Waikato DHB should determine involvement in the program and the model for facilitation. Ideally it would be a hybrid model with a representative from the Waikato DHB acting as program facilitator along with the aid of school staff.

If community programs or organisations (like Age Concern, for example) are involved then they may facilitate the program, or again it may be a hybrid model between them, the school staff and/or the Waikato DHB.

Rest Homes

Network with local rest homes and age related organisations to establish committed venues that can facilitate student visits.

Step 4: Pilot Programme

Prior to implementation, a pilot program should be trialed in a small-scale situation where risks are low and manageable. A recommended area could be Tokoroa, where some community health initiatives that are being developed could be utilised.

Branding:

Wiser Generations currently does not have a supporting brand behind it. A logo and brand standards manual will need to be developed before the programme can start.

INFORMATION

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APPENDICES

Appendix 1 - Survey

- What is your age
- Which of the following best describes your occupation
- What is your gender
- What is your ethnicity
- What is your town/city of residence
- Rate the following with importance to lifelong wellbeing
- What other things are important to you in terms of lifelong wellbeing
- How long since you last visited your GP
- Have you ever had a general health check up
- If you answered no to the previous question what are you reasons, what is stopping you
- How do you rate your knowledge of the following (smoking, age related illness, nutritional choices, and chronic illness)
- What kind of social activities do you engage in regularly
- Why are you involved in these activities
- Do you think that the degree of health educating is limited In today's society
- If you answered yes to the previous question where do you think an improvement is needed
- What are your thoughts with using technology in communicating with healthcare professionals
- To conclude what do you believe could be a pathway that would lead to better wellbeing and interconnectedness throughout the Waikato region.

Appendix 2 - Empathy Interview

1. What motivates you to take care of yourself?
2. How do you know you are healthy?
3. What ways do you interconnect with others? E.g. Community, Online
4. Where do you get support from? E.g. Health, wellbeing
    a. Who do you talk to/engage with about your wellbeing?
5. How do you learn about Health? (How could you)
6. What is wellbeing to you?
7. How do you use technology to support your wellbeing?
    a. What technology do you know off?
8. Do you know of communities that find it hard to get health and wellbeing support?
    a. What are their challenges?
9. Are you responsible for others wellbeing and how do you do that?

Appendix 3 - Empathy Insights

- Most people do not like to trust the internet for health information.
- Not every situation but seems like the majority of younger people don't care much about health as such, but it becomes more apparent as they get older
- Most seem to be afraid of losing something, their motivation is the fear of not being able anymore.
- Wellbeing is generally defined as a balance between the physical, mental and spiritual aspects
- For many, how they determine if they're healthy or not is simply based on how they feel. If they're in pain or in some discomfort they're not healthy, also if they feel good and free from pain and discomfort, they are healthy.
- It's hard to find reliable information. Also difficult to decipher credible scientific information from fads.
- Social media is a great tool for healthy recipes and exercise routines
- Education is important. We cannot change or implement something when we don't know we're doing something wrong
- Good health indicators for young adults are different to those for older people. Young adults generally don't have high blood pressure or heart problems. For them it's mostly based on diet, exercise, social interaction, sleep and home environment. Should there be a specific health check up for young adults that can look at these areas?
- Processed foods is bad
- People tend to take more interest in their health as they get older
- Doctors don't discuss diet as a way of preventing and treating issues
- Chances of success in any area of wellbeing (Nutrition, exercise, overcoming addictions etc) is high when surrounded by like minded people for support
- There's a link between parents health and the health of the children. Parents play huge role in their child's health
- Educate the parents, free seminars or something, and they can change the home

Appendix 4 - Communication with Contemporary School Teacher

"Inter-school social work competition"

A day is set aside for schools to allow students to take the day off, and instead volunteer at rest homes, hospice, cancer society etc. Student hours are tallied, and the winning school wins a prize (or certain amounts of hours unlock prizes)

DHB

- Eases workload for workers
- Gets students involved in the health sector
- Gets students learning about health, wellbeing, social development

School

- Day off?
- Gets students involved in the community
- Students learn about health, wellbeing, social development

Students

- Fuels passion for social work, health
- Learn from old people (intergenerational socialising)
- Learn about illnesses & diseases, what causes them (e.g. lifestyle diseases)
- day off?
- Win prizes

"Health NCEA Course Expansion"

An NCEA course is available for Health, but a component could be implemented that focuses on nutrition, social development etc. The course would encompass a greater focus on wellbeing, rather than just health.

- Gets children more involved in their own health/health of others
- Fuels passion for health & social work

"I love that interschool social work programme. At our place we've just kicked started community outreach programmes, but haven't even thought about approaching rest homes, hospice or the cancer society. We have done some outreach at the Neonatal until at Waikato hospital, and the kids were soooo engaged and so into it, made the learning super real and got them to think outside of their little lives for a change. it is hard for teachers to set up those connections though, takes a lot of extra work for us ya know? So there's a bit of a gap there, it would be amazingly helpful if there was a group that could facilitate that process for us. Our kids would love having that opportunity! I just know they'd jump at a chance to really give back"

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 9.4

RURAL PROJECT: SERVICES UPDATE

Purpose	1) For information

Introduction
The DHB Board received a series of briefings on the health status of its rural population and the sustainability of rural services in the 2016 year. The need for significant refocussing of attention onto the needs of the DHB's rural population was identified as a result. A high level work programme was indicated in the final report. This report is a progress update.

At the current time there are no specific staff allocated to progressing the rural work programme. Activity is being undertaken as part of normal operational management activity. Understandably there has been less progress against the original work plan than was initially intended. To a fairly large degree the iterative development of the Long Term Investment Plan now governs when the core issues of service remodelling and rural facility redesign will be able to be commenced with any certainty.

Overall progress relative to the first year of the work programme is summarised in the appendix attached to this report.

Recommendation
THAT
The report be received.

MARK SPITTAL
EXECUTIVE DIRECTOR, COMMUNITY & CLINICAL SUPPORT SERVICES

Work Stream Focus	Status	Update as at end of quarter four, 2016/17
Detailed service design to support the reconfiguration of services and facilities in the Taumarunui area		▪ Discussions with the onsite GP practice have recently commenced with a view to creating a single point of entry for all unplanned patients attending the hospital facility. Similar systems exist at Kaitaia hospital and at Te Kuiti.
The redesign of primary maternity services across the DHB's rural catchment		▪ Key service design decisions have been taken. Implementation of the service changes (which spans 2017 - 19) is progressing.
The redesign of laboratory services across the DHB's rural catchment		▪ Capital has been approved for the upgrade of Haematology analysers in the rural sites. Implementation is scheduled for early 2017/18. ▪ A review of the transport and logistics available to the laboratory has commenced. There is clear evidence that the turnaround time for some lab tests (such as throat swabs for rheumatic fever) is significantly slower for rural people due to transport system issues.
The redesign of urgent care services across the DHB's rural catchment		**Emergency/ Urgent Care component** ▪ Local provider discussions have recently commenced with a view to shifting to a single point of entry service model for all unplanned patients attending the Taumarunui hospital facility. ▪ A Smart Health kiosk is currently being trialled in the Tokoroa Hospital ED. **Inter-ED & rural hospital Retrieval component** ▪ $2M per annum has been set aside (commencing January 2018) to implement an improved rural to base hospital retrieval system. Design of the service model is underway.
The development of population based financial data capture and reporting		▪ The technical reference group has produced several options as to how DHB spend by locality populations might be made visible to the Board and executive. A final proposal is intended to be tabled with the Health Strategy Committee later in the 2017/18 year.
Other minor works		**Surgical TOP Services** ▪ The service change with BoPDHB and LDHB was unable to be implemented from 1 July as intended due to provider issues in Rotorua. A more formal notice of service change will now be issued, effective January 2018. Waikato has agreed to continue provision until December. **Thames Radiology** ▪ The CT scanner at Thames is on track to be replaced in September. This will involve in a number of patients currently scanned in Hamilton being scanned in Thames. Patient redirection is already occurring to a limited degree. **Technology enablement** ▪ The next tranche of telehealth equipment in the three Southern hospital sites has been installed. The Virtual Care team are working with Waikato Hospital services to implement virtual rather than visiting clinics.

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 9.5

WOMEN'S HEALTH TRANSFORMATION PROGRAMME

Purpose	1) For information

Introduction
The attached report provides an overview of progress on the Women's Health Transformation Programme over the last 17 months, since its genesis in March 2016.

Background
The Women's Health service has had a long and troubled history over at least a decade. Despite numerous reviews, reports and recommendations, the service has struggled to address the intransigent problems and implement the changes required to improve the service.

As a result of the above, the Women's Health Service failed to meet the core registrar training accreditation standards for the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) in October 2015. Subsequently, accreditation for training was withdrawn as of December 2015.

Concurrent with the review by RANZCOG, an in-depth service review was undertaken by Ernst Young (EY). The EY report was published in November 2015 and included numerous recommendations, inclusive of the RANZCOG recommendations, across the following areas:

- Workforce and resourcing
- Leadership
- Culture and operations
- Training, education and research
- Quality and performance improvement

The state of the Women's Health service at the time of the EY review was summarised as follows:

> *"The current situation of poor collegiality, chronic staff vacancies in midwifery, and persistently substandard O&G registrar training are symptomatic of deeper, long standing issues which have never been fully addressed. Given the high-risk clinical environment of the Service, there is a pressing need to take ownership of these issues" (EY, 2015, p2).*

The report also made the *"unusual but necessary recommendation to establish a Taskforce to drive and support implementation".*

The Transformation Taskforce (the Taskforce) convened for the first time in March 2016. A Commissioner was also appointed at this time with the dual role of chairing the Taskforce and leading the transformational change within the Women's Health Service.

Progress
The progress and status against the key recommendations is shown in the attached progress report. Almost all recommendations from the EY and RANZOCG reports have been implemented. The outstanding areas for completion by the Commissioner and Transformation team are noted in the section below.

Next Steps
The focus for the Commissioner and Transformation team over the next few months will be to prepare the service for the RANZCOG accreditation review.

Following the submission of a comprehensive report to RANZCOG in July, the Chair of the New Zealand training committee has agreed to an informal review on 11 September. The NZ committee will then make a recommendation to the Melbourne-based accreditation team about whether the service is ready for a formal review. We hope to secure their agreement to undertake a formal review in October or November as we believe that the service is now clearly meeting the accreditation standards.

The other areas of work to be completed over the next five months are as follows:

- **Midwifery workforce –** evaluation of the 12-hour shift trial in September 2017.

- **Medical Workforce and team structure** – continue the recruitment focus and complete the implementation of teams by December 2017.

- **Service culture** – changes to the culture have been ongoing since the beginning of the transformation programme but more active efforts will be made to embed the organisation values in the service over the next few months. This will include a patient stories campaign and workshops to bring the organisation values to life within the service.

- **Ward reconfiguration** – Complete the consultation document on the ward reconfiguration and implement the changes accordingly (November 2017).

- **Induction of Labour improvement** – Complete the business case for the development of an induction suite next to the delivery suite (business case due for completion October 2017).

Recommendation
THAT
The Committee notes the content of the report.

TANYA MALONEY
COMMISSIONER, WOMEN'S HEALTH TRANSFORMATION

TRANSFORMATION PROGRAMME - PROGRESS REPORT

28 JULY 2017

WORKFORCE AND RESOURCING

SUMMARY OF RECOMMENDATIONS	PROGRESS & COMMENTS	STATUS[1]
• Address immediate concerns regarding medical workforce resourcing issues.	The most pressing workforce resourcing issue over the last 17 months has been establishing a full registrar workforce following the loss of trainee registrars in December 2015. It became apparent a few months into the transformation work that the service' recruitment process was slow and numerous applicants were lost before interviews were arranged and/or appointments were made. Due to the lack of progress with recruitment, a recruitment coordinator was appointed in October 2016, reporting directly to the Commissioner. This position has taken responsibility for the coordination of all steps of the recruitment process for midwives and medical staff. Thirteen registrars have been appointed over the last 17 months. Unfortunately five have left the service over this period, including two registrars who were lost to the service as they were accepted into the RANZCOG training programme. A further two registrars have been accepted into the training programme this year and will depart in December 2017. The service expects to have only 1.0 registrar vacancy by August and to be fully appointed for registrars in October, with a number of senior registrars commencing in December to offset the loss of the trainees. Over the last 17 months, six SMOs have terminated their employment with the DHB. These changes were an expected outcome of many of the changes made under the transformation programme. A further two part time SMOs will cease employment with the service in August, but will be retained on a contract for service basis due to their high level laparoscopic skills and their status as supervisors for fellows in advanced laparoscopy. This is a very positive outcome which allows the service to continue to provide an advanced laparoscopy service and a fellowship position, whilst further developing the capability within the permanent SMO workforce. Whilst the turnover noted above was not unexpected, it has resulted in considerable pressure to recruit to SMO positions.	✓ Complete Hand back to service management Nov 2017.

[1] "Complete" indicates that the work of the Transformation Programme has been achieved and ongoing monitoring and management will be handed back to the senior leadership group

SUMMARY OF RECOMMENDATIONS	PROGRESS & COMMENTS	STATUS[1]
	Six new fulltime SMOs have commenced between April 2016 and July 2017. There is a residual SMO vacancy of 1.7 FTE up until December when another full time SMO commences. However, three locums have been engaged to work in the service over the next 5 months. The service will have a fully appointed Senior Medical Officer workforce by April 2018.	
• In order to understand resourcing requirements undertake: o Service sizing o Senior Medical Officer job sizing	Service sizing was completed in June 2016. This provided a strong indication that the current senior medical workforce numbers are approximately correct for the volume of service delivery and teaching. The individual job sizing will be completed once the team structure is fully implemented as SMO clinical schedules will change when the SMO and Registrar workforce are fully appointed at the end of 2017.	✓ Completed ❖ Awaiting full medical workforce
• Address the high level of vacancies in the midwifery workforce	Following almost a decade of significant midwifery vacancies at Waikato Hospital, the service was fully appointed to all midwifery positions in June 2017. A number of strategies were implemented to stop the attrition, attract midwives to the service and encourage midwives to increase their FTE (the average FTE was 0.6 up until May 2017). The actions included: • A change in rostering approach to ensure permanent midwives have their roster preferences met • The introduction of a 12 hour shift option (following feedback from a survey) • Proactive efforts to minimise any delays in the recruitment process	✓ Completed Hand back to service management November 2017.

TEAM STRUCTURE

SUMMARY OF RECOMMENDATIONS	PROGRESS & COMMENTS	STATUS
• Establish a team-based structure as the base units for the delivery of clinical work, teaching and supervision of residents and students, and the focus for interdisciplinary referral of patients • Develop relevant sub-speciality interests	A four team structure has been agreed. SMOs, registrars and SHOs have been assigned to each team. Each team has a special interest as follows: Team one - Urogynaecology Team two - Laparoscopy Team three - High risk obstetrics Team four - Gynae oncology & Colposcopy All teams provide obstetrics and gynaecology care and cover a set day of the on-call roster.	❖ Significant delays due to medical workforce vacancies but due for completion by Dec 2017
• Develop a system for rostering junior and senior medical staff	All senior medical staff clinical schedules were revised in June 2016 to enable team-based working, continuity of clinics (and care), and regular on-call duties. However, this has not been able to be fully implemented due to SMOs covering registrar duties. The registrar rosters have recently been reviewed and it has been determined that two additional registrars are required to ensure compliance with the MECA.	✓ Review complete However, implementation has been delayed due to vacancies (as above)

LEADERSHIP

SUMMARY OF RECOMMENDATIONS	PROGRESS & COMMENTS	STATUS
• Re-establish the clinical Service Leadership Group to support more effective planning, and prioritisation.	The Service Leadership Group (SLG) was re-established in February 2016, consisting of clinical and non-clinical members. The SLG leads and implements strategic direction and clear goals for the Women's Health Service.	✓ Completed
• Review service leadership structure including the following: o Redefine the unit manager position o Redefine the Associate Director Midwifery position	A new leadership structure for Women's and Children's Health was determined in June 2017 and is in the final stages of implementation. The changes strengthen the clinical managerial partnerships and improve the operational management and service development functions of the Women's and Children's Health services. The establishment of a new Clinical Midwife Director position within the Women's Health service has afforded authority to midwifery leadership thereby strengthening the role (an Associate Director of Midwifery position has formerly sat outside of Women's Health and did not have delegated authority within the service). The changes also provide much greater clarity about responsibilities and accountabilities which had been sorely lacking in the Women's Health service. It is of note that, through performance management, the leadership restructure and some natural attrition the service now has new people in the following positions (since March 2016): • Clinical Unit Leader • Clinical Director, Obstetrics • Director, Women's and Children's Health • Clinical Midwife Director • Service Manager, Women's and Children's Health (appointment imminent) • Charge Midwife Manager Delivery Suite • Charge Midwife Manager E1 • Charge Midwife Manager Women's Assessment Unit • Charge Midwife Manager Outpatients These changes in leadership have had a significantly positive impact on the culture of the service.	✓ Review completed ✓ On track Implementation to be completed 31 August 2017

CULTURE AND OPERATIONS

SUMMARY OF RECOMMENDATIONS	PROGRESS & COMMENTS	STATUS
Address issues of poor collegiality and low morale	A climate survey was undertaken in August 2016 which indicated that the two areas of most concern for staff were communication and feeling valued. Improvements in communication have been challenging to progress as sharing information is not part of the culture of the service. However a number of actions have taken hold such as a monthly service newsletter ('People at Heart') and regular meetings of the Director with medical and midwifery workforces. The Director meets with the registrar group on a monthly basis to listen to and respond to their concerns (or more often when required). Despite there still being some vacancies in both workforces, the overall 'mood' of the service has significantly improved. The Climate survey will be undertaken again in September once the new management structure has been embedded. Changes of personnel in the medical and midwifery workforce and the appointment of the Clinical Unit Leader and Director have assisted to build a positive and supportive culture and learning environment. There is a notable change in the collaborative efforts by the medical and non-medical workforce to continue to improve the service and to foster positive working relationships that enable a supportive training environment. Whilst the 'mood' of the service is much improved, and numerous staff have noted a more positive culture, there is significant work to do to ensure that the improvements are visible and recognised. The old narratives about the service are challenging to shift thus a proactive campaign is being undertaken in preparation for the anticipated RANZCOG review in November. Workshops will be held over the next three months which will focus on the organisation values and also allow for team building. A poster campaign with positive patient stories is underway and will be launched in August.	✓ On track Due for completion November 2017

SUMMARY OF RECOMMENDATIONS	PROGRESS & COMMENTS	STATUS
Roles, responsibilities and expectations of Service SMOs are revisited and agreed • Develop a new Service Manual based on the Service vision, governance and systems for the delivery of service excellence	The roles, responsibilities and expectations of SMOs have been clarified in the decision on team structure and organisation of the medical workforce in June 2016. This decision included very clear expectations for the SMO workforce, many of which are also included in the Service Manual as described below. The Service Manual is due to be completed mid-August 2017 and includes: o SMO Responsibilities, o Guidelines for effective team functioning, and o Service Operating Procedures	✓ On track Due for completion August 2017
• Revise Model of Service Delivery to improve patient flow and quality of care	There have been numerous improvements to the model of care over the last 17 months including: • Changes to the provision of elective caesareans • The development of a HSCAN Rapid Access clinic for gynae-oncology • Outpatient hysteroscopy clinics • Re-establishment of in-house Urodynamics clinics • The opening of a new Day Assessment Unit (DAU) - a midwife-led clinic which allows for a more coordinated service for women who require ongoing monitoring and care during the antenatal period. The outstanding model of care change is the reconfiguration of the antenatal and gynaecology wards, including improvements to the induction of labour process.	✓ On track Ward reconfiguration due for completion November 2017

TRAINING, EDUCATION AND RESEARCH

SUMMARY OF RECOMMENDATIONS	PROGRESS & COMMENTS	STATUS
• Improve level of support of trainees by all consultants including handovers, post-acute rounds and on-call	During week days there are now two SMOS on-call rather than one; one is assigned to acute obstetrics and one to acute gynaecology. This allows SMO to be available to directly supervise the junior registrars. A greater presence by the SMOs for ward rounds and handovers, and changes in senior medical personnel, has assisted in providing a higher level of commitment to fully support the registrars. There is consistent feedback from registrars within the fortnightly registrar meetings that they have no concerns accessing support and supervision from SMOs. All SMOs support registrar teaching and hold the acute phones during teaching sessions. Additional support is now being provided to junior registrars through a new buddy/mentor system. All junior registrars are now assigned a SMO mentor, separate to their formal MCNZ supervisor, who provides regular support to the registrar, both in terms of teaching and training and pastoral care.	✓ Complete Ongoing monitoring and improvement by the service leadership group
• Establish routine time out for non-clinical activity to allow time for teaching and education activity	An advanced trainee has taken on a "Chief Resident" role and has made significant progress in developing the teaching programme including: • Establishment of protected weekly registrar teaching sessions (SMOs carry the pager) • Establishment of weekly CTG education meetings • Journal Club every 4 to 6 weeks • Re-establishment of Ultrasound training	✓ Complete Ongoing monitoring and development by service leadership group
• Research opportunities need to be more actively encouraged; registrar research activities should be supported by the provision of paid protected time	The appointment of an SMO with a half time appointment at Auckland University is being finalised. There are currently two SMOs with part-time academic roles and there are several SMOs who are actively involved in research. The unit has prioritised protected time for research for the two advanced trainees, which is generating exciting research projects, with both trainees having secured ethics approval for their research.	✓ On track Ongoing monitoring and development by service leadership group

QUALITY AND PERFORMANCE IMPROVEMENT

SUMMARY OF RECOMMENDATIONS	PROGRESS & COMMENTS	STATUS
• Review MQSP and other quality and safety work to ensure they provide a clear pathway for stakeholders to take ideas about potential areas of improvement and matters related to quality and safety.	MQSP is an integral part of regular Senior Leadership Team meetings.	Review and improvements to quality and safety work will be the responsibility of the new senior leadership group
• Develop systems for data and information collection and management with a view to better supporting service quality and performance improvement efforts	The development of a service quality dashboard is underway and due for completion by December 2017.	✓ On track

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 9.6

ELECTIVE SERVICES IMPROVEMENT: COMMISSIONER PROGRESS REPORT

Purpose	1) For information

Introduction
This report provides an update on the work undertaken in the area of elective services improvement since the last report at the end of May. It is based around the five key areas of work, identified both in the initial report into elective services issues and in the Action Plan agreed for the commissioner role.

Key Focus Areas

Wait list management and ESPI Compliance
There has been more consistency in the management of wait lists over the last few months and it is pleasing to see that we have been compliant in ESPI 2 for two consecutive months (April and May) and the same for ESPI 5 (June and July).

ESPI results to end May (the most recent available from the Ministry of Health) are at Appendix 1. Final results for June and preliminary internal results for July will be available for the meeting on 9 August.

Orthopaedics still remains the specialty where there is difficulty in managing the inflows and outflows through both outpatients and inpatients.

ESPI 2 (Outpatients waiting more than four months for assessment)

All services are now reporting ESPI 2 based on the date the referral was received, rather than the date it was accepted. This is in line with Ministry expectations.

There is a lot of work to be done to regain compliance over the next few months. The services accepted a much greater number of patients for assessment in May than other months and these patients will need to be seen by the end of September. Planning is underway for additional clinics etc.

ESPI 5 (Inpatients waiting more than four months for treatment)

As noted above, we achieved compliance in June and July (on internal results). However, orthopaedics is still the outlier in terms of the number of non-compliant patients and work will

continue to reduce this number. This in turn will give the DHB a 'buffer' for unexpected events in other services.

Delivery of elective volumes
While final Ministry results will be available for the meeting, our internal results show that we easily delivered the Health Target, which is a volume based target and include procedures such as skin lesion removal and intra-ocular injections. Our electives funding is mainly based on caseweight delivery.

Due to the large quantity of outsourcing completed in the last six months, we improved our delivery to over 97% of the caseweight target. This allowed us to 'wash up' with other non-admitted volumes and meant we earned all but approx. $500k of the $30m available. This was a significant achievement, given where we sat at the end of December. Internal results to the end of June are attached as Appendix 2.

Electives funding for 17/18
Electives funding is able to be spread across the Electives Initiative (as above) and the Ambulatory Initiative (which includes FSAs and non-admitted procedures such as colonoscopies). For 2017/18, we have agreed an allocation with the Ministry that spreads the funding across all electives components. This will therefore minimise the revenue risk and allow volumes already being delivered to be funded through this external revenue.

Outsourcing for 17/18
This has been a major area of focus over the last two months. The outcome is that we have agreed a mix of facility only (where we provide the surgeon) and fully outsourced contracts with a number of providers, both in and out of region. The facility contracts cover all the main surgical services, while the outsourced contracts are focused on orthopaedics and colonoscopies.

As we could not secure all the theatre sessions we would have wanted, some budget remains to outsource some remaining volumes if this proves to be necessary. On the other hand, if the internal delivery is greater than anticipated, we have a clause in the contract for a six monthly volume review and can adjust these accordingly.

It should be noted that the original outsourcing RFP was based on an internal production planning gap of approximately 4,000 cases. Most recently, that gap is showing as 5,500 cases. However, we negotiated the allocation of electives funding (above) based more on the actual delivery for 16/17 than the 17/18 production plan. Therefore I am confident, that together with a small increase in internal delivery, the outsourced volumes will ensure the DHB meets the Ministry's targets.

Systems and Processes
As previously noted, work has focused on the outsourcing plan and modifying the outsourcing processes / documentation to ensure these cover all the necessary details.

Work has also focused on key reporting requirements for monitoring electives delivery across both internal and outsourced delivery.

There is ongoing work around:

- Transitioning the urology service to be fully compliant with both implementation and reporting of wait list data to the Ministry;
- Reporting from the Pre-Hospital Preparedness project, to measure time from assessment to wait list;
- Modifying the production plans to reflect the Ministry negotiated volumes;

- Expanding the weekly wait list meeting to include all ESPIs;
- Developing the electives reporting to combine aspects of both ESPI and delivery.

Clinical decisions
No specific work has been focused on clinical prioritisation or other clinical decisions, except as incidental to other work. However, we are now beginning to address the areas within the hospital where there is divergence from the use of nationally accepted prioritisation tools.

Project governance and operational oversight
These groups continue to meet on a regular basis.

Recommendation
THAT
The Committee notes the report.

BRENDA WILLS
ELECTIVE SERVICES IMPROVEMENT COMMISSIONER

Appendix 1

MoH Elective Services Online

Summary of Patient Flow Indicator (ESPI) results for each DHB

DHB Name: Waikato

	2016 Jun			2016 Jul			2016 Aug			2016 Sep			2016 Oct			2016 Nov			2016 Dec			2017 Jan			2017 Feb			2017 Mar			2017 Apr			2017 May		
	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.
1. DHB services that appropriately acknowledge and process patient referrals within required timeframe.	25 of 26	*96.2%*	1	22 of 26	*84.6%*	4	21 of 26	*80.8%*	5	18 of 26	*69.2%*	8	18 of 26	*69.2%*	8	3 of 26	*11.5%*	23	6 of 26	*23.1%*	20	20 of 26	*76.9%*	6	14 of 26	*53.8%*	12	6 of 26	*23.1%*	20	3 of 26	*11.5%*	23	8 of 26	*30.8%*	18
2. Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	262	**2.7%**	-262	585	**5.4%**	-585	464	**4.5%**	-464	30	*0.3%*	-30	140	**1.4%**	-140	393	**3.7%**	-393	406	**4.0%**	-406	342	**3.4%**	-342	189	**2.0%**	-189	122	**1.3%**	-122	24	*0.3%*	-24	32	*0.4%*	-32
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	93	*0.6%*	-93	82	*0.5%*	-82	61	*0.4%*	-61	44	*0.3%*	-44	42	*0.3%*	-42	15	*0.1%*	-15	10	*0.1%*	-10	11	*0.1%*	-11	14	*0.1%*	-14	14	*0.1%*	-14	24	*0.1%*	-24	29	*0.2%*	-29
5.Patients given a commitment to treatment but not treated within the required timeframe.	38	*1.0%*	-38	46	**1.3%**	-46	43	**1.2%**	-43	45	**1.3%**	-45	27	*0.7%*	-27	34	*0.8%*	-34	63	**1.5%**	-63	181	**3.9%**	-181	99	**2.2%**	-99	41	*0.9%*	-41	142	**3.3%**	-142	85	**1.9%**	-85
6. Patients in active review who have not received a clinical assessment within the last six months.	4	*4.0%*	-4	4	*4.5%*	-4	1	*1.5%*	-1	4	*8.5%*	-4	20	**45.5%**	-20	4	*25.0%*	-4	2	*11.1%*	-2	2	*9.1%*	-2	2	*11.8%*	-2	0	**0.0%**	0	3	*10.7%*	-3	4	*10.8%*	-4
8. The proportion of patients who were prioritised using approved nationally recognised processes or tools.	1118	*99.8%*	2	916	*93.2%*	67	1183	*93.4%*	83	1080	*93.8%*	72	932	*90.0%*	103	1362	*93.9%*	89	912	*90.0%*	101	908	*94.7%*	51	1121	*94.6%*	64	1552	*92.7%*	123	1021	*92.3%*	85	1488	*90.3%*	160

Data Warehouse Refresh Date: 30/Jun/2017

Report Run Date: 03/Jul/2017

Appendix 2a: Volumes

Actuals as at : 30/06/2017

IDF outflow as at:30/06/2017

Waikato - 2016/17 Electives Initiative
YTD Discharge Summary and Full Year Plan

Purchase Unit Group	Purchase Unit Code and Name	YTD Base Planned Discharges	YTD Additional Planned Discharges	YTD Total Planned Discharges	Actual Discharge Delivery	Base to Actual Discharge Variance	Total to Actual Discharge Variance	% YTD Discharge Delivery	2016/17 Base Planned Discharges	2016/17 Additional Planned Discharges	2016/17 Total Planned Discharges
Other	D01.01 Inpatient Dental	617	252	869	1,028	411	159	**118.3%**	617	252	**869**
	M10.01 Cardiology	457	191	648	869	412	221	**134.1%**	457	191	**648**
Other	**Other PUCs Total:**	**1,074**	**443**	**1,517**	**1,897**	**823**	**380**	**125.0%**	**1,074**	**443**	**1,517**
Surgical	S00.01 General Surgery	1,615	478	2,093	2,330	715	237	**111.3%**	1,615	478	**2,093**
	- Less additional General Surgery				-309						
	S00.01 General Surgery Less additonal volumes recorded against additional below	1,615	478	2,093	2,021	406	(72)	**96.6%**	1,615	478	2,093
	S05.01 Anaesthesia	81	28	109	158	77	49	**145.0%**	81	28	**109**
	S15.01 Cardiothoracic	114	64	178	144	30	(34)	**80.9%**	114	64	**178**
	S25.01 ENT	1,715		1,715	1,681	-34	(34)	**98.0%**	1,715		**1,715**
	S30.01 Gynaecology	1,148	305	1,453	1,176	28	(277)	**80.9%**	1,148	305	**1,453**
	S35.01 Neurosurgery	98	65	163	188	90	25	**115.3%**	98	65	**163**
	S40.01 Ophthalmology	1,627	160	1,787	1,670	43	(117)	**93.5%**	1,627	160	**1,787**
	S40007 Intraocular injections		800	800	2,692	2,692	1,892	**336.5%**		800	**800**
	S45.01 Orthopaedics	924	912	1,836	1,590	666	(246)	**86.6%**	924	912	**1,836**
	S55.01 Paed Surgical	412	199	611	513	101	(98)	**84.0%**	412	199	**611**
	S60.01 Plastics	1,277	516	1,793	1,981	704	188	**110.5%**	1,277	516	**1,793**
	S70.01 Urology	728		728	544	-184	(184)	**74.7%**	728		**728**
	S75.01 Vascular	364	215	579	657	293	78	**113.5%**	364	215	**579**
Surgical	**Surgical PUCs Total:**	**10,103**	**3,742**	**13,845**	**15,015**	**4,912**	**1,170**	**108.5%**	**10,103**	**3,742**	**13,845**
	MS02016 Skin Lesion Removal	741	453	1,194	1,956	1,215	762	**163.8%**	741	453	**1,194**
	PUCs Total:	**741**	**453**	**1,194**	**1,956**	**1,215**	**762**		**741**	**453**	**1,194**
	Total Discharges:	**11,918**	**4,638**	**16,556**	**18,868**	**6,950**	**2,312**	**114.0%**	**11,918**	**4,638**	**16,556**
	S00.01 General Surgery - additonal		309	309	309			**100.0%**		309	**309**
	Check total	11,918	4,947	16,865	19,177	6,950	2,312	**113.7%**			

Appendix 2b: Caseweights

as at **30/06/2017**

Waikato - 2016/17 Electives Initiative

Purchase Unit Group	Purchase Unit Code and Name	YTD Base Planned CWD Volume	YTD Additional Planned CWD Volume	YTD Total Planned CWD Volume	Actual CWD Delivery	Base Plan to Actual Variance	Total to Actual CWD Variance	% YTD CWD Volume Delivery	2016/17 Base Planned CWD Volume	2016/17 Additional Planned CWD Volume	2016/17 Total Planned CWD Volume
Other	D01.01 Inpatient Dental	262.9	126.4	389.3	492.6	229.68	103.28	126.5%	262.9	126.4	389
	M10.01 Cardiology	460.9	311.4	772.3	1,276.0	815.10	503.71	165.2%	460.9	311.4	772
Other	**Other PUCs Total:**	**723.8**	**437.8**	**1,161.6**	**1,768.6**	**1,044.78**	**606.99**	**152.3%**	**723.8**	**437.8**	**1,162**
Surgical	S00.01 General Surgery	2,337.9	694.7	3,032.6	3,370.8	1,032.89	338.22	111.2%	2,337.9	694.7	3,033
	S05.01 Anaesthesia	20.8	7.0	27.8	46.8	26.01	19.01	168.4%	20.8	7.0	28
	S15.01 Cardiothoracic	757.1	427.0	1,184.2	929.2	172.03	(254.99)	78.5%	757.1	427.0	1,184
	S25.01 ENT	1,229.1		1,229.1	1,176.8	(52.39)	(52.39)	95.7%	1,229.1		1,229
	S30.01 Gynaecology	1,127.1	296.8	1,423.9	1,154.0	26.95	(269.84)	81.0%	1,127.1	296.8	1,424
	S35.01 Neurosurgery	346.1	228.3	574.4	644.4	298.33	70.03	112.2%	346.1	228.3	574
	S40.01 Ophthalmology	983.0	96.5	1,079.5	976.1	(6.95)	(103.45)	90.4%	983.0	96.5	1,080
	S40007 Intraocular injections		47.3	47.3	130.4	130.42	83.08	275.5%		47.3	47
	S45.01 Orthopaedics	2,478.5	2,387.9	4,866.4	4,152.1	1,673.61	(714.28)	85.3%	2,478.5	2,387.9	4,866
	S55.01 Paed Surgical	315.2	150.5	465.7	402.4	87.18	(63.32)	86.4%	315.2	150.5	466
	S60.01 Plastics	991.5	400.4	1,391.9	1,394.2	402.76	2.34	100.2%	991.5	400.4	1,392
	S70.01 Urology	975.7		975.7	695.9	(279.85)	(279.85)	71.3%	975.8		976
	S75.01 Vascular	619.2	361.7	980.9	942.8	323.54	(38.12)	96.1%	619.2	361.7	981
Surgical	**Surgical PUCs Total:**	**12,181.3**	**5,098.1**	**17,279.4**	**16,015.8**	**3,834.54**	**(1,263.56)**	**92.7%**	**12,181.3**	**5,098.1**	**17,279**
	MS02016 Skin Lesion Removal	177.8	109.2	287.0	474.3	296.49	187.31	165.3%	177.8	109.2	287
	PUCs Total:	**177.8**	**109.2**	**287.0**	**474.3**	**296.49**	**187.31**	**165.3%**	**177.8**	**109.2**	**287**
	Total CWD Volume:	**13,082.9**	**5,645.1**	**18,728.0**	**18,258.7**	**5,175.81**	**(469.26)**	**97.5%**	**13,082.9**	**5,645.1**	**18,728**

Next update at October meeting

Next update at October meeting

A proposed third Waikato Medical School for New Zealand – an Update August 2017

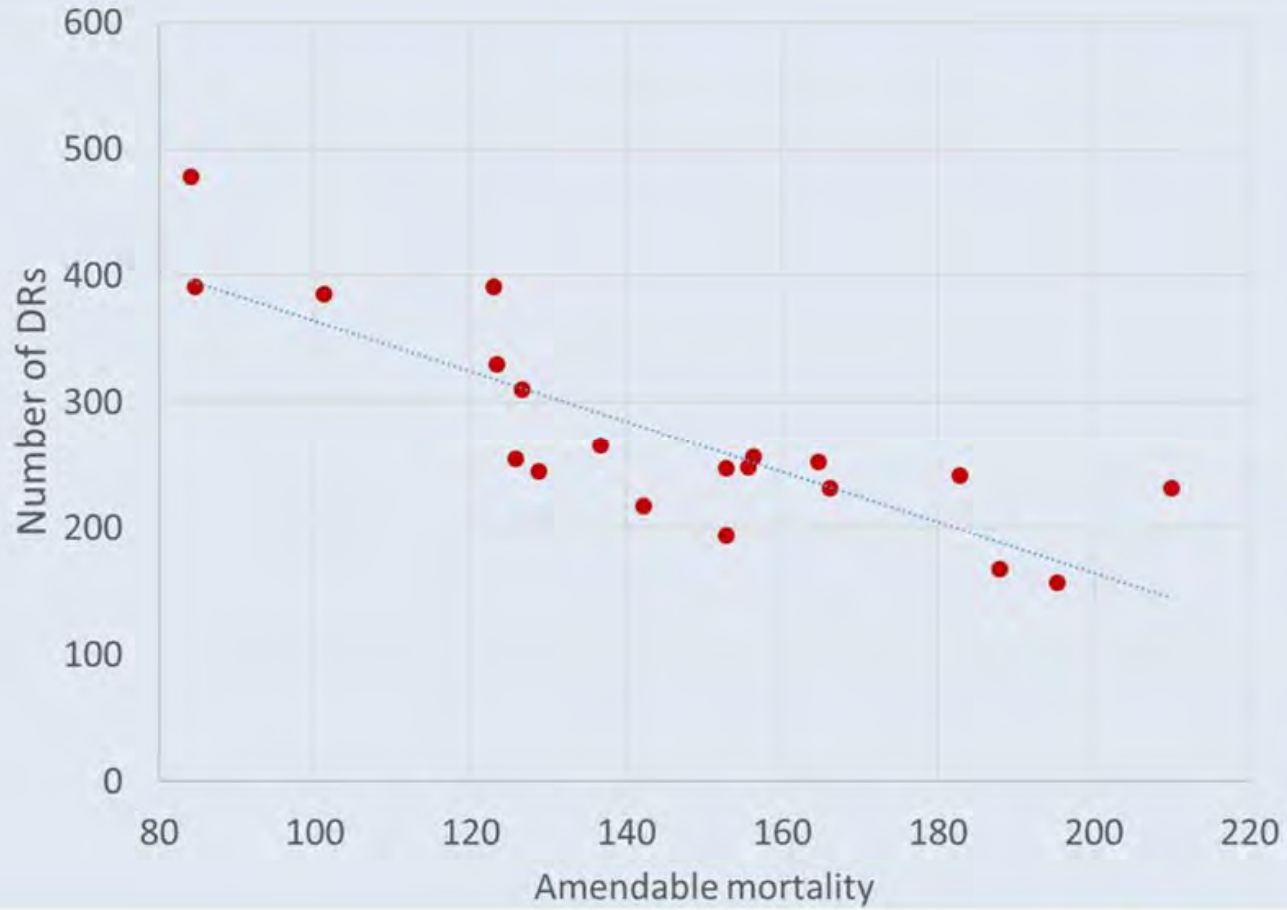
Ross Lawrenson
Professor of Population Health, University of Waikato
Clinical Director of Strategy and Funding, Waikato DHB

Overview

- New Zealand has wide disparities in health outcomes which are strongly associated with socio-economic and ethnic differences.
- New Zealand also has a shortage and maldistribution of doctors particularly in high needs rural and provincial areas
- Rural and provincial centres therefore rely on overseas trained doctors to serve the high needs populations that the current New Zealand graduating workforce shy away from
- International experience suggests that the introduction of a socially accountable medical education program can address the health inequities

Waikato Medical School proposal

- Aims to address the health inequity in our high needs communities and populations through a Community Engaged approach
- High needs include our Maori and rural communities, our elderly population and those with mental health disabilities
- Concerned by regional shortages and “inverse care” effect where those most at need have greatest difficulty accessing care



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9.9

Waikato District Health Board

Curriculum

- 4 year integrated program
- Community involvement from year 1
- Longitudinal inter-professional attachments in community based learning centres in year 3
- Year 4 preparation for PGY1
- Must meet Australian Medical Council standards

Postgraduate pipeline

- Working with DHB partners to provide the postgraduate pipeline
- Expand numbers in PGY1 and 2
- Expand the provision of community placements in PGY1 and 2
- Provide extra incentives locally for high needs specialties – psychiatry, geriatric, GP, rural hospital medicine etc

Progress since previous Board meeting

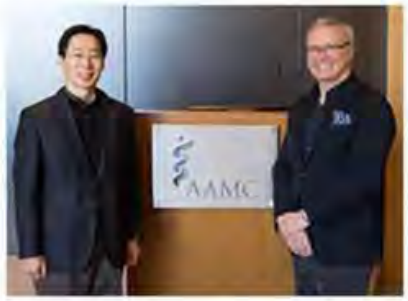
- Updated business case submitted 31st May 2017
- Meeting with Ministry of Health
- Meeting with other key stakeholders
- Media publicity
- Smart Health MOU with University

Meeting with the Ministry of Health / HWNZ

Emmanuel wins Data Olympics at International Health Workforce Collaborative

Updated on 8 November, 2016 - 14:33

Emmanuel Jo, Principal Technical Specialist, from Workforce Education Intelligence and Planning, HWNZ, People and Transformation, has taken out the top prize at the 'Data Olympics' held as part of the recent International Health Workforce Collaborative (IHWC).



Emmanuel Jo and HWNZ Board Executive Chair Professor Des Gorman

The 16th Collaborative was held in Washington, DC from 24-28 October 2016 hosted at Association of American Medical Colleges. The invitation only conference, provided delegates with a unique opportunity to discuss key global and local workforce issues in the United States, Canada, the United Kingdom, Australia and New Zealand. This is first time the New Zealand Ministry of Health participated in the IHWC. Emmanuel gave an outstanding presentation at the Data Olympics and won gold for New Zealand in challenge 1.

The 'Data Olympics' explored three challenges:

- How are you modelling future health workforce supply, accounting for workforce and broader health system changes?

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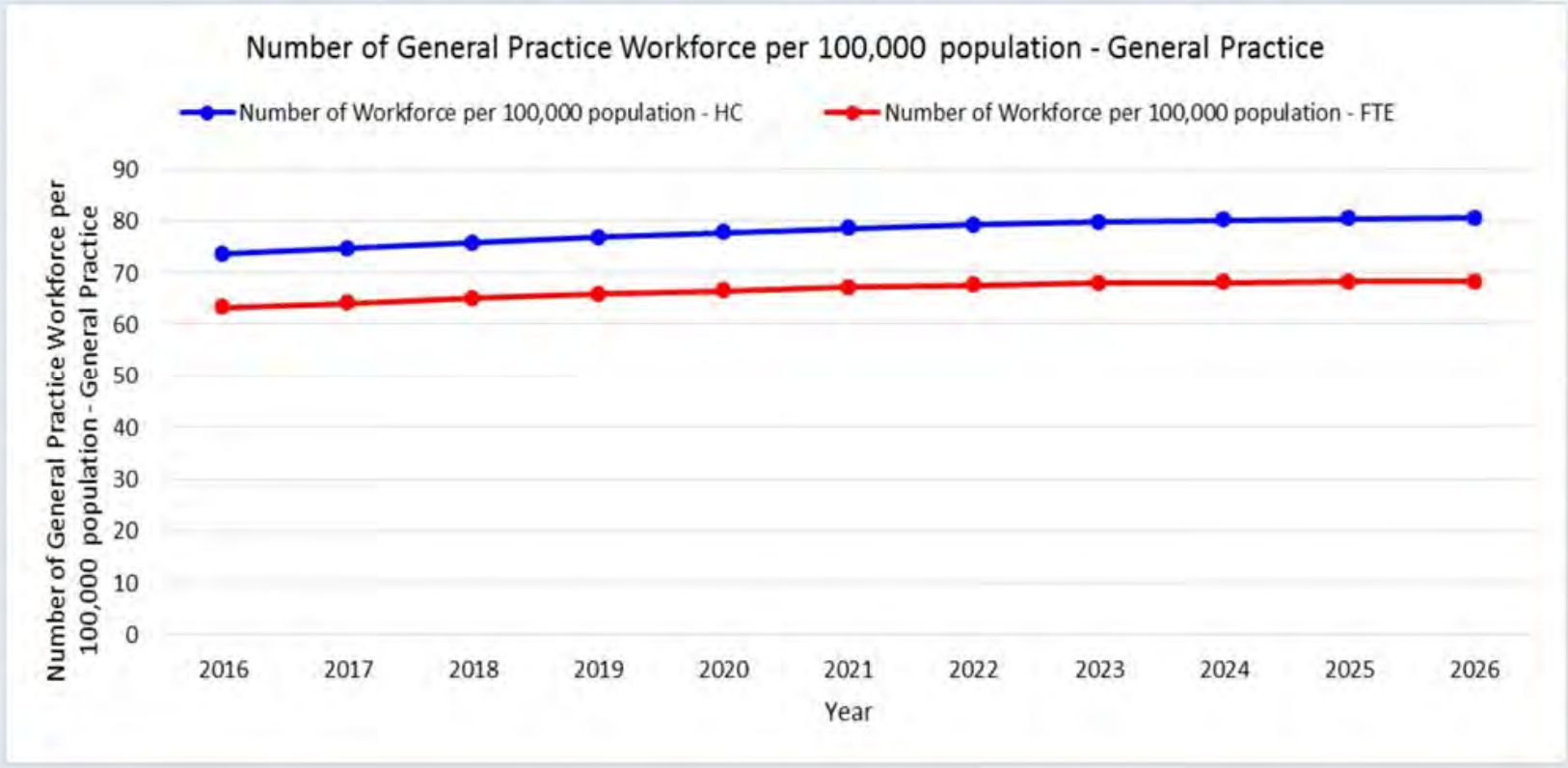
9.9

HWNZ predicted increase in GP workforce per FTE



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Projected number of New Zealand graduates expected to register pa with addition of WMS and projected need based on growth at 2.5% and retirements

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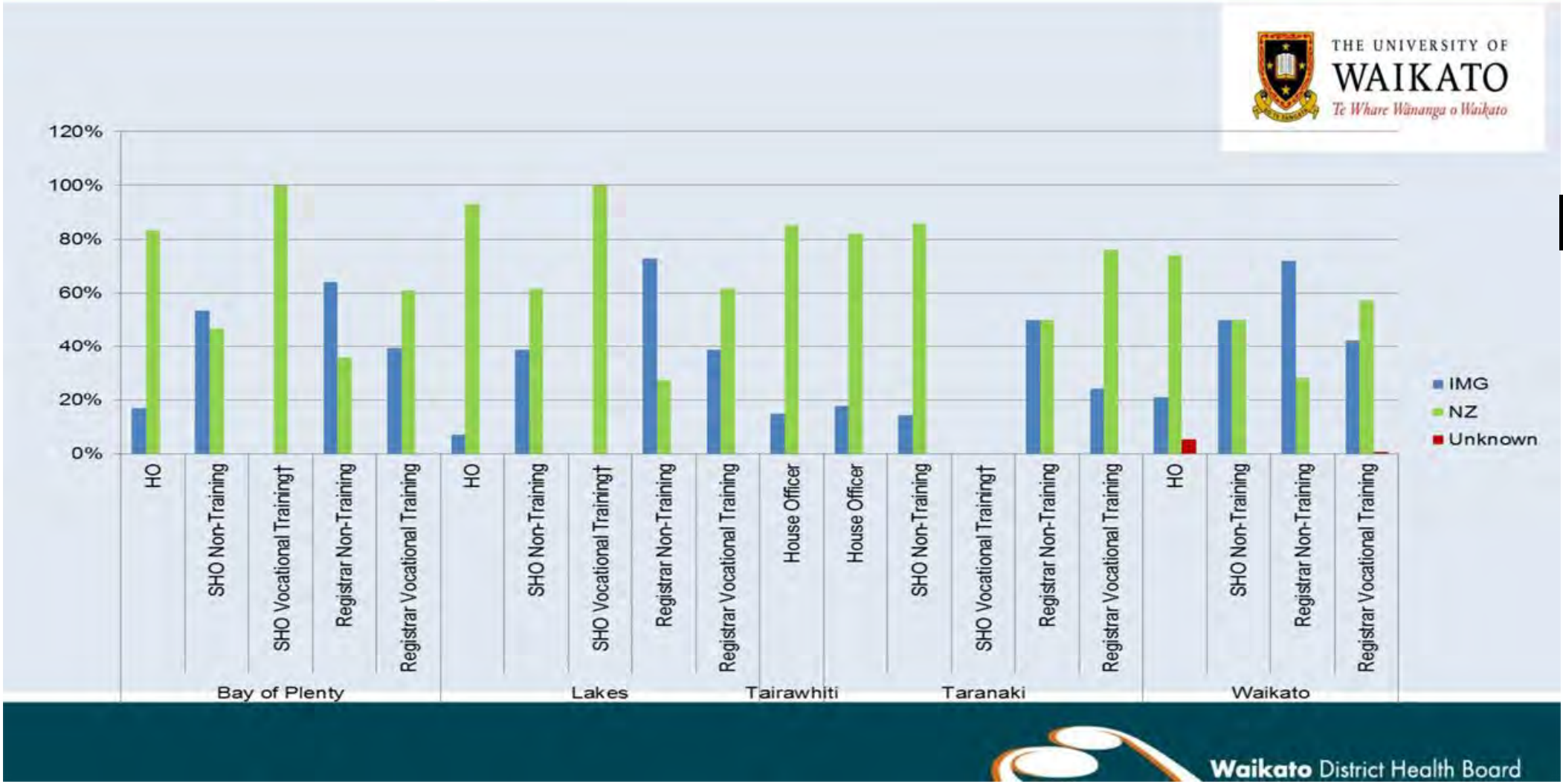
Waikato District Health Board

9.9

DHB Training posts 2015



9.9

Waikato DHB RMO Workforce 2016

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9.9

Occupation Title	Total	International Medical Graduates
House Officer	85.0	20.0%
Senior House Officer Non-Training	32.0	59.4%
Registrar Non-Training	67.6	55.6%
Registrar Vocational Training	181.7	44.4%

Other specialties

- Psychiatry (59% IMG)
- Geriatrics
- Palliative care (59% IMG)
- Rehabilitation medicine (62% IMG)
- General medicine
- Obstetric and gynaecology (56% IMG)

Meeting with other key stakeholders

- Medical Council
- RNZCGP (including Conference presentation by Prof Neil Quigley)
- Medical Students (UMSA Conference in Christchurch)
- NZ Nursing Organisation
- Potential partners for inter-professional learning opportunities

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9.9

Media

- Waikato DHB website
- University website
- Newspapers

Hamilton politicians and hopefuls back Waikato Medical School proposal

- The proposed Waikato medical school is shaping up to be a key issue in the lead-up to this year's general election.
- Currently the proposal, a joint initiative between Waikato University and the Waikato DHB, is being considered by Health Minister Jonathan Coleman and Tertiary Education, Skills and Employment Minister Paul Goldsmith.
- Prime Minister Bill English has declined to say whether a decision on the proposal will be made before the election on September 23.
- Today, Hamilton's MPs and aspiring parliamentarians give their views on Waikato's bold med school bid.

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9.9

Waikato District Health Board

Business think tank backs Waikato Medical School bid

- Waikato Means Business steering group chairman Dallas Fisher said members strongly support the region's Waikato Medical School bid.
- Some of Waikato top business leaders have thrown their support behind the region's Waikato Medical School bid.
- Members of Waikato Means Business have endorsed the proposed Waikato Medical School, saying parts of the region are being held back due to a shortage of healthcare workers.

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9.9

Waikato District Health Board

Waikato med school needed to fix ‘dire’ GP shortage

- Putaruru GP Doctor David Srinivasagam has worked in the South Waikato for 17 years and loves its close-knit community.
- A solution to heartland New Zealand’s GP crisis lies with its young people, a rural stalwart says.
- Doctor David Srinivasagam has worked as a GP in Putaruru for the past 17 years and knows too well the difficulties of attracting doctors to rural communities.
- He’s one of only two permanent doctors serving more than 5500 patients across Putaruru and Tirau.

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9.9

Waikato District Health Board

Media attention

- Kiwi students back Aussie medical school model
  26 June 2017 9:47 am
  The Waikato bid draws inspiration from the Flinders model with its proposal to put graduate-entry students through four years of training, including one year based in a community setting

- Aspiring doctors head offshore due a lack of graduate-entry options
  Thursday, 22 June 2017 5:32 pm
  New Zealand is losing aspiring doctors to other countries because it lacks a graduate-entry medical program.

CEME

Waikato District Health Board

Expanding Rural Health Services

A national solution to a national issue

What's the problem?

What are we doing about it?

What is a rural hub?

What more can we do?

The only national solution

The cost-effective solution

When could this happen?

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9.9

Waikato District Health Board

Smart Health

- MOU has been agreed
- Darrin Hackett has met with Prof Geoff Holmes

- Research plans being discussed

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Training for Health Equity Network : THEnet

- https://thenetcommunity.org/resources

- https://www.youtube.com/watch?v=J7N0L8ldo-k

Overview

- Wider understanding of the issues and the strength of the Waikato bid
- Better visibility with politicians
- Progress on underpinning bid with activity in the health field
- Still waiting to hear a decision to the proposal

Next update at October meeting

Next update at October meeting

Priority Programme Plans

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 10.1

PRIORITY PROGRAMME PLAN PROJECT UPDATE AND REQUEST

Purpose	1) For assessment and input

Introduction
This paper presents a re-cap on the Priority Programme Plan Project. Attached to this paper is a project update (appendix A) for information and a request for input (Appendix B).

Re-cap
A part of the development phase of the Waikato DHB Strategy Refresh Project a clear problem was identified. That problem was:

> *"…..that the main concern is our strategic priorities do not link to or drive how the organisation operates on a day-to-day basis. Staff identified a need to have a strategic direction that supports the parts of the organisation to work as a collective whole for a common purpose. Staff indicated they feel their day-to-day work occurs in a vacuum and that it is not linked directly enough to a clear sense of the DHB's overall priorities….."*

While the strategy refresh process had its' complexities, a lot of thinking and work had occurred to shape up the priority programme plan approach as a strategy implementation vehicle. Aside from the overarching focus of improving the health of our population and eliminating inequities, the priority programme planning approach is part of the solution to the initial problems around:

- Linking the strategy to day-today activity
- Having a strategic direction that drives the organisation to work as a collective on a common purpose
- Providing a clear sense our priorities

Objectives of the Priority Programme Plan Project
Achieving the Priority Programme Plan Project requires the following objectives to be realised:

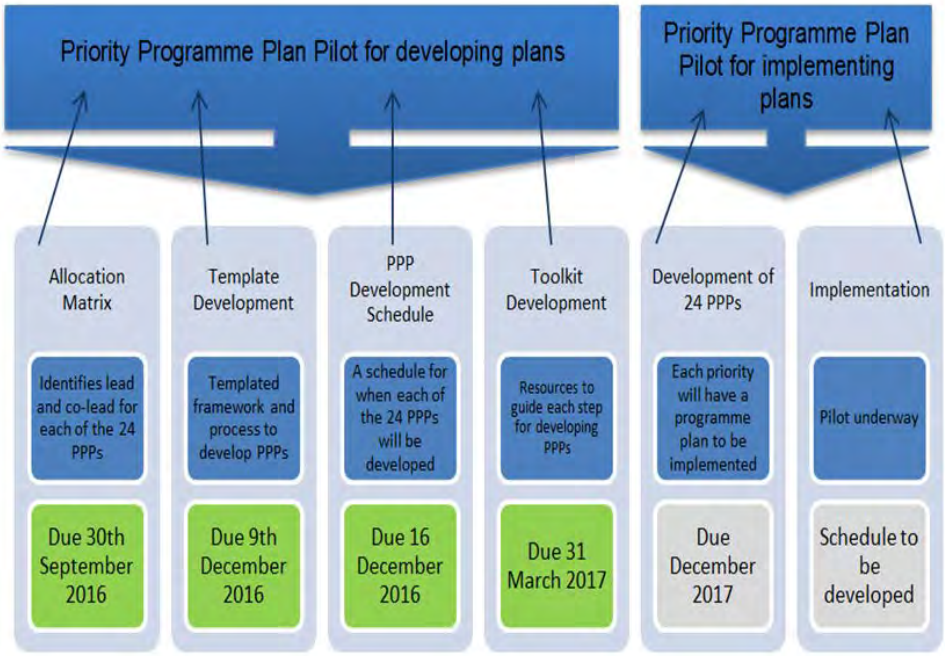
- Identification of projects and activities at a National, Regional, and Local level (with the aim to reduce duplication)
- Organise work currently being carried out and scheduled to be carried out by the Waikato DHB
- Identify gaps and plan activities to fill the gaps in the long and short term
- Identify ways to work more proactively where possible

- Strengthen processes to identify and respond to priority areas
- Work more collaboratively with each other / stop silos (where possible and/or required)
- Ensure accountability and responsibility is clear
- Ensure robust information for decision making is available
- Develop a process that responds to the diversity of the organisation's business and activities

Approach

The overarching Priority Programme Plan Project is responsible for designing the process for the development of all Priority Programme Plans. Priority Programme Plan methodology and approach have been developed using a scalable and templated process to ensure consistency and robustness of approach. Tested templates support the process and tools to optimise delivery of the objectives.

The Priority Programme Plan Project approach is summarised in the diagram below.



Recommendation

THAT

1) The Committee notes the content of Appendix A
2) The Committee provides comment on Appendix B

ESMAE MCKENZIE-NORTON
PLANNING AND INTEGRATION MANAGER
STRATEGY AND FUNDING

NICOLA PARKER
CHANGE MANAGER
CHANGE TEAM

Appendix A

Update on PPP Project progress

Below is a status table for the activities and process for developing the plans:

Activity	Detail of activity	Status
Allocation Matrix	All priorities have been allocated to the Executive Group This matrix identifies one or more lead/s (Alpha) and one or more co-lead/s (Bravo). The Alpha and Bravo roles are made up of the Executive Group. The working groups that will be developed for each priority will include staff and non-staff (consumers, providers etc.) where appropriate.	Completed 30th September 2016
Priority Programme Plan Template	A priority programme plan template has been developed to guide executives and working groups in the development of priority programme plans. The Pilot and Executive Group feedback was key to developing the template.	Completed 9th December 2016
Development Schedule	The development schedule identifies the timing of when each priority programme plan will be developed. The rationale used for the scheduling was due to the nature of the priorities and the different requirements of each. Phase One was identified as expected to take longer due to the size and requirement for relationship building. Phase two include the priorities that are more foundational priorities. Phase Three include the priorities that focus on building the activity listed in the priority. Phase Four include priorities that take more of a delivery approach. Using a phased approach will also allow following phases to leverage off the work developed in earlier phases.	Completed 16th December 2016
Pilot Priority Programme Plan	A pilot for developing the priority programme plans was completed in February 2017 and the Health Strategy Committee gave approval for implementation on 8th March 2017. The priority piloted is 4.4: Enable a culture of innovation to achieve excellence in health and care services. A pilot was undertaken so staff could utilise the momentum of the new strategy while developing a robust process for developing priority programme plans.	Completed 28th February 2017
Toolkit for developing Priority Programme Plans	A toolkit for developing priority programme plans is being developed with the majority of the collateral for the toolkit developed through the Pilot process. The development of the toolkit will increase the sustainability of current and future priority programme plans and is a key deliverable for succession planning.	Completed 1st May 2017
Reporting dashboard	A dashboard providing the status of each PPP's development following the agreed process has been developed. An updated dashboard is delivered at each Executive Group meeting and at each Health Strategy Committee meeting. The dashboard provides some narrative on 'wins', 'risks', 'next steps'.	Completed 14th June 2017

Update on PPP development - Dashboard

Priority Programme Plans Update for Executive Group – 28 July 2017

KEY:
Green=Complete or on track
Orange= Work occurring
Red= Off track with no work occurring

Priority #	Priority Name	Alpha	Alpha	Alpha / Bravo	Working Group	Definition	Alignment	Related Activity	PESTLE	SWOT	Literature Review	HEAT	Analysis Template	Programme Development	Finalise Documentation	Sign off by EG	IMC Feedback	Sign off by Health Strategy
					PPP Development Process					Evidence Base								
					Workshop 1			Workshop 2						Workshop 3				
4.4	**Pilot** - Enable a culture of innovation to achieve excellence in health and care services	DH																
1.4	Enable a workforce to deliver culturally appropriate services	SH																
	Start Date 1 February 2017 - 200 Day PPP - Due 13 November 2017		01/02/2017	15/02/2017	04/08/2017	04/08/2017	18/08/2017			18/08/2017			01/09/2017	29/09/2017	27/10/2017	10/11/2017	02/11/2017	13/12/2017
1.1	Radical Improvement in Māori health outcomes by eliminating health inequities for Māori	NM/LE																
1.2	Eliminate health inequities for people in rural communities	MS																
1.3	Remove barriers for people experiencing disabilities	BP/DW																
	Phase 1 - 70 Day PPPs - Due 15 May 2017		01/02/2017	08/02/2017	09/02/2017	03/03/2017	07/04/2017			07/04/2017			12/04/2017	17/04/2017	22/04/2017	12/05/2017 14/07/2017	03/08/2017	14/06/2017 09/08/2017
2.1	Deliver timely, high quality, safe care based on a culture of accountability, responsibility, continuous improvement and innovation	MN																
3.3	Enable a culture of professional cooperation to deliver services	MN																
6.1	Incorporate te Tiriti o Waitangi in everything we do	LE																
6.2	Authentic collaboration with partner agencies and communities	JW																
	Phase 2 - 70 Day PPPs - Due 21 August 2017		16/06/2017	23/06/2017	14/07/2017	14/07/2017	21/07/2017			21/07/2017			04/08/2017	18/08/2017	01/09/2017	08/09/2017		11/10/2017
2.2	Prioritise fit-for-purpose care environments	CC																
2.3	Early intervention for services in need	TM																
3.1	Utilise the expertise of communities, providers, agencies, and specialists in the design of health and care services	DW																
3.4	Promote health services and information to our diverse population to increase health literacy	LA																
4.3	Redesign services to be effective and efficient without compromising the care delivered	MB																
6.4	Work towards integration between health and social care services	JW																
	Timeline and process TBC																	
Pae Taumata	A centre of excellence in learning, training, research, and innovation	TBC																
	Phase 3 - 70 Day PPPs - Due 27 November 2017		01/09/2017	08/09/2017	29/09/2017	29/09/2017	06/10/2017			06/10/2017			20/10/2017	03/11/2017	17/11/2017	24/11/2017		13/12/2017
2.4	Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives	JW																
3.2	Provide care and services that are respectful and responsive to individual and whānau needs and values	SH																
4.1	Live within our means	MC																
4.2	Achieve and maintain a sustainable workforce	MC																
6.3	Focus on effective community interventions using community development and prevention strategies	MS																

WINS

Project team developing presentation for Alpha's to use when they take their Plan to HSC. Project team to include (following testing) in toolkit
Waikato Plan (includes priorities from the Strategy) is in the final phase of adoption - expected August 1st
Phase 2:
The workshops so far have been robust and positive with lots of good information provided by the working group members.
There are more workshops planned for these priorities.
Phase 1:
We have had movement in several Phase 1 plans
All definition work has progressed to DRAFT stage and the working groups are working through any changes
1.4 is going back to HSC for sign off next week.
The three large priorities (1.1, 1.2 & 1.3):
Fortnightly meetings have been set up to keep track of these three priorities.
1.3 is in the process of developing a large world cafe style workshop.

RISKS - ongoing

Risk of limited engagement with clinicians and patient facing staff due to full capacity
Delays due to workloads within project team
Risks - new:
Phase 1 was due to be presented to EG 14/07/17
Phase 2 some workshops have had to be postponed due to slow responses and development of the evidence base is delayed due to resource constraints

NEXT STEPS

Continue to progress all phase 1 and phase 2 PPPs
Continue to offer support to Alpha and Bravo's from phase 1 and phase 2 to achieve their plans
Alignment with LTIP
Memo regarding priorities sitting under Strategic Imperative
Pae Taumata - Project Team to scope out process and return to EG with draft process
1.4 will be resubmitted to HSC on 9th August, responding to questions asked

Appendix B
Request for input:

PPP 1.3: Priority 1.3 – Remove barriers for people experiencing disabilities
The Priority for removing barriers for people experiencing disabilities will be holding a community workshop on 20th September from 10:30 to 3:30.

A first draft of attendees is in the table below. We, Brett Paradine (Executive Director of Waikato Hospital Services) and Derek Wright (Executive Director of Mental Health) are requesting your input to the attendee table. We would be grateful if you could please identify people or areas for representation that you think should be added or amended:

Attendee Table	
People	**Area for representation**
Crystal Beavis	Previous Chair for DSAC and Board member
David Sloan	Previous DSAC member
John Dobson	Chairperson from Life Unlimited
John McIntosh	Disabled Persons Assembly
Dr Pauline Boyles	Director of Disability Strategy and Performance - Capital and Coast DHB
Judy Small	Hamilton City Council Disability Advisor
Marese McGee	Community Living Trust
Gerri Pomeroy	CCS-Action for All
Andrew Corkill	GM People and Communities - Sports Waikato
	Consumer advocates for:
	Mental Health
	Youth Mental Health
	Māori Mental Health
	Intellectual Disabilities
	Physical Disabilities
	Sensory Disabilities
	Youth
	Māori
	Rural
	Older People
	Ministry of Health

MEMORANDUM TO THE HEALTH STRATEGY COMMITTEE
9 AUGUST 2017

AGENDA ITEM 10.2

PRIORITY PROGRAMME PLAN 1.4: ENABLE A WORKFORCE TO DELIVER CULTURALLY APPROPRIATE SERVICES

Purpose	1) For approval

Introduction
Attached is the second of the twenty-four priority programme plans prepared to operationalise the Waikato DHB's Strategy. The priority plan presented is working towards achieving the Strategic Imperative Oranga – health equity for high-need populations.

This Plan was delivered to the Health Strategy Committee on 14 June 2017. The Committee resolved that:

- The report be received.
- Management to submit a simplified list of targeted activities and actions that will make a direct impact on improving the delivery of culturally appropriate services and associated timelines for the Committee's consideration at their August meeting.
- Future submissions to the Committee to include the priority programme plan document and specific bibliography only.

This paper identifies changes made to the Priority Programme Plan 1.4: Enable a workforce to deliver culturally appropriate services. These changes include are summarised in the paper below and a revised Plan is attached as Appendix A.

Objectives for PPP 1.4: Enable a workforce to deliver culturally appropriate services

1. Diversity
2. Cultural Competency
3. Cultural Humility
4. Organisation Accountability
5. Bi Cultural

Proposed Activity
Population demographic hiring
Cultural Competency training to be part of orientation
Cultural arrest team
Staff WOF
Service and Team WOF
Physical spaces that reflects our bi-culture
Celebrations
Staff journey of self-development and discovery
Customer service training for all staff, not just frontline
Complaints
Mentors and Supervisors

Recommendation
THAT

1) The Committee approves the changes made to PPP1.4: “Enable a workforce to deliver culturally appropriate services”.
2) The Committee notes that because PPPs are being developed progressively there will be ongoing reviews as implementation happens to manage overlaps and effects on/from other PPPs as they are identified.
3) The Committee notes further that because implementation of PPPs is subject to budget it will be necessary to stagger implementation to align with the funding available.
4) At the conclusion of the work to develop PPPs and on an annual basis thereafter the Committee is presented with a consolidated view of the recommended timing for all projects and progress on them.
5) Projects arising from the PPPs are approved for commencement under the general delegation framework of the Waikato DHB.

SUE HAYWARD
CHIEF NURSING AND MIDWIFERY OFFICER

Supported by the PPP Project Team

2017

Priority Programme Plan - 1.4: Enable a workforce to deliver culturally appropriate services

10.2

Strategic Imperative:
Health equity for high need populations
Oranga

Sue Hayward and team
Waikato DHB

The information in this document was compiled to plan for the delivery of the Waikato DHB's priority 1.4: Enable a workforce to deliver culturally appropriate services, one of four priorities to be delivered in order to meet the strategic imperative "Health equity for high need populations". For more information on this priority or the Waikato DHBs Strategy please go to:
http://www.waikatodhb.health.nz/about-us/our-vision-and-strategy/

The information in this document has been summarised through a template designed to capture key information to inform this plan. For detail on this priority, use the following paths:
Executive Director for the priority: Sue Hayward
Website location: xxx
Intranet location: xxx

Strategy "What will this look like"

The Waikato DHB staff/workforce will reflect the population it serves. A one-size fits all approach will not work. The Waikato DHB is a large complex organisation with a wide variety of activities and areas of work and each are will need to ensure that their service delivery caters to the particular community being served.

Priority Definition

Enabling a workforce to deliver culturally appropriate services is about equiping those who partner in health care now and in the future with skills and knowledge to provide care and services that meet the diverse values, beliefs, and cultural needs of our people.

Priority Plan

Current View
Our workforce does not culturally represent our population
Patients are customers with greater information, equal say and accountability for their care.
Assumptions get made, there are multiple cultural lenses.
Some areas we are struggling to recruit, we have great staff leaving.
Bullying, lack of tolerance, fear of failure
Diversity - multiple ethnicities, multiple cultures
Consumer feedback / complaints
Our organisation is output focused, not outcome focused.
Population health needs are becoming more complex with many lifelong chronic expensive illnesses

Strengths	**Weaknesses**
- Commitment from the wider organisation to values and beliefs, accountability and responsibility are being described and built into things such as job descriptions and orientation - We have a strong base with professional values. - There is an understanding from education providers that culturally appropriate services are built into training. - We have a cultural competency framework in place (TPO). - Recognition of the need for changes to the way we provide services, to all of our population (external and internal). - Pockets of cultural support for staff currently exist - Funding has been made available for Māori and Pacific opportunities - Value workshops are available throughout the organisation including the executive level - Waikato Hospital is the heart of the Kingitanga - Staff are adaptable to supporting patient needs in a culturally appropriate way.	- We are not enabling our staff to attend cultural training. Service will always have priority over education. - It is part of our current culture that our own belief sets are allowed to be exposed. - There are no consequences for poor behavior - Whilst there is cultural competency framework in place it is not practiced - There is no equal status given to cultural and clinical competency - We do not understand how the treaty underpins the work we do. We lack confidence to say we don't understand and worry we will insult others. - We lack confidence to be vulnerable and concerned - Orientation is not consistent across the organisation, there are many different versions making it difficult to demonstrate organisation values to new employees - Our organisation does not currently understand accountability, responsibility or professional cooperation. - Patients lack trust in our organisation. - We have a blame culture within the organisation, even when we feel we are doing the right thing. - There can be restrictions placed on staff members to advocate for diversity.

Future View – Priority Objectives		**Measure**
1	**Diversity**	Data indicates a

	A workforce that reflects the diversity of our population. Holistic view to the diverse needs of our population Healthy relationship with diversity Entire workforce accepts diversity from Executive to coal face. Develop, engage and commit.	move to having staff that reflect the population cultural demographics
2	**Culturally Competency** *A set of academic, experiential and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on the values, traditions, and customs of other cultural groups, and to work with knowledgeable persons from other cultures in developing targeted interventions, communications and other supports. (Lit Review, PPP 1.4 Plan Pg 69)* Accept not knowing, we commit to learning, we are investing and developing our workforce. Everyone understands their accountability, responsibility, power position and authority, clearly understanding the what, how, can. Staff and consumers of our care feel structurally empowered.	Reduction in complaints
3	**Cultural Humility** *Hook, Davis, Owen, Worthington and Utsey (2013) conceptualize cultural humility as the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]" (p. 2).* How do we work with you to achieve good outcomes? Empowering staff to feel comfortable celebrating their culture	Response to patient interviews carried out as part of the 2x yearly Care Standards audits
4	**Organisation Accountability** An organisation that lives by its values, supporting each other to ensure cultural safety. Bad behaviour is dealt with at all levels	Staff surveys
5	**Bi Cultural** Promoting our organisation as bi cultural. Enabling bi-cultural delivery of services. Enable people to identify with their own culture first, then secondly identify with their role.	Climate surveys

Existing Activity

Activities/ Projects	Description of activity	Obj	Timelines	Ownership and project reference code
Nursing Documentation Project	4 year improvement project that has dramatically reduced the number of forms nurses use for assessing patients, and instead refocuses them on patient care and what really matters to each patient. Implementation is due in mid-May 2017.	3	Commenced June 2017	Sue Hayward
Standard for Recruiting for Nurses and Midwives	Under the guidance of board advisory group Iwi Māori Council every employment applicant that identifies as Māori obtains an interview. Standard employment criteria is followed after this point.	2, 3, 5		Sue Hayward
Nursing Workforce Programme Governance Group (Nationally)	Additional resource is in place to work alongside Māori nurses to support them culturally and display in practice modelling	5	By 2028 the Māori nursing workforce will equal the percentage of Māori in population	Sue Hayward
Kai Ora Hauora	To encourage and support Māori to pursue health professional careers within the health and disability sector	3	Current contract expires 31/12/2017	Te Puna Oranga
Waikato DHB Cultural Trainings	Support Waikato DHB staff to develop knowledge and skill s Māori cultural:	2	Ongoing	Te Puna Oranga with Learning and Development

	- Te Ara Totika - Tikanga Best Practice Learning Package (new staff)			
Interpreters policy facilitator & Learning and Development	Culturally and Linguistically Diverse (CALD) on line courses can be made available if applicable due to connection with Ko Awatea LEARN.	1	Ongoing	Learning and Development

Potential Activity

The following list of ideas has not been prioritised or filtered and simply represents feedback that has been presented by the PPP 1.4 working group and the Executive Group on possible activities or projects for further exploration.

Activities/ Projects	Objectives of project/action plans	Objectives	Timelines (commencing)	Proposed Ownership & project reference code
Population demographic hiring	We are explicit in hiring staff whose culture is reflective of our population. We are explicit in DHB expectations and values when recruiting.	1, 5	Commenced 2016	
External provider of Effective Use of Interpreters workshop		1	2017	Learning and Development
Cultural Competency training to be part of orientation	• E Learning • Working through Scenarios • Work with Te Puna Oranga on a staged orientation, for example: ½ day welcome on Marae with introductory cultural training 1 month later an online cultural course ½ day workshop 4-5 months later	2	Commenced 2017	Te Puna Oranga
Cultural arrest team	I need help with a cultural critical incident with another staff member /patient /stakeholder	2	Oct 2017	
Staff WOF	Performance reviews that do a warrant of fitness for cultural competency and safety.	2	TBA	
Service and Team WOF	Stocktake cultural state of services and assess need for culture change. Modifying or implementing recommended changes to service delivery.	2		
Physical spaces that reflects our bi-culture	• Bilingual signage • Area in front of ED (Waikato hospital) can show who we are • Enquiries desk at ED is made more welcoming Our physical spaces needs to reflect who we are, who our population are, and the needs they have of our facilities	3	TBA work with Media	
Celebrations	• What does your team do to celebrate diversity • What does your team do to celebrate each other • What does your team do to celebrate you • Patient stories • Staff stories	3	Feb 2018	
Staff journey of self-development and discovery	Sharing stories of staff's reflection on situations, learnings etc. TED Talk style?	3	2019	

Customer service training for all staff, not just frontline	Waikato Host Training (Kiwi Host): The Waikato Way We have internal and external 'customers'	4		
Complaints	Develop a structure and procedure for complaints, concerns or grievances by patients or staff about unfair, culturally insensitive or discriminatory treatment or difficulty in accessing services	4		
Mentors and Supervisors	Encourage and employ people to act as mentors and supervisors to create an environment where people feel comfortable and enabled to be their culture first and role second.	5		

General Business

Date of next meeting
11 October 2017