Community and Public Health Advisory Committee Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	8 August 2018	**Time:**	1:00 pm

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

Next Meeting Date:	10 October 2018	
Contact Details:	Phone: 07 834 3622	Facsimile: 07 839 8680

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Community and Public Health Advisory Committee Agenda

Item

1. Apologies

2. **INTERESTS**
   - 2.1 Schedule of Interests
   - 2.2 Conflicts Related to Items on the Agenda

3. **MINUTES AND MATTERS ARISING**
   - 3.1 Waikato DHB Community and Public Health Advisory Committee; 13 June 2018
   - 3.2 Lakes DHB Community and Public Health Advisory Committee; 11 June 2018

4. **DISABILITY SERVICES**
   - 4.1 Waikato DHB Disability Responsiveness Plan Terms of Reference
   - 4.2 Committee Representation on the Disability Responsiveness Plan Reference Group

5. **PAPERS FOR DECISION**
   - 5.1 2018-21 Suicide Prevention and Postvention Plan

6. **PAPERS FOR INFORMATION**
   - 6.1 Proposal for Change to Strategy, Funding and Public Health
   - 6.2 Health Improvement Settings Approach
   - 6.3 Ki te Taumata o Pae Ora update
   - 6.4 Waikato DHB Tobacco Control Action Plan

7. **PRESENTATIONS**
   - 7.1 Oral Health Services Update
   - 7.2 Project Energize, Update from Sport Waikato

8. **GENERAL BUSINESS**

9. **DATE OF NEXT MEETING**
   - 9.1 10 October 2018

Apologies

Interests

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

Clyde Wade

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

Tania Hodges

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

Note 1: Interests listed in every agenda.

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

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

Sally Webb

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

Crystal Beavis

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

Pippa Mahood

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

Note 1: Interests listed in every agenda.

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

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

Sharon Mariu

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

John McIntosh

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

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

David Slone

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

Fungai Mhlanga

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

Rob Vigor-Brown

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

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

Mark Arundel

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

Judy Small

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

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

Conflicts related to items on the agenda

Minutes
and
Matter Arising

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
8 AUGUST 2018

AGENDA ITEM 3

MINUTES COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETINGS

Attached are the following minutes from the Community & Public Health Advisory Committee (CPHAC) meetings:-

- Waikato DHB Community and Public Health Strategy Committee; 13 June 2018
- Lakes DHB, Community & Public Health Advisory Committee; 11 June 2018

The Bay of Plenty combined Community & Public Health and Disability Support Advisory Committee has not meet since 9 April 2018, the minutes of which were circulated with the June Waikato DHB CPHAC agenda.

Recommendation
THAT
The minutes be noted.

CLYDE WADE
CHAIR, COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Community and Public Health Advisory Committee held on 13 June 2018 commencing at 12.35pm

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

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

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

The Chair acknowledged Ms J Small, attending on behalf of the Consumer Council. A nominated representative from the Consumer Council will be part of the Community and Public Health Advisory Committee pending Waikato DHB Board approval of the nominee.

ITEM 1: APOLOGIES

Apologies from Ms S Mariu, and Mr F Mhlanga were received.

Resolved
THAT
The apologies were received.

ITEM 2: INTERESTS

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

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

ITEM 3: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Ms MA Gill highlighted the Silver Economy presentation given at the Bay of Plenty DHB 4 April meeting regarding the value of the aged 65+ population on the economy. It was suggested it could fit well with the future Community and Public Health Advisory Committee update on aging and older people.

Clarification was sought by the Chair on the prudence of having an evergreen national pharmacy contract. Ms T Maloney confirmed that the old contract had been extended by three months to allow for further consultation on implementing an evergreen contract.

Resolved
THAT

1) The minutes of a meeting of the Waikato DHB Community and Public Health Advisory Committee held on 11 April 2018 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 9 April and the Lakes DHB Disability Support advisory Committee held on 7 May 2018 be noted.
3) The minutes of a meeting of the Bay of Plenty DHB combined Community & Public Health Advisory Committee and Disability Advisory Service Committee held on 4 April 2018 be noted.

ITEM 4: DISABILITY SERVICES

4.1 Waikato DHB Disability Responsiveness Plan Terms of Reference

The Terms of Reference for the Waikato DHB Disability Responsiveness Plan were discussed by the Committee which included the following feedback/comments:

- The Disability Responsiveness Plan would be an enabler to the Health Systems Plan.
- Engagement had occurred with Consumer Council but would also occur with Iwi Māori Council.
- There is no “generic” type of person with disabilities; a Māori person with disabilities may have different needs to a non-Māori with disabilities. The Ministry of Health’s Maori Disability Action Plan (Whāia Te Ao Mārama 2018 to 2022) framework included whānau ora principles and may provide suggestions to consider plan development from a different perspective.
- Consideration to be given to including DHB employees in the scope.
- The framework should be aligned with what the disabled community were striving for.
- Confirmation to be sought regarding whether the Ministry was still undertaking a programme regarding intellectual disability, and if so the Disability Responsiveness Plan should be linked to it.

Resolved
THAT
The Committee approved the Terms of Reference pending modifications as outlined above, particularly with respect to alignment with Whāia Te Ao Mārama 2018 to 2022.

ITEM 5: WORKPLAN

5.1 Work Programme

Mr W Skipage attended for this item. An updated draft work plan which was now aligned with the strategic imperatives of the DHB was presented to the Committee.

It was emphasised that nutrition is a significant issue and requires strategic focus. It should be included in the Care in the Community Plan. It was noted that Public Health have developed a Nutrition and Activity Strategy. A copy of the Strategy would be circulated to members for their information.

The impact of diabetes and oral hygiene on health was highlighted. Members requested an update be provided within the Community and Public Health Advisory Committee workplan on current activities and the feasibility of producing strategies on these topics taking into account other areas of work currently underway.

At the request of the Committee, the progress update on the Care in the Community Plan scheduled for August would now be provided at the August Committee.

Resolved
THAT
The Committee noted the work programme for 2018.

ITEM 6: PAPERS FOR DECISION

6.1 Waikato DHB Tobacco Control Plan

Presented by Mr W Skippage, the Committee were provided with an overview of the Waikato DHB Tobacco Control Plan.

Points highlighted included:

- Acknowledgement that the census statistics used were five years old but were considered to be the most accurate data available.
- The importance of engaging directly with the community who fit the risk profile demographic and focusing the plan on feedback from these people.
- The need to obtain input from Māori providers who are successfully working in this area.

- An increased focus on reducing smoking initiation which may involve education.
- The need to focus the Plan on the groups who are at most risk; Māori and people with mental health and addiction issues.

Mr W Skippage agreed to confirm the number of staff recently recruited into this area who are Māori.

Resolved
THAT
The Waikato DHB Tobacco Control Plan be brought to the August Community and Public Health Committee meeting with details of initiation strategies and target groups.

ITEM 7: PAPERS FOR INFORMATION

7.1 Waikato DHB Annual Plan 2018/19

An update on the 2018/19 Annual Planning process was provided. The challenge of obtaining approval of Annual Plans and Statements of Performance Expectations mid-way through the respective year was highlighted. The Annual Plan Financial templates would be submitted separately at a later date.

Resolved
THAT
The Committee noted the paper

7.2 Health System Plan

Present by Mr D Wu, the Committee were provided with an update on the Health System Plan and the supporting Care in the Community Plan.

It was noted that the correct name of the Māori Health Strategy is Ki te Taumata o Pae Ora.

Resolved
THAT
The Committee noted the update on actions and timelines to develop a Health System Plan.

ITEM 8: PRESENTATIONS

8.1 Work Plan, and Priorities, Consumer Council

Ms A Barnett presented this item on behalf of Ms G Pomeroy and Ms Louise Were (Consumer Council co-chairs) who were unable to attend. An update on the Consumer Council progress on the development of its Draft Plan to Address Priority Issues was provided.

A copy of the presentation would be circulated to Committee members.

The Consumer Council provide updates to the Waikato DHB Board via the Waikato DHB Chief Executive, with the Co-chairs attending Board meetings as and when necessary.

Resolved
THAT
The Committee noted the presentation.

8.2 Community Engagement, Developing a DHB Approach

Presented by Mr W Skipage, a discussion was held on Waikato DHBs engagement approach.

Points highlighted included:

- Ensure that expectations of the purpose of engagement are clear; is it to inform or to empower to work together.
- Ensure engagement is with the right groups and should and should include the "hard to reach".
- Observance of Iwi Māori Council Memorandum of Understanding with respect to engagement and participation.
- Undertake "active listening"; listen for outside scope issues that could be used in other areas of work.
- Consider inviting and identifying champions who want to talk from different groups.
- Acknowledgement that a number of groups have engagement fatigue.

Resolved
THA
The Committee noted that their input will be incorporated into the development of a community engagement policy for Waikato DHB.

ITEM 9: GENERAL BUSINESS

There were no general business items raised.

ITEM 10: DATE OF NEXT MEETING

8 August 2018

Meeting finished at 2:40 pm

LAKES DISTRICT HEALTH BOARD

MINUTES OF A MEETING OF THE COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE HELD MONDAY 11th JUNE 2018 BOARDROOM, ROTORUA HOSPITAL, PUKEROA HILL, ROTORUA

Meeting: **[145]**

Present: L Thurston (Chair), W Webber, M Raukawa-Tait, B Edlin and A Pedersen

In Attendance: R Dunham, Dr J Miller, J Hanvey, K Stone, B Bayne, N Grant, K Evison, K Rex, M Ranclaud, P Tangitu, P Blackmore (Pinnacle MHN representative in support of presenter – M Ranclaud), S Tapsell (for presentation only) and B E Harris (Board Secretariat)

1.0 MEETING CONDUCT

The Chair welcomed everyone to the meeting, acknowledging the presence of Pen Blackmore from Pinnacle MHN. P Tangitu led the opening karakia.

1.1 Apologies: J Morreau, D Shaw, P Mahood, D Epp and S Te Moni.
Resolution:
THAT the apologies be received.
L Thurston : W Webber
CARRIED

1.2 Schedule of Interests Register
The register was circulated during the meeting with no entries made.

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

1.4 Items for General Business : Nil

1.5 Presentation on Community Care Early Engagement Project
by
Marita Ranclaud

M Ranclaud presented on behalf of the organisations involved in the Community Care and Early Intervention project – a project to strengthen the capacity of primary care in the Southern Lakes. Highlights were:-

- *Context* – primary mental health initiatives, GP focus, Adults enrolled Maori, PI, low income, Youth aged 12-19 regardless of enrolment
- *Why this project?* – increase in mental distress, current services unable to meet needs of population, evidence-base that suggests things could be done differently, not clear about the difference being made
- *Current state* – PRIMHIS, extended consultations, real
- *What people told us* – Primary care is broader than general practice, stepped care approach
- *Mechanism for Change* – "Stepped Care from a Community Perspective" – ideology of current state – ideology of proposed state
- *Recommendation* – a co-design process is used to develop a plan for development of service solutions for the Southern Lakes region

In response to a query, M Ranclaud stated that the opportunity had not yet arisen to hold discussions with RAPHS regarding Mangakino receiving the service. M Ranclaud undertook to send the current version of recommendations to Mangakino for community feedback. Delivery of the model is expected to occur in mid-October.

Dr J Miller spoke on the issue of a public health approach. M Ranclaud recalled the conversation around this saying there were two pieces of work involved.

K Evison advised that this was the first airing of what's happening in the community and the next steps were for the group to finalise the report for feedback.

The Chair thanked M Ranclaud for an excellent presentation.

2.0 SIGNIFICANT ISSUES

2.1 Influenza Vaccination update

Resolution:
THAT the committee receives the update for its information.
L Thurston : W Webber
CARRIED

2.2 **Primary Health**

2.2.1 Pinnacle MHN Quarterly Report January-March 2018

B Bayne and P Blackmore briefly spoke to the above quarterly report, highlighting the following areas:-

- 30% calls handed over and supported by the GP after hours service in primary care
- 40% of calls being for children under 14 years
- B4 School Checks
- 95% fully immunised eight month old children
- Integrated extended care team – number of shared care plans with other members is proving very effective – Taupoki Wira and the Off Highways men's group.
- Holding regular meetings with Whanau Ora

Resolution:
THAT the Pinnacle MHN report be received.
B Bayne : B Edlin
CARRIED

2.2.2 RAPHS report

K Stone advised:-

- Had a static population for many years and are now seeing growth
- Numbers increased by 2% - a reflection of movement into the district and practices
- Service utilisation is providing transparency
- Workforce is changing
- Work with ED – support frequent users of health services and respond to needs
- Focus on Alliance activity

Resolution:
THAT the RAPHS report be received.
K Stone : L Thurston
CARRIED

2.2.3 Whanau Ora report

N Grant's report covered:-

- Te Arawa Whanau Ora Whanau Plan
- Healthy families

- Family harm
- Collective impact innovation – Whare Ora
- Te Arawa Whanau Ora
- Unhealthy Whare

Resolution:
THAT the Whanau Ora report be received.
N Grant : A Pedersen
CARRIED

2.3 **Mental Health**

2.3.1 Project Plan for Model of Care
M Ranclaud reported that the collation of information from the engagement hui around the survey monkey was still occurring. She was happy to receive further feedback.

2.3.2 Mauri Ora : May 2018
Lakes DHB is still working towards building a business case to take to Treasury. Progress is on track.
Resolution:
THAT the above information be received.
M Raukawa-Tait : W Webber
CARRIED

2.4 **Maori Health**

2.4.1 Maori Health report
This report was taken as read.

2.5 **Public Health**

2.5.1 Toi Te Ora Public Health Service

2.5.1.1 Public Health Services report
J Hanvey briefly touched on:-

- Submission of plans around peoples' health to Rotorua Lakes Council
- Healthy pregnancies education day held in Rotorua during April

Resolution:
THAT the Toi Te Ora Public Health Service report be received.
J Hanvey : L Thurston
CARRIED

2.5.1.2 Public Health Medical Officer report
The report for May 2018 covered Biophilic Public Health which Dr Miller stated was for the committee to read and think about. He wanted to place this item before CPHAC and to have it placed on the Lakes DHB website. This report had been written by Dr Neil de Wit.
Resolution:
THAT the Public Health Medical Officer report be received.
M Raukawa-Tait : B Edlin
CARRIED

2.6 Lakes Falls and Fracture Prevention Programme
It was noted that the appointment of programme lead with geriatric clinical expertise is currently under way and expected to be funded until June 2020 through ACC/DHB partnership agreement. A community-based nurse practitioner is being sought to lead this programme.
Resolution:
THAT the overview of the Lakes Falls and Fracture Prevention Programme be accepted.
K Stone : L Thurston

CARRIED

3.0	**SECRETARIAL**
3.1	Minutes of Community and Public Health Advisory Committee meeting 9th April 2018 **Resolution:** THAT the minutes of the Community and Public Health Advisory Committee meeting of 9th April 2018 be confirmed as a true and accurate record. **B Edlin : A Pedersen** CARRIED
3.2	Matters Arising: Nil
3.3	Schedule of Tasks ➢ *Media campaign "stop/quit smoking" and community initiatives this year* : K Rex waiting to hear what comes out of the Ministry around the smoking issue. Will look at the workplan and advise a date. ➢ *Toi Te ora Public Health – presentation by Microbiologist* : moved from August to October 2018 ➢ *Substance Abuse Compulsory Assessment and Treatment Legislation update* : remains at 6th August 2018
4.0	**REPORTS**
4.1	Community representative reports **A Pedersen** Gave a briefing on:- ➢ Te Kahui Oranga hui ➢ Mangakino health providers forum held on 20 April 2018 – CE to email action sheet from forum ➢ Senior Citizens Age Concern Health Expo ➢ Mental health hui with M Ranclaud ➢ Mangakino Maori Health forum ➢ Communicating via social media and local advertiser ➢ Intergenerational barriers to health need to be addressed
5.0	**INFORMATION AND CORRESPONDENCE**
5.1	BoP DHB CPHAC/DSAC minutes dated 4th April 2018
5.2	Waikato DHB CPHAC/DSAC minutes dated 11th April 2018
	The above minutes were provided for the information of the committee.
6.0	**PUBLIC EXCLUDED:**
6.1	Confidential minutes of CPHAC meeting held 9th April 2018
6.2	Draft Minutes of Team Rotorua ALT dated 12th April 2018
6.3	The Alliance Team Draft Framework – System Level Measures
6.4	The Acute Demand Programme
6.5	CPHAC Workplan **Resolution:** THAT the committee move into Public Excluded at 2.15pm **L Thurston : B Edlin** CARRIED

LAKES DISTRICT HEALTH BOARD

SCHEDULE OF TASKS FROM THE COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

11th JUNE 2018

Agenda Item	Action	Responsibility of	Timeframe
PRESENTATIONS			
Media campaign "stop/quit smoking and community initiatives this year	Presentation by Lakes DHB	Pip King	t.b.a.
Toi Te Ora Public Health	Presentation by Microbiologist	K Rex/Dr J Miller	8th October 2018
ITEMS			
Substance Abuse Compulsory Assessment and Treatment Legislation update	Item deferred for a future meeting of CPHAC.	K Rex/M Ranclaud	6th August 2018
Mangakino community health forum held 20 April 2018	That the action sheet be emailed to A Pedersen	CE	a.s.a.p.
Presentation on Community Care Early Engagement Project	Current version of recommendations be emailed to A Pedersen	M Ranclaud	a.s.a.p.

Waikato District Health Board
Te Hanga Whaioranga Mō Te Iwi – Building Healthy Communities

Disability Services

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
8 AUGUST 2018

AGENDA ITEM 4.1

WAIKATO DHB DISABILITY RESPONSIVENESS PLAN TERMS OF REFERENCE

Purpose	For information

At the joint June Community and Public Health Advisory Committee and Disability Support Advisory Committee meeting it was agreed that Strategy and Funding would ensure stronger linkage between the Disability Responsiveness Plan document and the national Whai te Ao Marama Plan. Attached is the updated document for your information; with reference to Whai te Ao Marama

Recommendation
THAT
The Committee notes the Terms of Reference.

WAYNE SKIPAGE
SENIOR PLANNING MANAGER
STRATEGY AND FUNDING

Waikato DHB Disability Responsiveness Plan

Draft Terms of Reference

1.0 Introduction

One in four New Zealanders (2013 census) live with a disability. Disability can include physical, mental health, intellectual, sensory or other impairments. Disability occurs when an individual experiences barriers that hinder the full and effective participation in society on an equal basis with others[1].

Waikato District Health Board is intending to develop a Disability Responsiveness Plan to provide guidance, direction and structure to all stakeholders involved, including DHB hospital and community services, funders, and contracted services.

The plan will provide clear direction for health sector leaders and managers working alongside disability communities to address inequities and ensure better health outcomes. It will identify a number of key areas for improvement across a defined range of dimensions, and it will set some clear performance measures for the DHBs Disability Support Advisory Committee (DSAC) to monitor.

2.0 DHB Responsibility in Respect to Disability Responsiveness

The Public Health and Disability Act 2000 sets out specific expectations for DHBs to follow regarding disability support. This was further strengthened by the New Zealand Disability Strategy (NZDS) launched in 2001 and recently updated in 2016, and the Whai Te Ao Strategy. The strategy provides clear guidance and expectations of policy makers and service designers to eradicate systemic, attitudinal and structural barriers in all aspects of service delivery. The vision is one of 'a society that highly values our lives and continually enhances our full participation'.

The NZDS states:

> *Disability is not something individuals have. What individuals have are impairments. Disability is the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have.*

The United Nations Convention on Rights of Persons with Disabilities (UNCRPD) further states:

> *Persons with disabilities have the right to attain the highest attainable standard of health without discrimination on the basis of disability.*

While it is difficult for any of us to imagine discriminating purposefully, discrimination against those with disabilities often occurs as a result of a number of unintentional organisational deficits:

(a) not adequately understanding what disabled people require to achieve equitable health outcomes

[1] This is an abridged version of the definition used in the NZ Disability Strategy and the United Nations Convention on the Rights of Persons with Disabilities.

(b) poor planning and resourcing

(c) poor staff training and organisational culture

(d) poor performance oversight

Disability Support Advisory Committees were established as a result of the Act requiring DHBs to reflect the principles from the updated NZDS and the UNCRPD in all health policies.

As a result, the DHB has a responsibility to ensure the services it provides or purchases are responsiveness to the Disability Community, and the proposed plan will enable the DHB to make further gains in this regard.

3.0 Linkages

The strategic framework, priorities and areas of action will be informed by and referenced to a mix of foundational documents including:

- New Zealand Disability Strategy 2001
- New Zealand Disability Action Plan
- New Zealand Public Health and Disability Act 2000
- Whaia Te Ao Marama: The Maori Disability Action Plan
- He Korowai Oranga: Maori Health Action Plan
- Faiva ora – National Pasifika Disability Plan
- The Treaty of Waitangi
- United Nations Convention on Rights of Persons with Disabilities (2008)

Given the DHB's key priority is to reduce health inequalities for Maori, we will ensure that the Disability Responsive Plan is aligned with the aspirations and actions of Whaia Te Ao Marama: the National Maori Disability Action Plan.

4.0 Framework

The Waikato DHB Disability Responsiveness Plan will be developed across eight key dimensions:

1. Leadership
2. Strengthening Governance and Accountability
3. Improving Access to Services
4. Reducing Health Inequalities
5. Empowering and Engaging People
6. Inclusion and Support
7. Environment and Facilities
8. Re-orienting Models of Care

Across the eight dimensions, the responsiveness plan will undertake the following:

1. Development of a foundational evidence base of our Waikato District's disabled population, including demographics, health outcomes, service utilisation etc

2. An analysis of current barriers and service gaps
3. Identification of opportunities for change
4. Development of a longitudinal action plan
5. Development of an outcomes monitoring and reporting framework for DSAC
6. Recommendations in respect to inter-sersectoral linkages
7. Recommendations in respect to disability community engagement and involvement in ongoing system and service development.

5.0 Incorporation of the Disability Priority Programme Activity

A significant amount of work has been undertaken over the past 12 months in respect to the DHBs Priority Programme 1.3 – Remove Barriers for People Experiencing Disability. This work will be incorporated into the development of the Disability Responsiveness Plan.

6.0 Involvement of the Consumer Council

The Waikato DHBs Consumer Council comprises a membership with deep disability lived-experience, public sector expertise and subject matter knowledge. It has also undertaken some extensive review activity that is driving areas of particular interest in its work plan.

To that end, the development of the Disability Responsiveness Plan will draw on the expertise of particular members of the Council, and the final plan will be developed with them to ensure it responds to the issues they have identified as consumer representatives.

7.0 Activity Timetable

Activity	Date
TOR Agreement	Mid-June 2018
Project Plan Developed	Early July 2018
Reference Group Established	Early July 2018
Health Needs Assessment	Aug 2018
Stakeholder Workshop	Aug 2018
Environment / Service / Policy Scan	September 2018
Gaps and Opportunities Analysis	Early October 2018
Workshop	October 2018
CPHAC Update	October 2018
Document Finalisation	November 2018

Presentation of Final Draft to CPHAC	December 2018

8.0 Resourcing and Leadership

The Disability Responsiveness Programme will be led and resourced from the Strategy and Funding Directorate.

- Project Sponsor will be Tanya Maloney, Executive Director Strategy and Funding.
- Project Owner will be Wayne Skipage, Senior Planning Manager
- Strategy and Funding Project Manager – TBA.

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
8 AUGUST 2018

AGENDA ITEM 4.2

COMMITTEE REPRESENTATION ON THE DISABILITY RESPONSIVENESS PLAN REFERENCE GROUP

Purpose	For approval

At the last Community and Public Health Advisory Committee (CPHAC) meeting, a draft Terms of Reference for the development of a Disability Responsiveness Plan was agreed.

A reference group is being established to focus the development of this plan, and it has been recommended by the initial project establishment group that one of the members of CPHAC/DSAC be included in its membership.

This paper seeks CPHAC's endorsement of Judy Small (who is also the Hamilton City Council Disability Advisor) to participate in the reference group. Judy has strong experience in developing organisational plans that are responsive to the needs of the disability community and people with impairments.

Judy Small has agreed (if CPHAC members agree), to represent CPHAC on the reference group.

Please note: Judy Small is an apology to the August CPHAC meeting.

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

Given the high rates of Māori with a disability or caring for a person with disability, it is critical that the Disability Responsiveness Plan addresses the needs of Māori. The reference group membership will include a representative from Te Puna Oranga to ensure alignment between the Ki Te Taumata o Pae Ora and the Disability Responsiveness Plan.

Recommendation
THAT
The Committee approves the report/proposal.

WAYNE SKIPAGE
SENIOR PLANNING MANAGER
STRATEGY AND FUNDING

Papers for Decision

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
8 AUGUST 2018

AGENDA ITEM 5.1

2018-21 SUICIDE PREVENTION AND POSTVENTION PLAN

Purpose	For Endorsement

Background

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

In 2017 we undertook an exercise to 'refresh' our Plan for the next 3 years by engaging with individuals and community groups to understand how we could improve our approach. The resulting draft plan was presented to the Health Strategy Committee (HSC) in October 2017 and whilst the plan was broadly supported, there was concern by some members that the actions fell largely to the DHB coordinator.

A final report was due to the Board in November 2017, but due to the HSC feedback and the further discussion at SPPHAG this paper was delayed. Subsequently the Board were asked by SPPHAG to endorse a 'zero suicide' aspiration for the Waikato DHB which would act as a driver to engage with the wider sector, noting that suicide prevention is wider than health – it's a multifaceted problem that requires the same multifaceted approach.

Our first intersectoral workshop was held in late June 2018 to gain commitment to work together to achieve our zero suicide aspiration, and to begin to gather ideas on how we could do this. The workshop included stories from those affected by suicide which was a powerful reminder for all. This was seen as a very positive kōrero by the attendees and one that we propose to repeat.

A wide cross-section of agencies including a consumer council member attended (see Appendix 1). The action plan has been re-drafted to show where agencies other than the DHB have identified they would lead initiatives.

The revised Plan

The Ministry of Health have been closely involved in the development of our methodology and support our approach.

While the section reflecting the voices of the key informants and individuals we spoke with in 2017 remains unchanged to ensure these voices continue to guide our

direction, the action plan now outlines where agencies other than the DHB will take a leadership role in facilitating initiatives.

Some agencies have indicated where they are in principle willing to do this, however in some cases their internal processes for formal approval have not been completed and therefore the Plan will remain a living document over the three years and annual intersectoral fora will be held to monitor progress.

Intersect Waikato[1] has a Governance role and 6 monthly presentations will continue to be made to that Committee

This wider ownership of suicide prevention means we should have an action plan that more accurately reflects the community voice and our high risk groups, in particular our rangitahi.

Recommendation
THAT
The Committee endorses the 2018-21 Waikato Suicide Prevention Plan
.

MO NEVILLE
DIRECTOR QUALITY AND PATIENT SAFETY

[1] CEOs/senior management of all government agencies in the Waikato

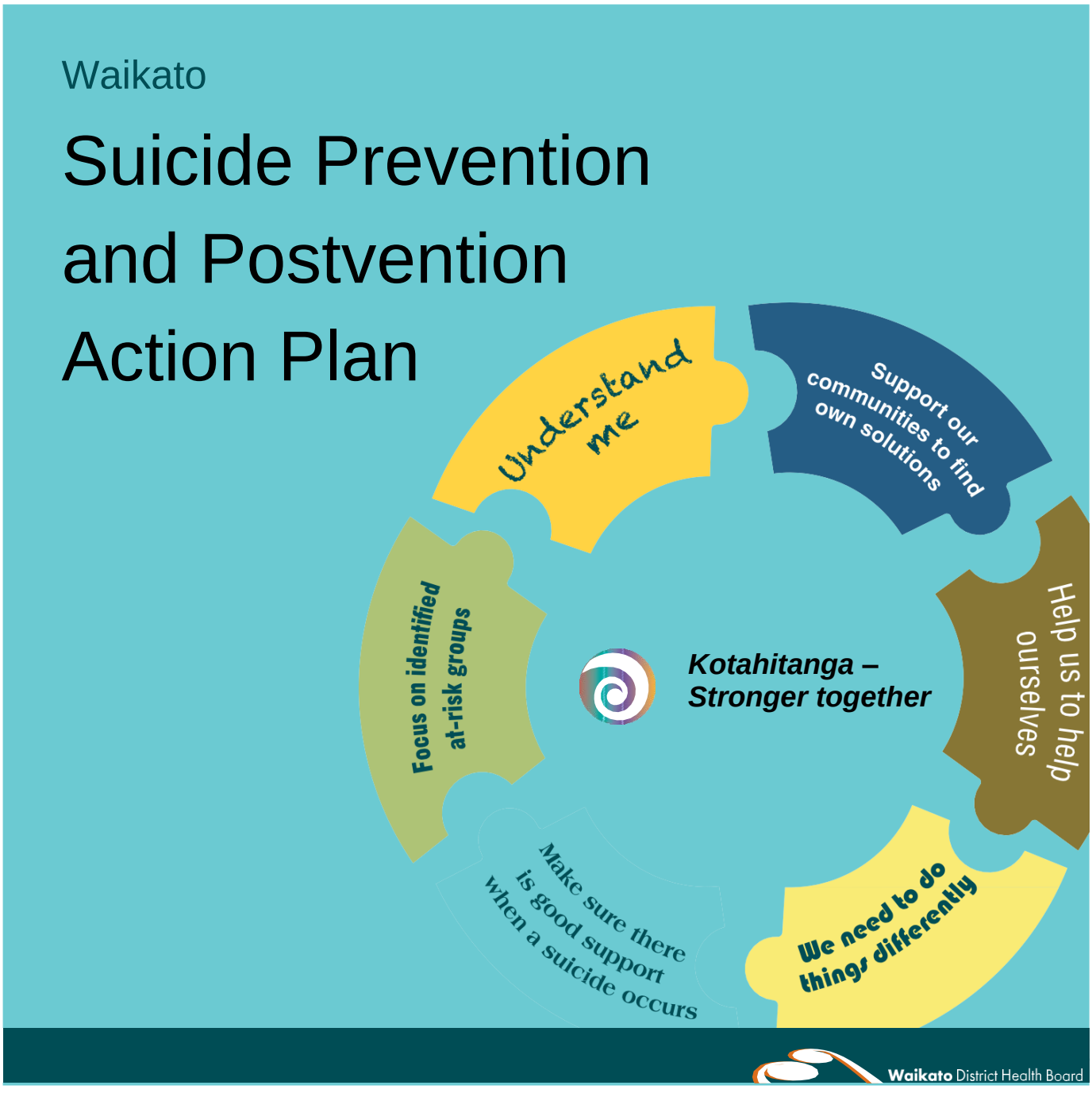
Appendix 1

	Organisations represented at the Intersectoral Workshop 25 June 2018
1	Hamilton City Council
2	Hauraki District Council
3	Waikato District Council
4	Population Health
5	Reach
6	AgeConcern
7	Pinnacle Midland PHO
8	Hauraki PHO
9	Ministry of Social Development
10	Ministry of Education
11	Rural Support Trust
12	Youth INTact
13	Te Rau Matatini
14	Waikato DHB Consumer Council
15	Rauawaawaa Kaumātua Trust
16	Taumarunui Kokiri Community Trust
17	Department of Corrections
18	Tokoroa Council of Social Services
19	Iwi Māori Council
20	Te Puna Oranga
21	Waikato DHB Executive group
22	Suicide Prevention and Postvention Health Advisory Group
23	Disability Support Link
24	Waikato DHB Mental Health and Addiction services
25	Waikato DHB Rural Emergency Department (Thames)

2018-2021

Waikato

Suicide Prevention and Postvention Action Plan



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Welcome Nau Mai

We are pleased to present the 2018-21 Waikato Suicide Prevention and Postvention Plan.

The development of this Plan has been built on the voice of the people in our communities and in collaboration with other government and social agencies, NGOs and support groups.

No one person or organisation can prevent suicide; we all need to be involved from government agencies, to employers, schools, neighbours and families/whanāu.

This Plan is the first time that other agencies and the Waikato DHB have joined together to address suicide prevention in our region.

The Plan sets out ways we can work together to prevent suicide and to strengthen support after a suicide or suicide attempt has occurred.

It outlines a set of priority areas identified through our engagement process, that are a focus of action for our combined efforts to move towards an aspiration of having zero suicides in the Waikato. These priorities support social and cultural well-being and are intended make a strong contribution to building strong, resilient communities.

The relationships created by working together in developing this Plan form an enduring strength of the Plan.

This Waikato Suicide Prevention and Postvention Plan is just the beginning – and we will be transparent in the progress we make over the next three years

Having agreed the means, the focus must now be on implementation. We invite you to continue this journey with us to build safe, resilient communities together.

Derek Wright
Interim CEO Waikato District Health Board

Mo Neville
Chair, Suicide Prevention / Postvention Health Advisory Group

1. Introduction and Background

Suicide is a major issue of concern to New Zealanders. Multiple risk factors and life events are involved in a person ending their life. The link between mental illness and suicidal behaviour is well known, however many people who suicide are not mental health service users and, as the Ministry of Health[1] explain, some of those contributors include:

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

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

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

1.1. The new plan

The 2014-2017 plan has been reviewed over 2017 and 2018 through a series of interviews, focus groups, community presentations, surveys and, lastly, an intersectoral stakeholder workshop in order to confirm our focus areas for the next three years. See Appendix C for the Engagement Report and the list of who has been involved in the development of the new plan.

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

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

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

1.2. Information on National Suicides

Although at present, we have only provisional statistics, nationally the subgroups of the New Zealand population with the highest suicide mortality rates in 2016/17 were: males, Māori (compared with non-Māori), male youth (those aged 20–24 years). Māori males and Māori youth showed particularly high suicide mortality rates.

See Appendix A for further information.

Rates per 100,00 people by DHB

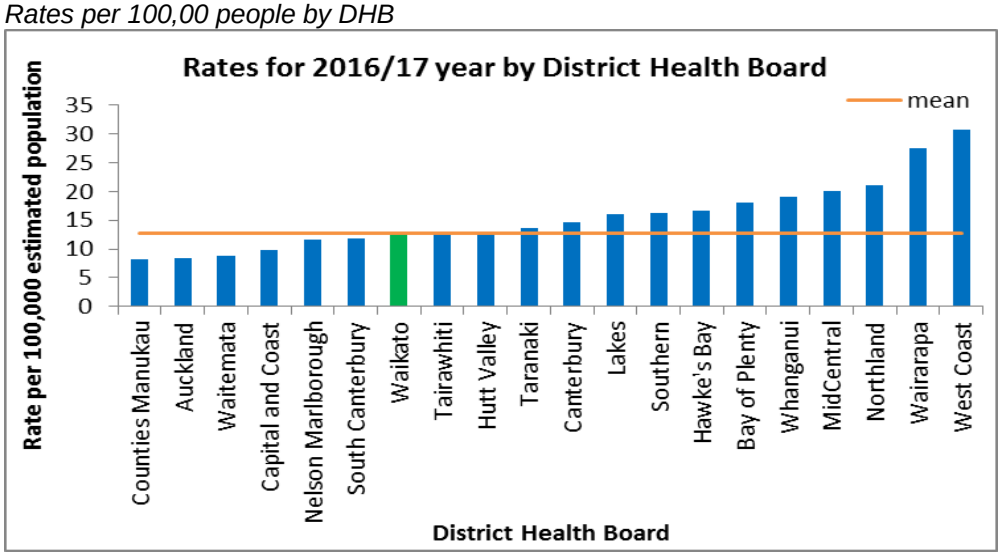


Figure 1. Provisional suicide numbers and rate per 100,000 of the estimated 2016 usually-resident population by District Health Board area. (Sources: Coronial Services of New Zealand. (2017); Statistics New Zealand. (2017)).

1.3. Provisional information on Waikato Suicides

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

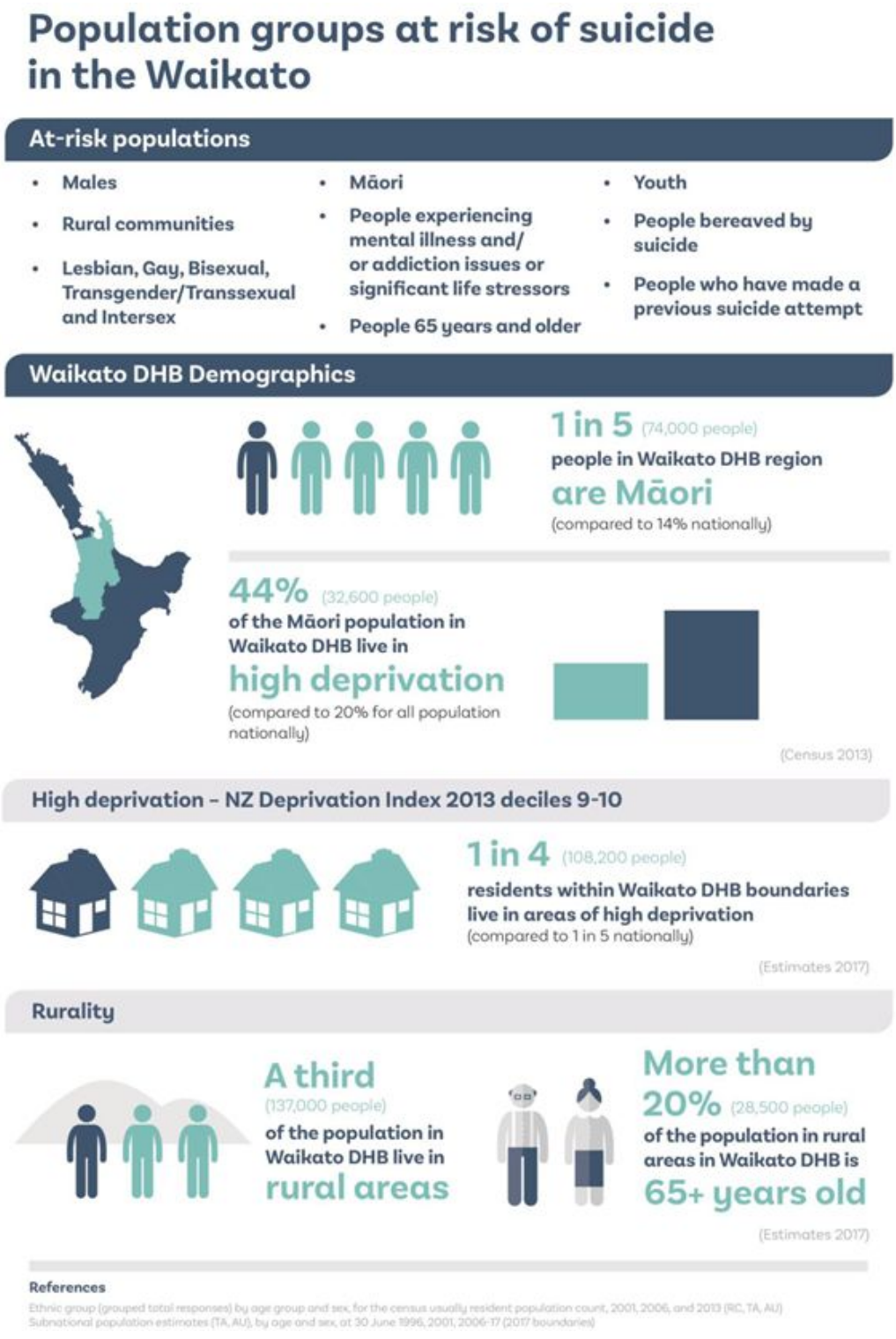
There were 50 deaths during 2016/17 in the Waikato DHB district giving a rate of 12.52 per 100,000 people (see Table 1 above).

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

1.4. At-risk populations in the Waikato DHB area

A key focus for our action plan is to ensure delivery of services is targeted to at-risk populations. When developing the action plan we considered both the Waikato DHB's demographics and the populations identified as at-risk through our data.

The following table shows the link between the Waikato DHB's particular demographic features with populations at-risk of suicide. It is an important point to remember; that anyone may at some point in their lives be at-risk of suicide.



2. Zero Suicide Concept

In early 2018 the Waikato DHB Board endorsed the above approach, believing that a target for suicide reduction as such is not appropriate to set in this sensitive area.

The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioural health systems are preventable. Internationally it is increasingly being extended to justice systems as research indicates that those within this system are at a greater chance of death by suicide. It presents both a bold goal and an aspirational challenge.

For health care systems, this approach represents a commitment:

- To patient safety, the most fundamental responsibility of health care
- To the safety and support of clinical and community based staff, who do the demanding work of treating and supporting suicidal patients

The programmatic approach of Zero Suicide is based on the realisation that suicidal individuals often fall through the cracks in a sometimes fragmented and distracted health care and justice systems. A systematic approach to quality improvement in these settings is both available and necessary.

The challenge and implementation of Zero Suicide cannot be borne solely by the practitioners providing clinical care. Zero Suicide requires a system-wide approach to improve outcomes and close gaps.

The concept was briefly outlined at the Waikato DHB Intersectoral Workshop on Suicide Prevention held in June 2018, and there was interest from other agencies. It will form the basis of ongoing conversations in the suicide prevention space.

It is not something that the DHB or even the general health system could do alone.

3. Governance

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

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

A Waikato DHB Suicide Prevention and Postvention Health Advisory Group was established in December 2015 to provide direction to the Suicide Prevention and Postvention Coordinator. There is senior representation on the group from hospital departments which can have the greatest influence on suicide prevention, and all the Primary Health Organisations with enrolled practices within the Waikato DHB area are represented. Latterly, representation from our largest Māori NGO has also been included.

Significant progress in supporting people who have been bereaved by suicide and initiating suicide prevention strategies has been made.

See Appendix E for achievements.

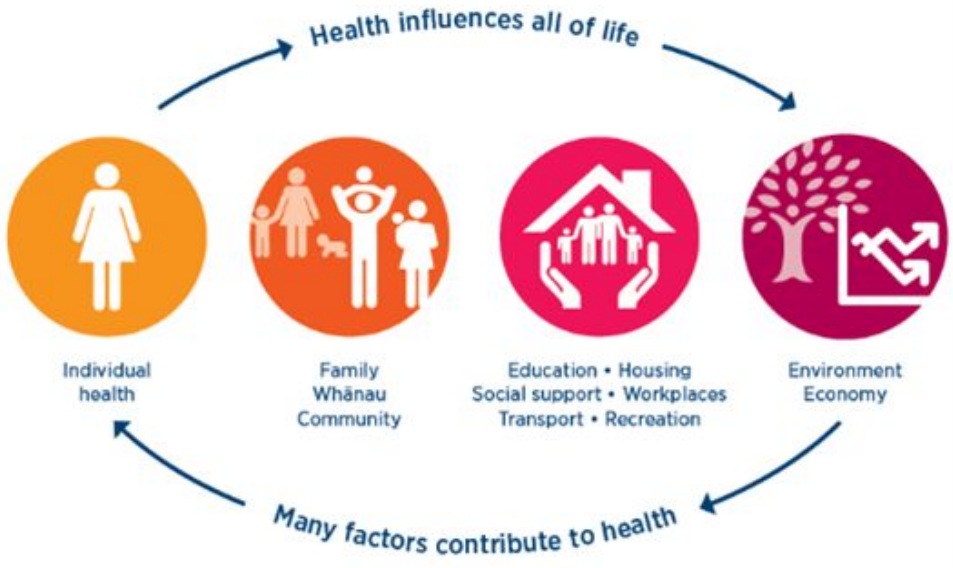
4. Putting the Jigsaw Together

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

We have identified people at risk in our DHB population, and where there opportunities to co-design solutions or there are national / regional trials or pilots to see whether ideas work, we will focus within these groups:

- young Māori, in particular young Māori men
- those living in the most deprived rural areas
- men generally
- people 65 years and older
- people who have made a previous suicide attempt.
- those who have made a previous suicide attempt
- those experiencing mental health and/or addiction issues or significant life stressors (including relationship break-downs)
- lesbian, gay, bi-sexual, transgender, trans-sexual and intersex people

With people at the very heart of our work, using the information gained through consultation with you, and in alignment with our strategic plan, we have incorporated what we learnt into our suicide prevention and postvention plan for 2018-2021. This information was then shared at an Intersectoral workshop with our major partner organisations and members of our consumer council. Together we determined collaborative and cross-sector objectives. This workshop has also been an opportunity to reinforce that suicide prevention needs to be embedded in all social services' work as it is so much wider than a health-sector issue.



Source: Ministry of Health (2016). Health in the wider context of people's lives. Retrieved May 28, 2018 from https://www.health.govt.nz/new-zealand-health-system/new-zealand-health-strategy-future-direction/health-wider-context-peoples-lives

The section that follows outlines what you told us and what practical steps we will be taking in partnership with communities and other agencies/organisations over the next three years to focus on reducing suicide in the Waikato DHB.


Understand me
Support our communities to find own solutions
Help us to help ourselves
We need to do things differently
Make sure there is good support when a suicide occurs
Focus on identified at-risk groups

4.1. Understand me

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

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

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

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

What you want:
Staff/people/communities that are non-judgmental.
An inclusive society; one that accepts difference.

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

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

Clinicians need to learn about asking patients (and their families) how they are feeling emotionally. Physical health and emotional wellbeing are inter-related.
Education for health workers around the language they use to their patients; attitude and pronunciation. People explained that all these things will have an impact on an emotionally vulnerable person.

The message is that difference is okay and being different is difficult and everyone needs love and support – not exclusion.
All support for a person in distress has to be focused on them and what is going on in their lives. If we do not understand the context, then we are less likely to be able to really help them for the long term.

What we are currently doing:
Translating our DHB value te iwi ngakaunui (people at heart) into action for all staff.

We have recently set up a Suicide Prevention Consumer Group of people with lived experience.

Working with the Suicide Prevention Consumer Group to develop appropriate messages for clinicians and workers when working with people who have attempted suicide.

What we and our partners in other sectors are going to do over the next 3 years

OBJECTIVE 1	Understand me			
ACTIONS	Develop or support workshops for parents run by Rainbow Youth Support workshops for parents about talking to young people about suicide	Explore a working group comprising mental health & addictions professionals, education specialists, local government, people with lived experience to create platform for discussion about how to destigmatise suicide in local communities.	Work with organisations such as Te Rau Matatini to increase cultural competence, improve pronunciation and to raise awareness of the importance of attitude	Standardize training for frontline staff in social sector agencies and develop a schedule of training using suite of best practice tools
LEAD AGENCY		Waikato DHB		Waikato DHB
SUCCESS WILL BE MEASURED BY	Number of workshops held	Local communities run their own destigmatisation - one social media campaign per year for 3 years	Number of programmes held Reduction in number of complaints relating to pronunciation	Schedule of training available Number of training sessions held

4.2. Support communities to find our own solutions to suicide prevention

What you told us:
Community connection was one of the main themes that came through in all the conversations during our consultation.

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

The out of hours times are when people feel worst.

Māori know what is best for Māori.

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

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

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

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

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

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

by phone but it needs to be for a bit to make sure that things are going okay.

What we are currently doing
Translating our DHB value kotahitanga (stronger together) into action.

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

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

What we and our partners in other sectors are going to do over the next 3 years

OBJECTIVE 2	Support communities to find our own solutions to suicide prevention				
ACTIONS	Development of local social support registers to ensure people know what help is available in their communities.	Work with clinical services to improve communications and follow up when someone has been discharged.	Develop culturally appropriate strategies for suicide prevention and explore the co-design of a whānau or marae champion training package and strategy such as LifeKeepers (Le Va) Build social awareness and encourage well-informed social attitudes around suicidal behaviour in Māori communities.	Assist communities with reducing social isolation by working with identified community leaders and champions Identify and support young people at risk through their schools Reduce truancy	Support communities to develop circles of support and accountability for identified groups eg, people coming out of prison and mental health & addiction services.
LEAD AGENCY	Hauraki PHO	Waikato DHB	Hauraki PHO in partnership with our Māori providers		
SUCCESS WILL BE MEASURED BY	Improved access to services Better informed communities	Annual reduction in re-admission to HRBC Annual reduction in repeat mental health and addiction-related visits to ED Increase in GP enrolments of mental health and addiction service users	Training package developed Number of Marae that have a trained champion	Number of communities with a plan/strategy for social inclusion Reduction in truancy	Number of communities with identified support for re-integration

4.3. Help us to help ourselves

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

What you told us

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

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

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

Communities already acknowledge the value of using standardized training rather than having all sorts of different options on offer.

What you want

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

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

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

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

Another community-based initiative is that of a "safe-place". A person could be given training and ongoing support in how to help someone who is distressed. This training might be much broader than suicide prevention but include a number of other social issues that can cause someone to think that there is little or no hope. The "safe-place" could have a sign denoting that there is a person available to help/listen or just be a buddy.

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

Train community members and they will train whānau.

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

What we are currently doing

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

Continue to support WAVES groups.

Continue to support Safetalk, Lifekeepers for community members and a standardised training package for clinical staff.

Continue to hold Health Hubs where communities invite us to.

Working with others nationally to develop a wallet card with how to recognise signs of distress and numbers to ring.

What we and our partners in other sectors are going to do over the next 3 years

OBJECTIVE 3	Help us to help ourselves - Give us information and training so we can help ourselves, and give our health services information so they know how to help us.				
ACTIONS	Work with the Rainbow community to develop information for frontline staff to strengthen inclusive practice. Standardised training packages/ workshops for frontline staff or communities	Explore and potentially trial the 'safe place' idea with communities. Develop an allied communication strategy	Work with communities to encourage setting up youth groups and improve information about available youth services.	Working with national campaigns around suicide prevention to develop local media messages and saturation strategies.	Identify how to progress Waka Hourua for our area.
LEAD AGENCY		Hauraki PHO	Hauraki PHO	Waikato DHB	
SUCCESS WILL BE MEASURED BY	Develop a training package/communication strategy Number of frontline staff by agency who have been trained Number of workshops delivered	Number of 'safe places' identified Number of community awareness campaigns delivered	Number and location of youth groups set up Improved information on Youth services available	Number and location of local saturation strategies delivered	Plan developed and approved

4.4. We need to do things differently

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

What you told us

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

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

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

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

What you want

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

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

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

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

Strengthen the relationships between primary and secondary mental health services.

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

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

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

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

Develop pathways and models that work for the most affected. These include Māori men, rangatahi, and people impacted by mental illness.
Support community workers - not qualified social workers but those who can provide early intervention.

What we are currently doing

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

Developing Map of Medicine pathway for suicidal presentations at GPs.

Providing free counselling sessions via GPs.

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

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

What we and our partners in other sectors are going to do over the next 3 years

OBJECTIVE 4 We need to do things differently - so we need to look at what works and abandon what has not worked.						
ACTIONS	Share generic profiles of those at risk so all agencies are aware of triggers, risk factors and actions if someone at risk presents to front line staff	Focus on men. Develop community options that men feel comfortable to use eg, Men's Sheds, fixing bikes from the dump for local kids, buddy systems/Mates Annual primary care assessment and green prescriptions are available to men who are on long term job seekers benefit by locality	Participate in the ACC Pilot to reduce suicide attempts and repeat deliberate self-harm injuries.	Support all agencies/ organisations to adopt the principles of whānau ora in their response to those at risk of suicide Annual multi-agency suicide prevention forum to share progress and ideas	Multi-agency suicide prevention community action plans for each community (Tokoroa and Taumarunui are currently developing these)	By locality, connect with industry groups to identify gaps in suicide prevention Work in partnership to develop initiatives to close gaps
LEAD AGENCY	Waikato DHB	Hauraki PHO	Waikato DHB	Waikato DHB	Communities as identified	Waikato DHB
SUCCESS WILL BE MEASURED BY	Number and type of agencies who are aware of risk factors	Number of new men's initiatives by locality and type Annual increase in green prescriptions to men who are on long term job seekers benefit by locality	Reduced attempted suicide/deliberate self harm presentations to Waikato Hospital ED	One forum per year	Number and names of communities where a plan has been developed	Gaps and initiatives documented by industry and location

4.5. Make sure there is good support when a suicide occurs

What you told us

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

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

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

What you want

When a suicide happens, the right people know so they can support people and the community.

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

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

What we are currently doing

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

We all know that the information that a person has died of suspected suicide is very sensitive information. The Chief Coroner has permitted the release of the name so that a small group of people in each DHB can support the bereaved and those close to the person who has died. Our small group is called the Postvention Action Team. When we learn of a death, the group is informed so that support can be offered as soon as possible to family, friends and workmates.

This is usually offered by Victim Support but another agency will take over if they already know the bereaved.

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

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

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

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

Support is provided to communities experiencing suicide clusters[2] or suicide contagion.

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

Wallet cards that can be given to the bereaved family by Victim Support or the Police have been developed. These cards give information about counselling (funded by the DHB) or other forms of no-charge bereavement support (such as the WAVES suicide-bereavement courses).

We regularly review our postvention response to learn what could be done better so that the whānau, and wider community is supported.

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

What we and our partners in other sectors are going to do over the next 3 years

OBJECTIVE 5	Make sure there is good support when a suicide occurs.				
ACTIONS	Implement the remaining recommendations that came from research about supporting grief commissioned by the Waikato DHB.	Liaise with other DHBs to review their postvention responses so we can all learn from each other.	Work with community groups and kaupapa Māori organisations to learn what will be most appropriate to support whānau and friends through suicide-related grief.	Establishment of a bereaved whānau support network	Development of locality-based acute postvention support groups
LEAD AGENCY	Waikato DHB	Waikato DHB	Hauraki PHO	Commissioned whānau member (Waikato DHB)	Waikato DHB
SUCCESS WILL BE MEASURED BY	Bereavement approaches used are supported by best practice	Postvention responses are informed by other DHBs approaches	Post suicide support for whānau and friends is appropriate	Implementation of a sustainable bereaved whānau network	Number and location of acute postvention support groups

4.6. Ensure a focus on identified at-risk groups

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

- young Māori, in particular young Māori men
- those living in the most deprived rural areas
- men generally
- people 65 years and older
- people who have made a previous suicide attempt.
- Those who have made a previous suicide attempt
- Those experiencing mental health and/or addiction issues or significant life stressors
- Lesbian, gay, bi-sexual, transgender, trans-sexual and intersex people

The previous section outlines what we and our partners will be doing over the next three years. In all actions the above at risk groups will be prioritised and we will continue to focus our resources on these groups.

5. Roadmap

[composite graphic to be added]

6. Conclusion

Suicide is a catastrophic issue and affects us all, whether directly or indirectly. Waikato DHB and our partners are determined to make a difference to our suicide rate.

This plan represents our commitment to the inclusion of our communities and partner agencies in a zero suicide aspiration. It reflects the voices of the people and communities we have engaged and the joint planning and responsibility for outcomes.

While the plan does not have timeframes as such we will review actions annually and will be transparent in our progress.

We acknowledge and gratefully thank the people who took the time to speak with us and who are at the heart of this plan.

Appendix A National Suicide Information

National suicide data[3] (please note this information is still provisional) for the period 1 July 2016 and 30 June 2017 shows:

- A total of 606 people died by suicide in New Zealand. This is a rate of 12.64 suicides per 100,000 population), which is 27.4 percent below the highest recorded rate in 1998
- New Zealand's suicide rate for both males and females is slightly above the median for the OECD countries.
- The male rate was 19.36 per 100,000 and the female rate was 6.12 per 100,000 of the population.
- The national rates for men 40 to 44 years were the highest at 33.90, followed by men 85 years and over (33.67 per 100,000 population) and men between 20 and 24 years old.
- The rate for Māori was 21.73 (all stated as a standardised rate per 100,000 people) whereas the rates for Asian were 5.73, 9.15 for Pasifika and 14.66 for European and other.

The Ministry of Health[4] state that:

- There were also over 7200 hospitalisations (including short-stay Emergency Department events[5]) for intentional self-harm injuries in New Zealand in 2013

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

[4] Ministry of Health. 2016. Suicide Facts: Deaths and intentional self-harm hospitalisations: 2013. Wellington: Ministry of Health

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

Appendix B The Waikato District Health Board area

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

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

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

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

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

Appendix C Engagement Report

[separate attachment]

Appendix D Governance structure

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

Appendix E Achievements 2014-17

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

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

Accident Compensation Corporation
Age Concern
Centre 401
Clinical Advisory Services Aotearoa (CASA)
Department of Corrections
Hamilton City Council
Hamilton Coronial Services
Huntly Rangatahi forum
Kainga Aroha, Te Awamutu
Kokiri Trust
LeVa
Lifeline
Ministry of Education
Ministry of Health
Ministry of Social Development
NZ Police
Oranga Tamariki
Otorohanga Support House
Progress to Health
Rauawaawaa Kaumātua Trust
Raukawa Trust, Tokoroa
Rural Health Alliance of Aotearoa New Zealand
Rural Support Trust
SPARX, University of Auckland
StayWell (wellness checks for the rural communities)
Te Kuiti Community House
Te Rau Matatini
Tokoroa Council of Social Services
University of Waikato Health Services
Victim Support
Waikato Queer Youth
Waikato District Council – Youth Engagement Advisor
Riders Against Teenage Suicide

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

Webpage
A series of webpages have been developed and available since the middle of 2016. In accordance with the importance placed on suicide prevention and postvention by the Waikato DHB, the SPP webpages can be accessed directly through the front page on the Waikato District Health Board website http://www.waikatodhb.health.nz/ or https://www.waikatodhb.health.nz/your-health/wellbeing-in-the-waikato/suicide-prevention/

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

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

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

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

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

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

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

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

- a discrete fund is available for bereavement counselling. All primary care practices and funeral directors within the Waikato DHB area are now informed of the availability of the fund for counselling or psychological services.
- two WAVES facilitator training courses were co-funded by the DHB– one in Hamilton and one in South Waikato. A total of 18 facilitators have been trained in running a closed suicide bereavement support group.
- the webpage has information about what support is available after a death.
- research was commissioned to research four areas specifically around supporting grief. This research was undertaken to determine what would be appropriate and

sustainable to ensure that people bereaved by suicide in the Waikato DHB are supported through the grieving process. Several recommendations have already been implemented and further recommendations are being considered.

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

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

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

Waikato DHB Suicide Prevention and Postvention Plan Refresh

Engagement Summary Report

Author: Jane Hudson and Clare Simcock

Last Updated: 14 August 2017

Document Name: Engagement Summary Report

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Introduction

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

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

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

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

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

Who did we talk with?

Community Health Forums

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

Focus Groups/Feedback from key informants

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

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

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

- The rainbow youth community; and

- Rangatahi/young people aged 15-17

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

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

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

Choice of focus groups/key informants

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

Feedback

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

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

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

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

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

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

Submissions

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

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

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

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

Surveys

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

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

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

Other statements had the following support:

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

Ministry of Health

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

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

- Building positive wellbeing[1] throughout people's lives
- Recognising and appropriately[2] supporting people in distress
- Relieving the impact of suicidal behaviour on people's lives.

Methodology issues

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

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

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

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

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

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

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

Conclusion

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

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

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

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

Appendix - who has contributed

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

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

Group	Geographical area	Methodology	When
Waikato DHB Community Forums	Tokoroa, Hamilton, Matamata, Paeroa, Thames, Taumarunui, Raglan, Huntly, Ororohanga, Te Kauwhata	Presentations/discussions	6-16 March 2017
		Well-being update	18 July-2 August 2017
Te Tūramarama Declaration	National		June16
Aged Care Sector	Thames	Focus Group (Hauraki AgeWise)	4 July 2017
Population Health	Waikato DHB area	Discussion with Public Health staff	May 17
Rainbow youth	Hamilton	Key informant who had canvassed his community	31 May 2017
NGO supporting people with chronic cognitive illness	Waikato DHB area	Key informant	Jul 17
Rangatahi/young people 15 -17 years (Maori and Pakeha)	Ngaruawahia	Written feedback from a key informant from three groups of Year 10 students (24 students. 18 boys, 6 girls)	14 June, 15 June, 21 June 2017
Māori		key informant from the Maori community	20 June 2017
Community workers/those with lived experience (Māori and Pakeha)	Thames	Focus Group	23 June 2017
Te Puna Oranga (DHB Māori Health Service) staff	Waikato DHB area	Focus group	July 2017
Mental Health & Addictions lived experience (Māori and Pakeha)	Hamilton	Focus Group	7 June 2017
Pasifika - Community workers/those with lived experience	Tokoroa	Focus Group	9 June 2017
Rural Men	Te Awamutu	Focus Group	Unable to schedule
Men's group		Key informant	July 2017
Suicide Prevention Group		Key informant	July 2017
Farming sector	Waikato DHB area	Key informant	July 2017
Mortality Review Group		Non-identifiable recommendations	July 2017

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

Appendix - Feedback

1. Understanding people

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

2. What people believe works

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

3. Information and education/training

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

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

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

4. Provision of service

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

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

Papers for Information

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
8 AUGUST 2018

AGENDA ITEM 6.1

PROPOSAL FOR CHANGE TO STRATEGY, FUNDING AND PUBLIC HEALTH

Purpose	For information and feedback

The strategy, planning and funding functions of a District Health Board (DHB) are critical levers in achieving the DHB's responsibilities to improve population health outcomes and ensure the provision of effective healthcare services. Most importantly, these functions can, when appropriately configured and supported, play a critical role in the DHB's key responsibilities to improve Māori health and reduce health inequities.

The Chief Executive (CE) has been clear about his expectation that the Strategy and Funding unit will be reviewed to ensure there is a greater focus on our strategic direction, and on shaping our health system to respond to the challenges now and in the future. Furthermore, the CE's new executive structure has placed the Public Health Unit alongside Strategy and Funding reporting to the same Executive Director. This has presented a significant opportunity to integrate the activities of both functions, and maximise health gain for our population through a more focussed approach on wellness and wellbeing in our communities.

The attached paper provides the rationale for change, an overview of the new commissioning approach, and a description of the proposed new structure. At the time of the Community and Public Health Advisory Committee (CPHAC) meeting, the formal consultation will have concluded. However, feedback from the committee will be valuable and will inform the final decision which is not due until 17 August 2018.

A presentation will provided at the CPHAC meeting.

Recommendation
THAT
The Committee provides feedback on the Proposal for Change.

TANYA MALONEY
EXECUTIVE DIRECTOR
STRATEGY, FUNDING AND PUBLIC HEALTH

Consultation Document

Author:	Tanya Maloney, Executive Director, Strategy, Funding and Public Health
Date:	12 July 2018
Document Name:	Proposal for change: Strategy, Funding and Public Health
Version:	FINAL

Contents

EXECUTIVE SUMMARY

This document proposes changes to the configuration of the Strategy and Funding Team and Public Health Unit in order to better deliver on our responsibilities and achieve our vision. The proposal seeks to achieve the following:

1. To improve the functioning of the Strategy and Funding Team through the introduction of a new model of commissioning;
2. To reconfigure positions to effect the new commissioning model and ensure we are well prepared to lead the implementation of the HSP and CCP once they are finalised;
3. To strengthen the management and leadership of the Strategy & Funding Directorate in order to provide appropriate leadership in system planning, change management and service development;
4. To maximise the benefit of having the Public Health Unit and Strategy and Funding team reporting to the one Executive Director position, by integrating the two teams.

The proposed changes will provide the foundation for the new (proposed) commissioning approach outlined in Appendix one. This approach is based on shared leadership, strong partnerships, co-design and a focus on outcomes.

The proposed structure includes the establishment of the following positions:

- Director - Health Intelligence and Performance
- Director - Planning, Population Health and Equity
- Director - Community Care and Wellbeing
- Director - Specialist and Complex Care
- Associate Clinical Director Primary Care (0.4)
- Programme Manager, Health System Plan
- Manager, Māori Health Gain
- Iwi Relationship Coordinator
- Service Development Manager, Long Term Conditions and SLMs
- Funding and Relationship Manager, Hospitals
- Service Development Manager, Whanau Ora
- Funding and Relationship Manager, Child Health and Maternity
- Service Development Manager, Mental Health and Addictions
- Funding and Relationship Manager, Mental Health and Addictions
- Service Development Manager, Health of Older People and Disability Services
- Funding and Relationship Manager, Health of Older People and Disability Services
- Service Development Manager, Primary Care
- Funding and Relationship Manager, Primary Care – Primary Health Organisations
- Funding and Relationship Manager, Primary Care - Pharmacy and Clinical Support Services
- Funding Analyst (x2)
- Performance Analyst (x2)
- Health Intelligence Advisor
- Contracts Manager
- Personal Assistant Community Care & Wellbeing and Specialist & Complex Care
- Personal Assistant Executive Director Strategy, Funding and Public Health

The proposed structure involves the disestablishment of the following positions:

- Director Integrated Care
- Senior Portfolio Manager
- Senior Funding Manager
- Planning and Integration Manager
- Portfolio Managers x 9
- Performance Analysts x5
- Project Manager (planning)
- Strategic and Community Engagement Manager

Further changes to positions, titles and reporting lines are detailed in the main document.

A consultation process will run from 13 July 2018 until 30 July 2018. We welcome feedback on the proposed changes from staff and key stakeholders.

1. INTRODUCTION

The strategy, planning and funding functions of a District Health Board (DHB) are critical levers in achieving the DHB's responsibilities to improve population health outcomes and ensure the provision of effective healthcare services. Most importantly, these functions can, when appropriately configured and supported, play a critical role in the DHB's key responsibilities to improve Māori health and reduce health inequities.

The Chief Executive has been clear about his expectation that Strategy and Funding unit will be reviewed to ensure there is a greater focus on our strategic direction, and on shaping our health system to respond to the challenges now and in the future. The CE appointed a new Executive Director, Strategy and Funding in March 2018[1] with the express expectation that she would undertake this review and make the changes necessary to ensure a commissioning approach based on partnerships, shared leadership and improved outcomes, particularly for Māori . Furthermore, the CE's new executive structure has placed the Public Health Unit alongside Strategy and Funding reporting to the same Executive Director. The focus of the Public Health Unit aligns well with the population health responsibilities of Strategy and Funding and there are opportunities for Strategy and Funding to improve its population health and equity approaches by closer working of the two teams.

This document proposes changes to the configuration of the Strategy and Funding Team and Public Health Unit in order to better deliver on our responsibilities and achieve our vision. The proposal seeks to achieve the following:

1. To improve the functioning of the Strategy and Funding Team through the introduction of a new model of commissioning;
2. To reconfigure positions to effect the new commissioning model and ensure we are well prepared to lead the implementation of the HSP and CCP once they are finalised;
3. To strengthen the management and leadership of the Strategy & Funding Directorate in order to provide appropriate leadership in system planning, change management and service development;
4. To maximise the benefit of having the Public Health Unit and Strategy and Funding team reporting to the one Executive Director position, by integrating the two teams.

2. BACKGROUND

2.1 A new approach to commissioning

In March 2018, the Executive Director, Strategy & Funding commissioned a review of Strategy and Funding directorate. The current limitations in capacity and capability of the Strategy and Funding directorate were outlined in the report Redefining Strategy & Funding (Duncan Innes, May 2018). In essence these limitations related to the team being inadequately resourced and poorly configured for effective commissioning, and to provide the leadership and system transformation that is required to address the significant challenges that the health system is experiencing.

The report recommended a number of changes to achieve an effective commissioning approach as follows:

1. Define a clear approach for commissioning
2. Increase the emphasis on Māori health gain
3. Enhance the team's skill set to ensure leadership in health system and service development
4. Increase management capacity to provide a more senior level of management beneath the Executive Director
5. Refocus the Portfolio Manager role to focus on relationships and system development
6. Set out clear expectations for service development
7. Adopt investment management techniques for planning and provide training in Investment Logic Mapping
8. Adopt one project management methodology within the Directorate
9. Enhance the use of data for commissioning
10. Set up a Business Support team to provide better support for managers and enable them to undertake a wider service development role.

[1] This is an interim appointment through until March 2019.

A new approach to commissioning is outlined in the attached paper, *Commissioning for Healthy People, Excellent Care and Health Equity.* The changes proposed below are intended to prepare the Strategy and Funding unit to enact this new approach and address the gaps identified in the *Redefining Strategy & Funding* review.

2.2 The alignment of Public Health

The Chief Executive's restructure of the executive team in May this year resulted in a new reporting line for the Public Health Unit to the Executive Director Strategy and Funding. The alignment of Strategy and Funding and Public Health is welcomed, in that the focus on population health, health improvement and protection, and health intelligence are shared by both teams. This proposal aims to integrate those 'like' functions in order to ensure alignment of work, reduce duplication and optimise the impact of both teams. It is important to note that both teams have unique statutory and/or contractual responsibilities, and the integration aims to ensure that those responsibilities will continue to be fulfilled.

2.3 Health System Plan

The DHB is undertaking a Health System planning process which is being led by Strategy and Funding. This includes the development of a 10-year Health System Plan (HSP) and a component Care in the Community Plan and Disability Responsiveness Plan. On completion of the planning phase in early 2019, Strategy and Funding will lead and coordinate the implementation of the HSP which will involve significant change management and leadership capability.

3. REASONS FOR THE PROPOSED CHANGES

The reasons for the changes proposed below are outlined in detail in the attached paper: *Commissioning for Healthy People, Excellent Care and Health Equity.* It is also precipitated by the change in reporting line of the Public Health Unit to the Executive Director, Strategy and Funding. In summary, the reasons for the proposed changes are:

- **Radical improvement in Māori Health outcomes –** in order to achieve our aspiration, and commitment, to improve Māori health and eliminate health inequities, the DHB must do something different with respect to service provision. Services that are not meeting the needs of Māori and other high needs populations must be improved, reconfigured or decommissioned. The Strategy and Funding team must be well equipped, and appropriately structured to meet this challenge

- **Developing an effective commissioning approach –** the system requires an approach that is based on strong partnerships, community and consumer participation (and co-design), effective leadership and shared accountability for outcomes. The approach requires new roles and capabilities, enhanced leadership and additional resource.

- **Insufficient business and administrative support** – as noted in the Innes review, there is insufficient support for contract management and administration. The team administers and oversees approximately 650 non-Government contracts all of which are administered by one contact administrator; it has been widely acknowledged for years that this position is overloaded and this arrangement is unsustainable. Furthermore, due to the minimal administration support, portfolio managers and analysts spend a significant portion of their time dealing with administrative tasks rather than performing tasks at the top of their scope and capability. There is a need to increase the administrative support in order to allow analysts and portfolio managers to focus on their priority responsibilities.

  It is also evident that the PA to the Executive Director and Clinical Director is overburdened with work and that one PA position is not sufficient to support both roles.

- **Enhanced leadership positions -** the history of the unit over the last couple of years has seen a centralisation of control, where the unit relies on the approval of the Executive Director for many decisions that could be delegated to managers and other staff. This decision making process has resulted in slow decision making and, more importantly, in the disempowerment of staff to make timely decisions about their portfolios, teams and other business. Furthermore, the roles

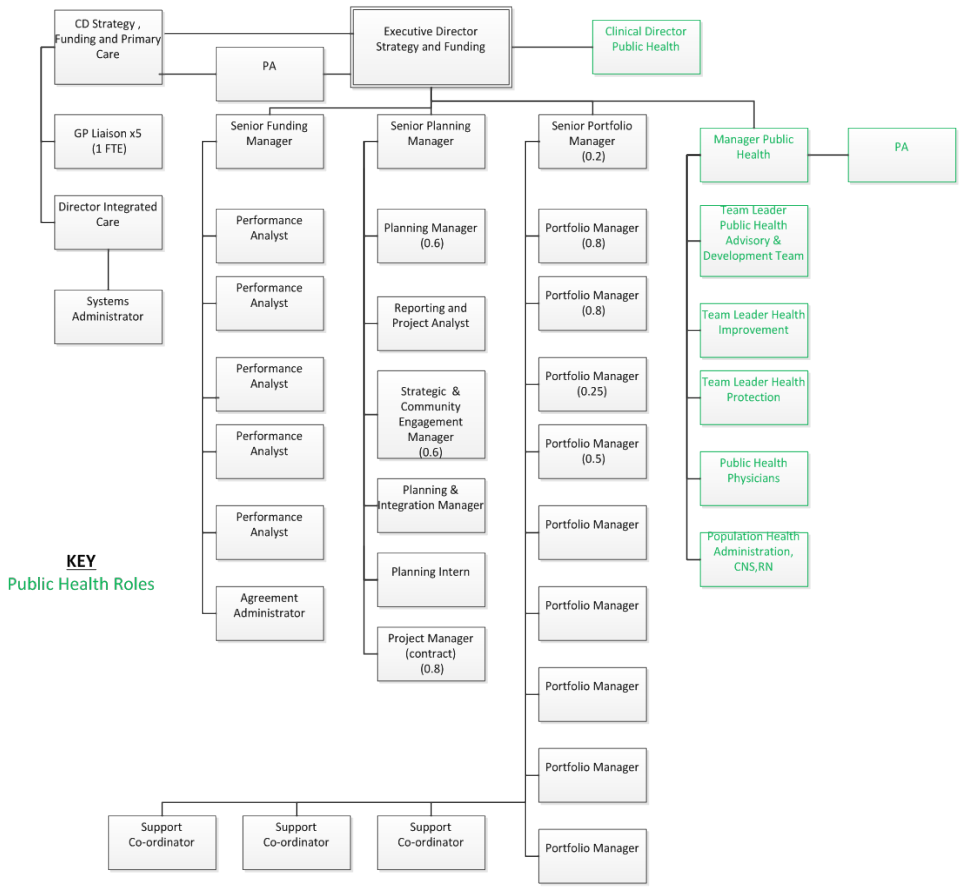
reporting to the Executive Director are 'Senior Managers'. In other parts of the DHB, and in other large DHBs' planning and funding units, there is a more senior level of management (Director or General Manager) reporting to the Executive Director. To enable the commissioning approach across a whole health system, the strength of leadership from the Strategy and Funding directorate must be enhanced and must enable devolved leadership of commissioning and transformational change.

- **Implementation of the Health System Plan –** As noted above, the DHB's Health System Plan will be completed in early 2019 at which time we will move into implementation phase. The implementation of these plans will involve significant resource and impose new demands for planning and service development resources. There will be a need for appropriate capacity and capability to implement these plans with additional service development and change management expertise.

- **Optimising the alignment of the Public Health team with Strategy and Funding –** as noted above, the opportunities presented by the shared management of Strategy and Funding and Public Health will only be realised by closer working of the various parts of each team. The integration of various functions will enhance the impact of our planning, health improvement and health intelligence functions.

4. CURRENT STATE

The current structure of the Strategy and Funding and Public Health Directorate is shown in this diagram:



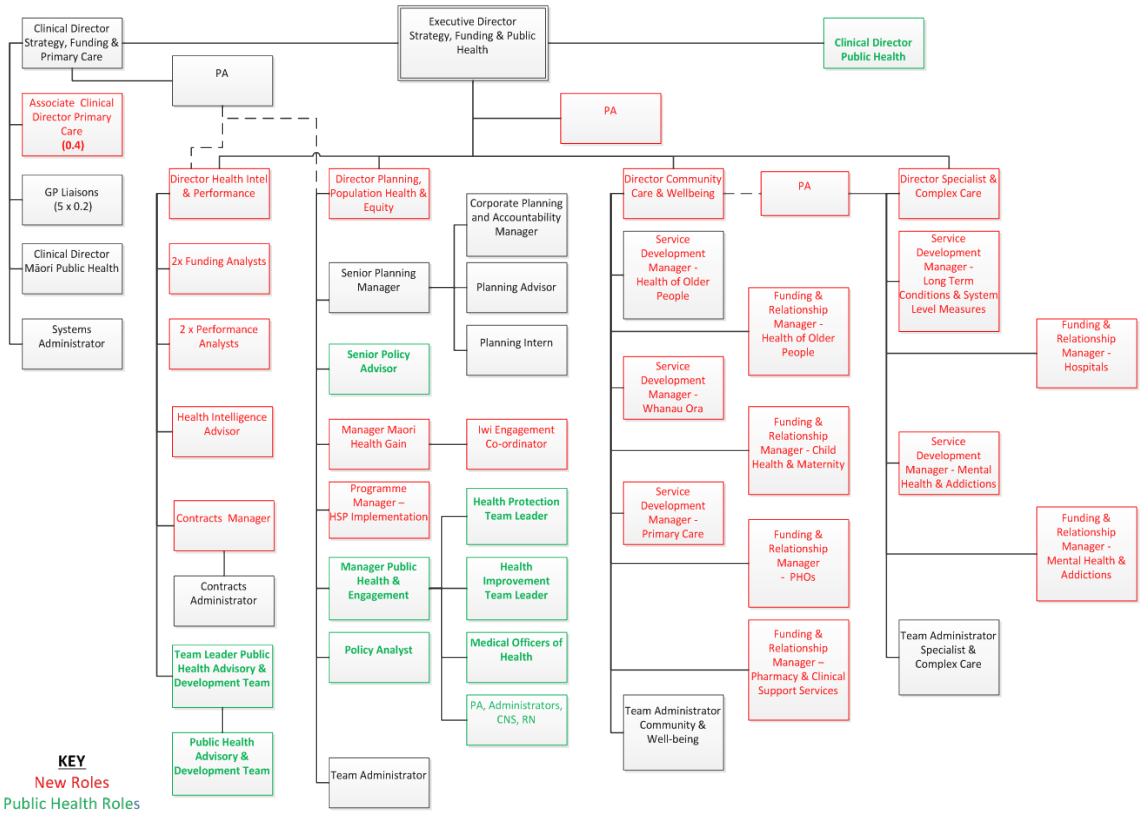
5. PROPOSED CHANGES

This proposal strengthens the DHBs capability for effective commissioning, system development and integration.

The proposed changes are designed to:

- Ensure the directorate has appropriate leadership to deliver effective commissioning to improve population health and reduce inequities
- Enhance the service development capability of the directorate
- Optimize the alignment of Public Health and Strategy and Funding functions
- Reconfigure administrative support to ensure appropriate capacity and clarity of roles

The proposed structure is shown below.



5.1 Management & Leadership Structure

New positions

The proposed structure includes the establishment of four director positions which will provide strategic leadership in the areas of Health Intelligence & Performance; Planning, Population Health & Equity; Community Care & Wellbeing; and Specialised & Complex Care.

The primary reasons for the establishment of these senior positions are:

- to ensure a more responsive directorate that is not reliant on the Executive Director for decision making across the whole health system
- to provide greater leadership in system development and change management

- to ensure the appropriate seniority of leadership, performance management and relationship management with all providers, including the provider arm.

The Director positions are responsible for management and leadership of their respective areas, and for ensuring ongoing system development and the commissioning of services to improve health outcomes and reduce health inequities. As such, the Directors are expected to have significant content knowledge and experience in their respective areas, particularly those leading the service development and funding teams.

As members of the Senior Leadership Team (SLT) the Directors will share accountability for the performance of the directorate as a whole.

The proposed changes include the establishment of the following positions:

- Director, Health Intelligence and Performance
- Director, Planning, Population Health and Equity
- Director, Community Care and Wellbeing
- Director, Specialist and Complex Care
- Associate Clinical Director, Primary Care

Associate Clinical Director Primary Care (0.4)
As a result of the CE's restructure in May, the Clinical Director,(CD) Primary Care took on additional responsibilities as CD, Strategy, Funding and Primary Care. This expanded leadership role, supporting commissioning and service development across the whole health system, has resulted in less capacity for the CD *Primary Care* responsibilities. Thus, it is proposed that an Associate CD Primary Care position is established. This position will work closely with the CD Strategy, Funding and Primary Care are to ensure effective relationships exist with General practice, PHOs and other NGOs to ensure a collaborative working environment. An important aspect of the role will be to lead the GP Liaison team and support the development of integrated clinical services across the Waikato DHB region. The role will provide clinical representation at the regional and local clinical pathway programme group meetings. This role will also provide clinical advice and support specifically to general practice and PHOs and the provider arm to ensure primary and secondary care are working effectively together.

Disestablished positions
The proposed changes to the leadership team include the disestablishment of the following positions:

- Director, Integrated Care
- Senior Funding Manager
- Senior Portfolio Manager

Change in reporting lines
The proposal includes a change in the reporting line for the Manager Public Health to the Director, Planning, Population Health and Equity.
With the proposed disestablishment of the Director Integrated Care, the Systems Administrator (primary care) will report to the Clinical Director, Strategy, Funding and Primary Care.

Senior Leadership Team Membership
It is proposed that the membership of the senior leadership team is broader than the Executive Directors 'direct reports' in order to ensure an enhanced focus on Māori Health gain and reducing inequities. Furthermore, it is critical to have consumers involved in the strategic work of Strategy, Funding and Public Health if we are to fully understand consumers' needs and wishes, and meet those needs in an informed, empathic and whanau and person-centred manner.

Thus, it is proposed that in addition to those positions included in the leadership structure above, Senior Leadership Team meetings and key decisions will also include the following:

- Clinical Director, Māori Public Health
- Executive Director, Te Puna Oranga
- Consumer Council Chairs

5.2 Health Intelligence & Performance Team

Health intelligence is a critical component of a commissioning approach, involving the capture, interpretation and utilisation of information to inform decision making to improve population health outcomes. This paper

proposes bringing together the analysts from the Strategy and Funding team and the Public Health Advisory and Development team from the Public Health Unit.

This team would be focused on health intelligence and provider and system financial and non-financial performance, to provide valuable insights to commissioning and to population health gain.

The functions of the team will include core analytical work covering:

- Measuring the equity gap between different populations;
- Monitoring, reviewing, and forecasting system performance both financial in terms of "funder budgets" and non-financial in terms of health targets, SLM results, and other agreed metrics;
- Monitoring provider performance against agreed KPIs and health targets;
- Designing and implement funding methodologies that achieve value for money and utilise outcomes based contracting where possible;
- Development of rolling Health Needs Assessments to inform service planning;
- Demographic profiling;
- Demographic and health needs modelling at a locality level;
- Providing insight to the data and support utilisation of knowledge and expertise;
- Administration functions of agreements and provider payments;
- Development of structured dashboards and accountability frameworks to inform system planning and improvement initiatives;
- Work with the other DHB analyst teams to support the work of the Chief Data Officer.

This team would retain the current contract administration function. However, it is proposed that there is an increase in resource for contract administration to ensure enhanced oversight of the contract management process, relieve the very high workload of the current Agreements Administrator, and allow other team members (Analysts and Funding & Relationship Managers[2]) to focus on their core responsibilities.

New Positions

There are currently five Strategy and Funding Performance Analysts all of whom operate in relatively distinct portfolio service areas and perform all functions of the analyst role for their respective areas; financial, analytical, monitoring, and reporting, and are considered subject experts in all quantifiable information that the DHB holds or has access to. They also have a hand in determining contract clauses and negotiating conditions and pricing with providers.

One of the weaknesses of this approach is that each analyst spends time dealing with some level of contract administration and low level transaction processing, as well as covering aspects of provider relationship management in some cases. Due to the quantity of small process tasks and compliance requirements there is often little capacity for system improvement or deeper analysis of population health needs. There is also a lack of succession planning and cover for critical functions.

It is proposed that three function-based analyst positions are established. These roles will cover a broader portfolio area but with a more focused set of tasks. Furthermore, it is proposed that many of the administrative tasks are moved to administration roles (team administrators or Contracts Manager), and provider contact and correspondence will be the full responsibility of the new Funding and Relationship Manager roles.

The proposed changes include the establishment of the following positions[3]:

- Funding Analysts (2.0 FTE)
- Performance Analysts (2.0 FTE)
- Health Intelligence Advisor (1.0 FTE)
- Contracts Manager (1.0 FTE)

Disestablished positions

The proposed changes include the disestablishment of the following positions:

- Performance Analysts (x5)

[2] See section 5.4 for information about the Funding and Relationship Manager positions
[3] See Appendix 2 for details on new positions

Changes to current positions

Agreement Administrator

It is proposed that the Agreement Administrator is re-titled as Contracts Administrator and will report to the new (proposed) Contracts Manager position. The only other change to this position is that the work load will be lessened as the Contracts Manager position will take on some of the workload.

Public Health Advisory and Development Team Leader

It is proposed that the reporting line for the Public Health Advisory and Development (PHAD) Team Leader is changed to report to the Director Health Intelligence and Performance. This change in reporting line for the Team Leader will result in minimal change in the activities of the team in the immediate future. However, it is expected that the expertise within each team will be shared and specific skill sets will be utilised across both Commissioning and Public Health Unit activities.

Policy Analyst

It is proposed that the Policy Analyst position, currently within the PHAD team, has a change in reporting line from the PHAD team leader to the Director Planning, Population Health and Equity. The focus of this role, including submissions on government policy, is well aligned with the Planning, Population Health and Equity team which will have a strong focus on whole of government and inter-sectorial work in addressing the social determinants of health.

5.3 Planning, Population Health and Equity

The proposed changes to this team are intended to enable a greater focus on planning for system responsiveness, improving health outcomes and reducing health inequities in addition to retaining its statutory functions relating to planning and reporting, such as the annual plan, SLM plans, quarterly reporting and annual reporting.

This team will have expanded responsibilities in the oversight and implementation of the Health Systems Plan, Care in the Community Plan, Disability Responsiveness Plan and Virtual Health Plan, all of which are under development. This will require a mix of different skill-sets and team members with an aptitude for implementation planning and leadership across the system.

The new team will be focused on the following:

- Improvement in health equity and population health gain
- Leadership, oversight and implementation planning of the Health System Plan (and component plans)
- Improved connectedness of planning activity across the Waikato health system (including Strategy and Funding planning requirements, Public Health planning requirements and Clinical Service planning)
- Stronger linkages to district and regional planning of other agencies to address social determinants of health
- Enhanced community and consumer voice in our planning work, and
- Planning that is better supported by research and insight.

It is proposed that this team is inclusive of the Public Health Unit (excluding the PHAD team) given the strong alignment of the Public Health Unit's responsibilities for population health, illness prevention and reducing health inequities. In particular, the following Public Health functions align well with the new Planning, Population Health and Equity team:

- Public Health Service Annual Planning
- Regional Public Health Policy Development
- Inter-sectoral Engagement, Policy and Submissions
- Health Improvement (Health Promotion)

New positions

The proposed changes include the establishment of the following positions:

Health System Plan Programme Manager

This role would have responsibility for leading and coordinating the implementation of the Health System Plan. In summary the responsibilities will include:

- Responsibility for leading a portfolio of programmes and projects to implement the HSP
- Develop and overall plan for implementation of the HSP
- Ensure an appropriate governance is in place to oversee the implementation, and provide regular reports to relevant groups/parties
- Ensure appropriate project and work groups are formed to support the implementation
- Work with Service Development Managers to ensure their activities support and are aligned with the HSP
- Provide strategic advice on the direction of the HSP to governance groups and the Executive and consider advice provided by stakeholders
- Continue to develop the HSP and implementation plans as circumstances evolve

Manager, Māori Health Gain
This Manager position would have responsibility for the following:

- Takes the lead in planning to address health inequalities across the system
- Provides advise to the directorate on evidence based and evidence informed models of service delivery that are effective in improving Māori Health and reducing inequitites
- Partner with Service Development Managers and Funding and Relationship Managers to identify service changes that focus investment on Māori health gain that will be effective improvement over short, medium and long term horizons
- Ensures Strategy and Funding's commissioning approach is aligned to the Board's agreement with IMC with respect to equity focus across both contracted (NGO, PHO) and Provider Arm services
- Builds a collaborative approach with Te Puna Oranga in aligning approaches to achieve Māori health gain
- Takes a lead in exploring and understanding equity related performance data and in developing a system or service response to inequities

Iwi Engagement Coordinator
It is important to improve our engagement with Iwi in the process of commissioning, from strategy development and planning through to co-design of services; thus, it is proposed that we establish an Iwi Engagement Coordinator to ensure we engage with Iwi in an appropriate and respectful manner. This role will report to and work closely with the Manager Māori Health Gain, and will also work with the Manager Public Health and Engagement, particularly in the development of a new Engagement Framework. The position would also support Service Development Managers to engage with Iwi in service design and change.

Changes to current positions

Manager Public Health and Engagement
As mentioned above, it is proposed that the Manager Public Health reports to the new (proposed) Director Planning, Population Health and Equity. It is also proposed that this position is expanded to manage our public/community engagement. The reason for this proposed change is that the public health unit, and in particular the health improvement team, is very well linked with communities and there is an opportunity to improve our engagement approach by building on these well-established networks. This also minimises the duplication of engagement that has been evident in the DHB's approach to engaging with communities.

Planning Manager
It is proposed that this position is retitled ***Corporate Planning and Accountability Manager*** to reflect the key responsibilities of this role which are the statutory planning and accountability documents required by the Public Health and Disability Act.

Reporting and Project Analyst
It is proposed that this position is retitled ***Planning Advisor***. The core areas of responsibility will be similar to the current role as follows:

- Supports development of the Annual Plan
- Supports development of the Annual Report
- Supports development of the Midlands Regional Services Plan

- Takes responsibility for quarterly reporting to the Ministry of Health
- Provides support to DHB services planning

Senior Policy Advisor (Public Health)
It is proposed that this position reports directly to the Director Population Health & Equity.

Disestablished positions

The proposed changes include the disestablishment of the following positions:

Strategic and Community Engagement Manager
Given the integration of public engagement into the Manager Public Health position, there is no longer a need for a Strategic and Community Engagement Manager position, thus it is proposed that this position is disestablished.

Planning and Integration Manager
This role has a mix of corporate accountability, strategy, equity, insight and integration activity included within the Position Description. This role was developed at a time when there were only two planning related positions in the Planning and Funding Directorate; this role was a key support to the Senior Planner. With the changes to the Commissioning approach and to the imminent focus on system transformation through implementation of the Health System Plan (and its component plans), there is now a need to employ a different mix of skillsets with a focus on operationalising the plans. The skills required for strategic planning and integration will be retained in the Director and Senior Manager positions as well as the Senior Policy Advisor (Public Health); thus, there is no longer the need for a generalist Planning and Integration Manager position.

Project Manager
This current role is a generic project manager role that sits in the Planning Team but has recently been focused on the project management of Te Pae Tawhiti which is almost complete. There is no longer a need for a generic project manager position given the proposed establishment of service development managers. Thus, it is proposed that the project manager position is disestablished.

5.4 Service Development and Funding Teams

The two service development and funding teams are primarily responsible for the service development, co-design, procurement, contracting, and performance management aspects of the commissioning cycle.

The development of strong relationships with provider organisations, consumers, and clinicians will be fundamental to achieving an effective service development function that addresses system challenges.

The focus of these teams will be to:

- Work proactively and collaboratively on system development, responding to challenges (such as increasing demand) from a whole of system (end to end care) perspective
- Lead co-design approaches to maximise the effectiveness of new service developments
- Lead the process of commissioning and decommissioning services to support implementation of the HSP
- Proactively manage funder budgets (with the support of funding analysts)
- Ensure that funding is maximised, risk minimised and service prioritisation is robust;
- Enable innovative approaches supported by appropriate evaluation and research
- Take responsibility for procurement and contract management

It is proposed that these teams will include Service Development Managers and Funding and Relationship Managers.

Service Development Managers will be responsible for:

- Leading the design of the service system within their portfolio area
- Providing leadership and advice on effective models of care (content expert)
- Ensure the use of co-design methodologies in the development of new services

- Take the lead (within their portfolio) for implementing changes in line with the HSP and component plans
- Provide change management and project leadership for all service development

The Funding and Relationship Managers will retain many of the responsibilities of the current portfolio managers but with an enhanced focus on provider relationships. They will also support the work of Service Development Managers in redesigning services. Responsibilities include:

- Develop and maintain strong relationships with providers
- Keep well informed about national and regional developments and contract negotiations
- Manage the procurement processes through to contracting
- Lead the negotiation on contract conditions and prices with providers
- Manage contracts and work with providers to ensure performance expectations are met

Community Care and Wellbeing

This team will be focussed on aspects of care that are predominantly provided in community settings. The use of the term 'wellbeing' points to the inclusion of services that are oriented to prevention and those supporting self and whanau care. This includes:

- Primary Care, including PHOs, Community Pharmacies and clinical support services such as Labs and Radiology
- Child Health and Maternity
- Whanau Ora
- Health of Older People and Disability Services

Specialist and Complex Care

This team will be focussed on portfolios that are more specialist in nature including:

- Hospital Services (Medicine, Surgery, Cancer) and Provider Arm community services
- Mental Health and Addictions
- Long Term Conditions
- Service Level Measures Programme

New positions

The proposed changes include the establishment of the following positions:

Service Development Manager, Long Term Conditions & SLMs
Service Development Manager, Mental Health and Addictions
Service Development Manager, Whanau Ora
Service Development Manager, Primary Care
Service Development Manager, Health of Older People and Disability Services

Funding and Relationship Manager, Hospitals
Funding and Relationship Manager, Mental Health and Addictions
Funding and Relationship Manager, Child Health and Maternity
Funding and Relationship Manager, Primary Care - PHOs
Funding and Relationship Manager, Primary Care – Pharmacy and referred services
Funding and Relationship Manager, Health of Older People and Disability Services

Disestablished positions

The proposed changes include the disestablishment of all Portfolio Manager positions. Whilst the Funding and Relationship Managers are similar to the Portfolio Manager positions, the changes include only six Funding and Relationship Manager positions thus automatic redeployment is not possible.

5.5 Administrative Support

Administrative support is critical to the effective functioning of a team; the type and amount of support is also unique to the team that is being supported. Given that the above (proposed) structure is yet to be agreed and implemented, it is difficult to determine the administrative support resource that will be needed across the teams. Thus, minimal changes have been made to administrative positions at this stage. It is

anticipated that a full administration review will be undertaken three-six months following the implementation of any wider restructure, such as the one proposed above.

However, the following changes are proposed:

Changes to current positions

Personal Assistant (to Executive Director and Clinical Director Strategy and Funding)
It is proposed that the reporting line for this position is changed to report to the Clinical Director Strategy, Funding and Primary Care. It is also proposed that the responsibilities are changed in that the position would support two Directors as well as the CD but would no longer provide PA support to the Executive Director.

Support Coordinators
It is proposed that there is a change in reporting line for these positions to the respective Directors (as shown on the organisation structure diagram). It is proposed that the titles are changed to Team Administrators to more accurately reflect the duties and responsibilities and align the title with others in the DHB.
The roles will be titled as follows:

Team Administrator, Community Care and Wellbeing
Team Administrator, Specialist and Complex Care
Team Administrator, Planning, Health Intelligence and Performance

New positions
Personal Assistant, Executive Director Strategy, Funding and Public Health
It is proposed that this new PA position is established to work with the Executive Director (ED). This is due to the high work load of the ED and the need for a dedicated PA. This position may be less than full time depending on the feedback received on this proposal.

Personal Assistant, Directors Community Care and Wellbeing, & Specialist and Complex Care
It is proposed that this new PA position is established to support the new (proposed) Director positions.

6. NEXT STEPS

6.1 Consultation process

This consultation process is an opportunity for staff and key stakeholders to provide feedback on the proposed changes. Outlined below is an overview of the proposed activities and timeframes.

All submissions will be considered by a review panel comprised of:

Tanya Maloney	Executive Director, Strategy and Funding
Damian Tomic	Clinical Director, Strategy, Funding and Primary Care
Greg Peploe	Director People and Performance
Anna King	HR Consultant
Ross Lawrenson	Professor of Population Health
Loraine Elliot	Executive Director Māori Health

Overview of the proposed activities and timeframes for consultation	
Timeframes	**Activity**
13 July 2018	Release consultation document to staff
30 July 2018	Consultation period ends
31 July- 10 August 2018	Review submissions
17 August 2018	Release final decision to staff
20 August 2018	Commence implementation

You can provide feedback on the proposal as groups or individuals. In particular, we invite suggestions about alternative approaches and/or structures about:

- The proposed approach to commissioning
- The proposed structure, including groupings, management/leadership and positions
- The integration of public health and strategy and funding functions.

The closing date for submissions is 5:00pm, Monday 30 July 2018

Written submissions should be forwarded to Rebecca Walker:
Rebecca.walker@waikatodhb.health.nz

6.2 Staff support

Staff are reminded that should they wish to access the Employee Assistance Programme for external support they can ring 0800 327 669.

Appendix 1

Commissioning for Healthy People, Excellent Care & Health Equity

Waikato DHB's proposed approach to planning, developing and procuring health services

This document forms part of the Strategy, Funding and Public Health Proposal for Change

Author: Tanya Maloney, Executive Director, Strategy, Funding and Public Health

Contents

1.0 Introduction

Waikato District Health Board ('the DHB') faces significant challenges to meet its responsibility and commitment to improve Māori health and reduce health inequities. It is also struggling to meet the growing demand on health services which has resulted in significant growth in ED presentations and hospitalisations over the past decade. The district faces further pressures with significant population growth, and an aging population which will inevitably further increase the demand on primary and secondary care services.

In order to address the challenges above, we need a significant change in how we plan, fund and provide services. The 10 year Health System Planning process that is currently underway, will describe a future health system that is likely to look quite different to the current one, and will require a shift in resources and investment. Implementation of such changes requires an effective commissioning process, along with strong relationships between communities, provider organisations and the DHB Strategy and Funding Directorate.

It is apparent that the DHB's current approach to planning and funding services is lacking in numerous areas that are essential to effective commissioning in complex public sector environments. Many of the gaps in the current approach were outlined in the recent review of Strategy and Funding which highlighted that the current focus is on contract management, with limited capacity for system leadership and service development.

This document outlines a proposed new approach to commissioning for Waikato DHB.

2.0 Waikato DHB – Population Overview

The Waikato is a unique region within New Zealand with respect to its geography and population profile. It is the largest DHB by geographical area, incorporates 10 Territorial Local Authorities, and has a broad mix of large urban, small urban, rural and significantly isolated communities. These unique characteristics present unique challenges in providing appropriate mixes of services that meet the needs of our population.

Additionally, as a DHB with one of New Zealand's largest proportional Māori populations, we have a particular need to reduce health inequalities amongst Māori. Māori health in the Waikato still lags woefully behind that of non-Māori; thus Māori health gain is therefore necessarily the primary focus of all of the DHB's planning, service delivery and investment approaches.

This section provides an overview of population health need across the District, with a particular focus on Māori inequalities.

2.1 Māori Health Needs

Demography

In 2018/19, 95,640 Māori live in the Waikato District Health Board area, 23% of the District's total population. The Waikato Māori population is currently youthful but showing signs of ageing. Over a third (37%) of the District's children under 15 years of age and 30% of those aged 15–24 years are Māori.

The Waikato Māori population is projected to experience a significant increase (30 per cent) between 2018/19-2033/34. The Māori population aged under 15 is set to rise by 14%, and the 15-24 age group of the Māori population is set to rise by 33% over the same period.

Social Determinants of Health

In 2013, 12% of Māori adults aged 15 years and over were unemployed, more than twice the non-Māori rate (5%). Two in five children and one in three adults in Māori households (defined as households with at least one Māori resident) were in households with low equivalised household incomes (under $15,172), compared to one in five children and adults in other households.

Using the NZDep2013 index of small area deprivation, 26% of Waikato Māori lived in the most deprived decile areas (decile 10) compared to 9% of non-Māori. Conversely, only 6% of Māori resided in the two least deprived decile neighbourhoods compared to 17% of non-Māori.

Waikato residents living in Māori households were 3 times as likely as those living in other households to be in crowded homes (i.e. requiring at least one additional bedroom) (20% compared to 7%).

Life Expectancy and Mortality Rates

In 2012–2014, life expectancy at birth for Māori in the Waikato Region was 76.5 years for females (7.5 years lower than for non-Māori females) and 72.2 years for males (8.1 years lower than for non-Māori). The all-cause mortality rate for Waikato Māori was twice as high as the non-Māori rate during 2008–2012.

Potentially avoidable mortality and mortality amenable to health care were 2.6 times and 2.7 times as high for Māori as for non-Māori in Waikato during 2007–2011.

Hospitalisation

During 2011–2013, among Māori children there were on average 136 admissions per year for serious skin infections (with the rate more than twice that of non-Māori children). The rate of hospitalisation due to injury was 19% higher for Māori than for non-Māori.

2.2 Rurality

The Waikato DHB region has a high proportion of rurality including Independent Urban Areas which are the most deprived areas and have the most health needs. People who live in rural areas have the highest incidence of cardiovascular disease, malignancy, renal and respiratory disease as well as the highest levels of potentially avoidable mortalities (amenable deaths - those occurring before 75 years of age). This populations constitutes a large percentage of secondary care activity.

2.3 Ageing

The overall population in Waikato is projected to rise by 13% from 419,890 in 2018/19 to 474,990 in 2033/34. The proportion of those 65+ among the DHB's resident population is projected to increase from 16% in 2018/19 to 22% by 2033/34. The age group between 65 and 74 is projected to increase by 34% and the age group over 75 is projected to increase by 86%. The Māori population aged 65 years and over will increase by 50% between 2013 and 2020.

More than two-thirds of the Waikato District's projected growth will be at 65+ years, while decline is expected at 45-59 years of age as the baby boomer cohort ages. Future population growth is centred around specific localities - Hamilton and surrounds, Matamata, and the Northern Corridor. The other localities are expected to experience varying population decline across most age groups, though the total population for Thames is projected to be flat through to 2033. All localities will experience growth in the number and proportion of those 65+ in the population.

The population groups described above must be the focus for more targeted and innovative investment approaches.

3.0 The Responsibilities of District Health Boards

District Health Boards are responsible for the health of their population. The statutory objectives and functions of District Health Boards are set out in the Public Health and Disability Act (the Act) 2000. The Act is clear that DHBs have a much broader role than the planning and provision of health services; the objectives of the DHBs include (inter alia) the following:

- To improve, promote and protect the health of people and communities;
- To reduce health disparities by improving health outcomes for Māori and other population groups;
- To promote the inclusion and participation in society, and the independence of people with disabilities; and
- To foster community participation in health improvement, and in service planning.

Amongst the statutory functions of DHBs, the following are the most relevant to the Strategy and Funding directorate:

- Investigate the health status and health needs of the population;
- Plan and co-ordinate for the most effective and efficient delivery of health and disability services;
- Enable Māori to participate in and contribute to strategies for Māori health improvement;
- To collaborate with relevant organisations in the planning and coordination of services;
- Ensure the provision of services (either through DHB Provider Arm services or by contracting with other providers); and
- Monitor the delivery and performance of services by the DHB and other providers.

The Strategy and Funding Directorate plays a critical role in ensuring that at a macro level the organisation is configured in a way that meets the legislation's objectives. Waikato DHB drives its contribution to these objectives through its overarching strategy and strategic imperatives, its 10 year health system plan (under development) and its annual planning process.

In undertaking its statutory functions, the DHB's Strategy and Funding Directorate must be configured and resourced appropriately to ensure effective system investment, and performance management. Complex adaptive systems (such as health), often need to be nimble and to flex over time with respect resource and skill-sets to support service development and integration. The proposed commissioning approach recognises the changes in the health services environment and will ensure the DHB has the right people and right approaches to continually improve performance against its statutory obligations.

4.0 Waikato DHB's Current Strategy and Funding Directorate

A recent review of Strategy and Funding identified that the fundamental structure and approach to the development procurement of services had not fundamentally changed since the DHB's inception. Whilst there is deep health sector knowledge within the team, there are also some fundamental gaps in terms of system and service planning, service design, and engagement.

Whilst many DHB's have grown their teams both in terms of adding different skill-sets and overall capacity, Waikato DHB's Strategy and Funding team has largely operated a traditional portfolio approach to contracting services that is not in line with more contemporary approaches to the commissioning of services and achieving health outcomes. The focus on only the contracted services side of the health system continuum has left the Strategy and Funding Directorate largely disconnected from its own Provider Arm services with respect to decisions about service development and responding to the challenges of increasing demand. This has resulted in a fragmented system of delivery, where opportunities have been missed in respect to sustainable hospital service development, and the adoption of horizontally integrated models of care.

The DHB has embarked on the development of a strategic Health System Plan alongside its Māori Health Strategy, Ki te Taumata o Pae Ora. These significant pieces of work will define a 2030 integrated system of health services delivery, and will outline implementation pathways that will guide service development over the next 10 years. It is the expectation of the Board and Executive that these plans will enable transformation of our Waikato health system, redirecting investment to areas that will drive progress against its strategic imperatives.

To implement the direction set by the Health System Plan, Strategy and Funding is currently being reconfigured to ensure it has the skills and capacity to accelerate change and manage the DHB's investment in health outcomes.

Fundamentally this will require a significant refocus of approach to ensure it:

- engages consumers, community, clinicians, providers and other stakeholders in co-design;
- enables change in the health system to improve Māori Health and reduce health inequities; and
- ensures system and service development is a key feature of the commissioning approach.

5.0 From Contracting to Commissioning

Despite DHBs being established with a structural purchaser/provider split, there has been recognition for some time that the adopted contracting and performance management approaches have done little to improve health outcomes, particularly for Māori and other disadvantaged communities.

Much of this can be attributed to the way services have been developed and performance managed. There has, in general, been a distinct lack of system thinking with respect to social determinants, and providers have been encouraged to deliver services strictly aligned to service contracts, which in effect, has stifled innovation. This has meant that opportunities for health improvement and service sustainability through innovation and better integration have not been exploited to the advantage of local populations.

There has been some significant learning from across New Zealand and the world in respect to effective commissioning approaches. The U.K has had mixed success, but in general the literature demonstrates that all successful models of commissioning should incorporate the following elements:

- Planning that is clearly linked to a **population's health needs**. This seems so simple, and yet so often the linkage between what is delivered to what is needed is tenuous. Unless a DHB fully understands what the needs (and the drivers of those needs) are, it has little chance of success in eliminating health inequalities amongst its most vulnerable communities.

- The planning and design of services should involve **effective engagement** of the public, service users and clinicians. From listening to communities about their particular needs through to co-designing services – a well-functioning system of commissioning should be inclusive and responsive to stakeholder perspectives.
- Services should cascade from a clear **strategic direction**. For a DHB, this direction is best established within a Health System Plan, where health service and social service delivery intersect, and services are integrated in such a way to ensure people stay well in their community. Key priorities (such as Radical Māori Health Improvement) should be well embedded in this strategic direction setting.
- An embedded culture of **collaboration and cooperation** (e.g. alliancing) ensures providers from across the sector have a stake in and commitment to a future vision of sustainable and outcome focussed service delivery.
- Ensuring programmes of work are built on sound intervention logic enable robust **monitoring and evaluation**. In turn this ensures the funder and the provider are working together to ensure the services provided are supported by **continuous quality improvement** to achieve the outcomes sought.
- A robust commissioning approach will based on a **partnership model** with shared leadership and accountability, rather than a blunt and punitive contract management approach.

6.0 Proposed Waikato Commissioning Approach

The DHB's commissioning approach will be founded on the DHB's commitment to working in partnership to improve population health and eliminate health inequities. Genuine partnership with consumers, communities, clinicians and providers is the goal in respect to developing services that maximise health gain.

The principles that guide our approach to commissioning are:

- equity for vulnerable populations: focus on reducing and if possible eliminating inequities in health;
- shared leadership: all the actors in the local health system share leadership in achieving health gain for the population;
- accountability: while each organisation has its own accountability mechanism, there will be shared accountability in Waikato for achieving health improvement; and
- whole of system, end to end care: commissioning of services will take into account the impact of any changes on the whole system of care. When commissioning new services or service changes, the principle will be to assess the improvement any service will bring to the end-to-end health experience of patients.

A number of commissioning models have been examined and as a result, we have developed the 'Commissioning Koru' below as our proposed approach for Waikato.

Figure 1: Waikato Commissioning Koru

6.1 The Commissioning Koru Components Explained

DHB Strategy Development

The DHB developed its Strategy in 2016 which has a clearly articulated vision and set of strategic imperatives. Typically these are only reviewed every ten years unless there is a significant direction change signalled by Government. Developing an overarching strategic framework is an important first step in the commissioning process, as it grounds all future decisions within a priority hierarchy.

Health Needs Assessment

Knowing where to invest in services to maximise health gain and reduce inequalities is wholly dependent on understanding the health needs of a population. Typically DHBs have undertaken Health Needs Assessments on a 3-5 year cycle.

Within the Waikato commissioning approach, the DHB will run an active Health Needs Assessment Programme where aspects will be updated as new data becomes available. The DHB may publish a regular report, but Planners and Service Development Managers will have access to as up-to-date analysis as possible through this approach.

Strategic Position Statements

Good planning requires clear definitions and descriptions of activities and areas of focus.

In order to ensure clarity about particular programmes of work, clear position statements are critical to the planning and wider commissioning processes.

Position statements are driven by our principles and rationale relating to areas of proposed strategic development. They provide a solid foundation upon which further engagement with wider stakeholder groups take place, and guide service development work.

Health System Design

The DHB has embarked on the development of its Waikato Health System Plan, which is another critical step in the Commissioning Process. A Health System Plan provides a schematic that outlines what a connected system of health services looks like at a future point in time. The DHB's schematic is focussed on its vision of a 2030 Waikato service mix.

A health system schematic represents what changes will take place, where people access their care, where DHB resources are deployed, and the role of social services in impacting social determinants of health. The health system plan also provides a mix of implementation pathways. This provides clear direction for on-going service planning and change management activity.

Engagement is a critical aspect in designing a system of delivery that is effective, and has the commitment of communities and stakeholders. To this end, a comprehensive whole of DHB approach to engagement is currently being developed which will ensure multiple stakeholders across communities, services users, provider organisations and clinicians are engaged. Additionally, Strategy and Funding will ensure sufficient opportunity for the Board, its Committees, Iwi Māori Council and the Consumer Council to drive the on-going system design.

Investment Prioritisation

This DHB is clear about its strategic direction and its intent to actively invest in services that maximise health gain and eliminate inequalities.

There will always be nationally driven contracts and service specifications that the DHB must manage. But additionally, there are always opportunities to think more creatively about service provision and where flexible funding will make the most difference. Strategy and Funding will use a mix of tools to transparently identify where investment is most likely to have the greatest impact, and to prioritise our investments based on clear evidence and rationale.

Business cases for change will be evidence based and will clearly identify how population outcomes are to be tracked over time. With intervention logic underpinning investment choices, decision makers will maintain a long term view around how and when planned outcomes will occur. Because this approach also allows for continuous review and service adaptation through shared accountability and leadership, it fosters confidence across executive and governance groups in respect to the investment's long term contribution to strategic imperatives.

Prioritising investment is intended to drive a people centred approach, and to ensure inequalities are eliminated. As a result, our population will become healthier.

Service Development

It is an intention to adopt a more collaborative approach to developing services, creating better connections across the sector to ensure services are more people centred and are focussed on reducing inequalities, particularly for Māori.

Co-design will be Strategy and Funding's preferred method of engaging stakeholders in the on-going development of services. The DHB has access to a rich network of stakeholders including its communities, its Board and Committees, its Iwi Māori Council and those in the Consumer Council who have a lived experience of current health services. Harnessing this knowledge and input will significantly improve how the DHB's services are configured, where they are located, and how they respond to people and their whanau.

Greater service design expertise will be employed within the Strategy and Funding Directorate, and district-wide alliancing through a Health System Leadership Group will ensure there is collective buy-in to a more integrated and outcome focussed mix of services.

Contracting for Outcomes

Adopting different frameworks (such as intervention logic) and reorienting contracts to be clearly linked to desired outcomes is a key means of ensuring the DHB is partnering with providers to deliver the right service to achieve the desired outcomes. Shared accountability and leadership will enable greater flexibility and allow for services to be developed around people and their families, rather than simply ticking boxes around interventions.

That said, contracts remain the key mechanism for measuring provider performance and the DHB must still operate within the Government's Rules of Sourcing in procurement of services. Ensuring the DHB operates in a transparent and collaborative approach with providers will be imperative to ensuring contracts work for both parties.

Monitoring and Managing Performance

With the DHB's contracts having stronger linkages to outcomes, and greater collaboration between the DHB and providers in respect to on-going service development - there will be a strong focus on monitoring performance and working together to remediate issues and exploit opportunities.

A stronger evaluation presence inside the Strategy and Funding Directorate will further strengthen the DHBs assurance around programmes of services and the impact they have against our strategic imperatives.

Outcome / VFM Measurement

As a precursor to the decision to re-commission or decommission, consideration will be given to all the performance and evaluation information to determine the relative value and outcomes of the service and investment.

Re-commission or Decommission Services

The relative value and contribution to outcomes is a critical aspect in the decision to re-commission or decommission a service. It is not the only consideration however. Changes in organisational priorities as determined by Government or Board will be considered, as will the emergence of opportunities to deliver services in a more effective way. Government's Rules of Sourcing may also require RFP or EOI

process to be undertaken, which could further impact and Re-commissioning or De-commissioning decision.

7.0 The Role of the Health System Leadership Group

This group has previously been referred to as the "Waikato District Alliance".

Representatives from the Inter-Alliance and DHB Strategy and Funding Directorate recently met to discuss the creation of a Health System Leadership Group (HSLG). This would comprise a core group of senior health system leaders who were well placed to oversee and advise on the development of a new integrated health system focussed on people centred care, the elimination of health inequalities for Māori and sustainability across all services.

The HSLG would also be responsible for advancing key integrative projects, and identifying opportunities to better target health investment.

A Terms of Reference is under development, and will bring together a core group of management and clinical expertise from across the sector to ensure broad support for the Health System and Care in the Community Plans under development. Moving forward, this group will support the development of programmes of work that will underpin change through the DHB's commissioning work. Membership may change as areas of focus require additional sector expertise relating to particular projects or strategic programmes. Through this activity, the HSLG will become a key informer to the Waikato Commissioning approach.

8.0 The Role of the Board and the Community & Public Health Advisory Committee

The DHB's Board is inextricably linked to the commissioning process through its participation and decision making in respect to strategic and organisational planning, its engagement in Strategy and Funding's work programme development, and its approval of significant service change. Regular system performance reporting will be provided through revised performance dashboards and specific reporting on programmes of work.

The Community and Public Health Advisory Committee (CPHAC) meets regularly to hear presentations and discuss those DHB investments in services and activities that are aimed at improving health outcomes and eliminating health inequalities. CPHAC advises the Board on the progress being made by Strategy and Funding in respect to its commissioning of services across the health continuum, and ensure Strategy and Funding's investment in preventative and early intervention approaches within communities is sustained.

Strategy and Funding will develop an annual work programme with CPHAC to ensure we can cover off all of the Committee's areas of interest across the DHB's 6 Strategic Imperatives.

APPENDIX 2

Health Intelligence and Performance – New Roles

Funding Analyst (2.0 FTE)
These positions would be responsible for:

- Monitoring and forecasting of provider expenditure and DHB revenue
- Measurement of budget variances to actual/forecast
- Ensure access to funding from Ministry of Health and other sources is maximised
- Annual funder budgeting and monthly forecasting
- IDF process and monitoring flows to other DHBs (including regional coordination function)
- Liaising closely with the funder accountant role in the Finance team to ensure funder transactions are properly accounted for in the DHB.
- Provide advice to the wider team on funding available for prioritisation
- Developing funding methodologies for service provision (in conjunction with other teams)
- Calculating and administering all provider wash-ups
- Setting prices for providers as benchmarked to other services or in recognition of nationally determined agreements
- Calculating annual price and volume changes for all providers including the provider arm
- Limited level 5 delegation to approve transactions within budget
- All other financial analysis as required

Performance Analyst (2.0 FTE)
These positions would be responsible for:

- Measuring and reporting on system wide performance both internally and to Board and Committees
- Measuring and reporting on provider performance against contracts or SLAs
- Setting targets for provider performance in conjunction with the Funding and Relationship Manager
- Systematically reviewing and implementing reporting requirements for all providers ensuring they:
    - Include outcomes where possible
    - Are developed using co-design principles where practicable
    - Have meaning for the DHB and do not include unnecessary metrics
    - Are consistent within (and across where possible) service areas
    - Include secure provision of NHI level reporting for use in combining with other data sets
    - Meet national requirements if applicable
    - Are robust enough to be utilised for future service reviews or evaluations
- Signing off rollover of contracts based on compliance with reporting requirements and value for money proposition in conjunction with the Funding Manager
- Ensures that analytical input into service prioritisation (investment and disinvestment) is robust
- Promoting an evaluation culture to support the commissioning environment
- Develop dashboards and reports for wider team consumption
- Combining data sets from many providers and service areas to provide analysis of system performance and opportunities

Health Intelligence Advisor (1.0 FTE)
This position would be responsible for:

- Analysis of population health status at a DHB wide and locality level
- Measurement and reporting of the Māori Health Equity gap on all measures
- Develops and maintains an understanding of the overall health environment and implications, if any, for Waikato DHB
- Works with the Planning Team to incorporate data into decision making on service plan development
- Builds and maintains a rolling HNA with appropriate regular reporting to the team and other stakeholders

Contracts Manager (1.0 FTE)
This position would be responsible for:

- Line management of the Contracts Administrator
- Managing the development of a contract management register (probable transition to Oracle)
- Developing agreement requests for Sector Services processing

- Assisting the Funding and Relationship Managers with the drafting of contractual clauses and service specifications
- Supporting the wider team to implement agreements

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
8 AUGUST 2018

AGENDA ITEM 6.2

HEALTH IMPROVEMENT SETTINGS APPROACH

Purpose	For information

The settings approach for health improvement

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

This imperative informs the health improvement (previously health promotion) service activities, contracted via the Ministry of Health, and provided across the Waikato District Health Board (DHB) Rohe by the Waikato Public Health Unit (2018/19).

For many years the Waikato Public Health Unit (PHU) provided health promotion services to address social determinants of health with a focus on issues such as smokefree, alcohol, nutrition and physical activity, in set locations (e.g. Hamilton City, Thames, Huntly, Te Kuiti, Taumarunui, Tokoroa) across the Waikato DHB District.

Following an extensive review of its service delivery and approach in the 2016/17 year, Waikato Public Health transitioned from a locality and issue-based focus, to adopting a settings based approach with an intentional emphasis on health equity, particularly for Māori and other vulnerable peoples and communities. This emphasis was reinforced in the Waikato DHB strategy released in July 2016.

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

Settings are described as "places or social contexts where people engage in daily activities, in which environmental, organisational and personal factors interact to affect health and well-being, and where people actively use and shape the environment, thus creating or solving health problems" (p.ii127)[2]. The

[1] WHO (1986) *The Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa: World Health Organisation
[2] Newman L., Baum F., Javanparast S., O'Rourke K., and Carlon L. (2015). Addressing social determinants of health inequities through settings: a rapid review. *Health Promotion International*, Vol.30, No S2 ii126-ii143.

settings based approach was chosen as a way to work more effectively with key decision makers and leaders in communities with the aim of influencing environments that will improve the health and wellbeing of peoples and communities in the Waikato DHB Rohe.

During 2016 staff relocated to the Hamilton Office[3], and three settings teams were established: Healthy Education, Healthy Whānau (Māori and Pacific) communities, and Healthy Workplaces. The teams are led by a Senior Health Improvement Advisor (HIA) and have 3-5 HIA team members. Towards the end of 2017 a further Senior HIA was employed in the Local Government/Healthy Policy setting. A fifth setting, Healthy Sports, had also been proposed, however this setting will not be established at this stage.

To ensure that some of the key focus areas of public health continue to be developed all HIA's are engaged in at least one of the four Public Health service-wide strategy groups: Alcohol; Tobacco; Physical Activity and Nutrition; and Mental Wellbeing. These strategy groups have been formed to keep up to date with research about issues, and the impact they are having across our communities. HIA's are then able to bring up-to-date information to the settings they are working in. The HI team have contributed to the research and development of the various profiles that have been produced by the Public Health Advisory and Development team, including Te Hauora o ngā iwi Māori o Waikato (Māori health profiles – Waikato), Pacific health profiles – Waikato, and the Early childhood health profile. These profiles have proven to be very useful in giving an overall picture and data of health and well-being to support the settings in their understandings of health concerns.

A health improvement process (figure 2) was developed as an operating framework to support the new settings based approach and integration of public health core functions. This process is aligned with Te Pae Mahutonga (Māori model of health promotion), and is consistent with the Ottawa Charter; health promotion values (equity, empowerment, community participation and partnership); and Health Promotion Competencies of Aotearoa NZ.

Figure 2: The Health Improvement Process

The settings in action

With a systems view in mind and consideration of a life course approach, targeted services and/or the inclusion of health in policy development are being negotiated with communities and organisations through four settings across the Waikato DHB Rohe.

[3] Thames office remains and staff travel to Hamilton or around the region at least 2 days per week

Healthy education
The education settings encompass early childhood education services (ECEs); years 1-8 in primary and intermediate schools[4] (previously covered by health promoting schools); and years 9-13 in secondary schools. Both alternative and tertiary settings may be considered as the approach develops.

The Healthy Education team is led by a Senior Health Improvement Advisor, with 4 Health Improvement Advisors (HIAs). The fourth HIA has been in the position for 3 months.

To create a health promoting setting, health improvement advisors work with Ngā Manukura (leadership) within education settings, where they consider three levels of influence:

- organisational structures and the impact these have on community wellbeing;
- environmental structures to better understand how the natural world can positively impact on wellbeing; and
- whānau wellbeing is focused on ensuring that whānau are able and encouraged to participate in activities and processes within the setting to sustain good health and wellbeing.

Using the HI process to review these three levels of influence the HIAs facilitate a setting to support Ngā Manukura as health concerns and issues are identified, while at the same time they ensure Te Manawhakahaere (autonomy) to find and embed appropriate solutions.

Education settings are a hub of community engagement and activities. They offer opportunities to explore, improve, promote and protect the health and wellbeing with children, young people, their whānau and communities; and also with people in governance, management, and teaching roles working in and connected to schools.

The Education team, with a focus on serving Māori and Pacific peoples, has had outreach into the priority areas of North Waikato, Waitomo, Greater Hamilton and South Waikato. The first ECE Advisory group covering North Waikato and Waitomo has been facilitated with the aim to co-design and lead health improvement activities across a number of centres to gain better support for raising and acting on health concerns. Other ECE Advisory groups are being considered for South Waikato and Hamilton City.

Healthy whānau concentrates on social and cultural settings that whānau connect with, such as churches and marae.

The team is led by a Senior HIA, with 4 HIAs and a current vacancy. Two HIAs have been in positions for approximately 3 months.

Building on connections HIA's have, attention is given to engaging effectively with Māori and Pacific communities (particularly in rural areas) to inquire about and identify the health and wellbeing needs they have and ways to support and improve their health and wellbeing. The PATH (Planning alternative tomorrows with hope) tool is being used to advance the engagement and inquiry processes with great success to date.

[4] The Sport Waikato energizer contract offers District–wide coverage of primary schools (years 1-8).

The HI process is being implemented with a focus on engagement and collaboration for wellbeing and influencing equity for communities.

Three partnerships to support Pacific health in Waikato being established with K'aute Pasifika; South Waikato Pacific Island Community Services (SWPICS); and Pasifika Futures. Further partnerships with seven communities for health improvement have been set up with SWPICS; SISWA Solomon Island community; Hamilton Pacific parents power up; Tokoroa High Y13 students - Pacific power up; Tokoroa High pacific Power Up Teachers; Forest View High Y9 Power Up students; and a Tokoroa Pacific church group.

In Māori settings over 70 engagement hui have been held with community leaders and/or stakeholders, and 21 inquiry hui held with marae/ Māori communities. Currently 22 productive partnerships are engaged and maintained. They include: a north Waikato marae cluster (12 marae); 1 Kohanga reo cluster (4 kohanga); 1 Waikato Tainui kaumātua marae group; 2 Hauraki Māori communities; 1 Tertiary education provider ; 1 kura kaupapa; and 1 oranga tamariki group.

A number of supportive collaborative engagements have also taken place including with 1 gang identified community; 1 High school; 1 Kaupapa Māori Hauora and 1 Ngāti Haua marae. Although to date this has not resulted in the setting being involved in the HI process, these partnerships have been established to support health improvement for the communities.

Healthy workplaces, is a new setting for the Public Health Unit. It is acknowledged that people spend at least one third of their life at work and therefore the workplace is a significant setting to improve, promote and protect the wellbeing of adults.

The Workplaces team is led by a Senior HIA, with 2 HIAs. The Senior and one HIA have been in their positions for approximately 6 months.

WorkWell is an evidence based programme developed by Toi Te Ora - Public Health service, delivered nationally and across the Waikato region. WorkWell operates on a continuous improvement cycle (Engage, Assess & Prioritise, Plan, Apply & Implement, Evaluate & Improve) and a stepped accreditation process (Bronze, Silver, Gold). A targeted engagement strategy determines the most appropriate industries and geographical locations for promotion or workplace wellbeing and active recruitment of WorkWell businesses. The workplaces team use a weighted; equity based scoring system to prioritise businesses as priority 1-5. This ensures equitable delivery of service across the enrolled WorkWell businesses.

There are ten businesses currently registered and participating in WorkWell, combined they encompass over 3000 employees; Kimihia Rest Home and Hospital (Waikato District); Thames High School (Thames Coromandel District) (Planning Stage); SWPICS (South Waikato District) achieved Bronze accreditation (Apply and Implement Stage); WINTEC (Hamilton City) achieved Bronze accreditation (Apply and Implement Stage); Waikato DHB – CCS division (Across multiple districts) achieved Bronze accreditation (Apply and Implement), Hobbiton (Matamata Piako District) (Engage stage); Pohlen Hospital (Matamata Piako District) (Assess and Prioritise); Waikeria Prison: (Otorohanga District) (Engage stage) and Hauraki District Council (Hauraki District) (Engage stage).

Local Government/ Healthy policies setting, was initiated with the appointment of a Senior HIA in November 2017. This setting has an internal Waikato DHB, a wider

Public Health, and external Local Government focus, along with strengthening policy and implementation for existing collaboration activity.

Internally, an Integration group with PHU and Strategy and Funding has been formed and linkages made with the CPHAC Work Programme.

A Public Health Policy Network has been established across PHUs nationwide to strengthen consistency and collaboration on policy activity.

In the local government sector, and in partnership with DHB Strategy and Funding, engagement, planning and action has occurred with the district wide *Waikato Plan*, which upon review has recognised mental health, housing, youth education and development, and Māori cultural awareness as key areas of interest. Further engagement and planning has occurred with the Growth management collaboration (Future Proof) (Hamilton City Council, Waikato District Council, Waipa District Council, Waikato Regional Council, NZ Transport Agency and Iwi) who are putting greater attention on community place-making and monitoring. Early engagement has occurred with Hauraki District Council as a rural local government organisation.

Engagement is occurring with the NZ Transport Agency and local government in the Waikato and Bay of Plenty related to wellbeing-based monitoring and reporting linked to the NZ Living Standards Framework and Dashboard.

The first year transition to the settings based approach was evaluated and a report prepared: ***Health Improvement Transition to a Settings-based Approach*** *(1 July 2016 – 30 June 2017): Internal Evaluation Report*, by Teresa Binoka, Zaynel Sushil and Kerri Huaki, Research and Evaluation, Public Health Advisory and Development Team (available on request).

Recommendation
THAT
The Committee note the paper.

DERYL PENJUELI
MANAGER PUBLIC HEALTH

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
8 AUGUST 2018

AGENDA ITEM 7.1

KI TE TAUMATA O PAE ORA - IWI MĀORI HEALTH STRATEGY UPDATE

Purpose	For noting

The update progress report is a standard item on the Māori Strategic Committee agenda that takes place 3rd Wednesday of every month and provides a progress update on:

- Ki te Taumata o Pae Ora - The Iwi Māori Health Strategy.
- Te Puna Oranga priority programme as it relates to the strategic intent of radical improvement of Māori health outcomes by eliminating Health inequities for Māori. (see overview attached)

Updates in current programmes of work also associated with the radical improvement of Māori health are also being undertaken but not exclusive in the following:

The Health System Plan, Care in the Community Plan, Clinical Service Plan (HSP, CCP, CSP)

- Equity focused reporting
- Creating Our Futures/Te Pae Tawhiti

Ki te Taumata o Pae Ora

Work on the Iwi Māori Health Strategy continues particularly with advisement for the HSP, CCP and CSP. Current work in this space includes equity focused reporting and other organisational and population analytics as well as facilitation within the Care in the Community Plan wānanga. Best practice models that focus on oranga tangata, oranga whānau and oranga iwi Māori will inform the ultimate outcomes framework for Ki te Taumata o Pae Ora.

Puna Waiora (previously known as Why Ora)

The Why Ora business case was approved by the Board on June 27. Recruitment is in progress with the aim to have the Puna Waiora team operating from August 20, 2018. There are currently three appointments pending final recruitment checks and a further three appointments are still to be made.

Health System Plan, Care in the Community Plan

At the most recent Māori Strategic Committee meeting it was noted that the CCP Iwi wānanga communication strategy needs to be more deliberate in relation to rangatahi Māori and using a more sophisticated approach such as social media as current methods are not adequate. Te Puna Oranga are currently working with the project leads to advise upon a more Māori responsive communication approach.

Equity Focused KPI Reporting

Equity focused reporting continues to be a priority area of work and is paramount for the elimination of health inequities. The next equity focused report (EFR) is now due. Te Puna Oranga continues to work across the organisation to progress this work. An example of the equity focused reporting is attached as Appendix 1; the CEO is currently leading the process to address this inequity.

Community Projects

Te Puna Oranga priority programme (see overview attached) identifies two areas for community projects. Discussions for potential partnerships in this space are being explored.

Puna - Māori strategic capability

Te Puna Oranga priority programme (see overview attached) identifies securing high level Māori strategic capacity and capability to support the leadership required to drive the implementation of the Māori strategic plan. Te Puna Oranga are intending on progressing with the appointment of two strategic leaders with the intent to appoint a further two FTE at a later date.

Māori Access Change Project (DNA)

Te Puna Oranga is currently leading work in the T-Hospitals to eliminate Māori DNA inequities. The project approach includes:

- Kaitiaki lead to facilitate the process and work alongside whānau Māori
- Deep dive data analysis
- Relationship building with local Māori providers
- Public health nurse resource to support
- Smarter booking and rebooking systems
- Patient surveys
- Clear responsibility mechanisms allocated within the hospital
- Ongoing monitoring and reporting system developed for accountability within the hospital.

Harti Māma

Hapū Wānanga is a unique kaupapa Māori approach to pregnancy and parenting. The programme was established in 2012 to provide culturally appropriate antenatal education for expectant mothers and their whānau. Hāpu Wānanga is entrenched with tikanga Māori and aligns to the Pregnancy and Parenting Education service specifications set out by the Ministry of Health.

The Hapū Wānanga programme continues to meet and exceed targets. This includes

- A 121% target completion average from June 2016 to June 2018.
- Support of more than 600 women over the duration of the programme.
- Contribution to the elimination of Māori health inequities with a total of 71% Māori participants in the January to June 2018 period.

The Hui Mana Wahine Expo held 7 June 2018 saw the participation of 924 attendees (92% Māori) engaged in connecting with whānau services.

Harti Māma will expand up the already highly successful kaupapa Māori approach with the goal to increase the number of Hapū Wānanga throughout the Waikato DHB region and connect more whānau with the right information, the right care and the right services at the right time.

Memorandum of Understanding

For your information please find attached the **Memorandum Of Understanding Between Waikato District Health Board And Iwi Within Its District.** Strategy & Funding has started the process of amending provider contracts to include “Māori health outcomes” clauses.

Recommendation
THAT:

The Community and Public Health Advisory Committee note the update progress report**.**

LORAINE ELLIOTT
EXECUTIVE DIRECTOR OF MĀORI HEALTH

Appendix I: Equity Focused Reporting Example (June 27 Board Report)

1. Overall OP DNA rate:
The OP DNA rate and difference between Māori and non-Māori has been static for the last 4 years.

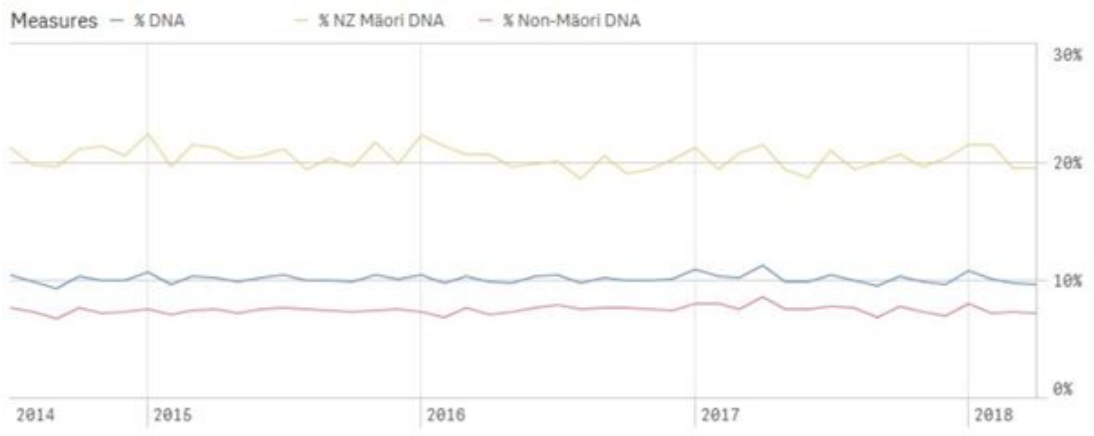


Figure 1: Overall Outpatient DNA Rates 2014 – 2018

2. By hospital site, gender and patient age group:
DNA rates are lowest in Taumarunui and Te Kuiti hospitals. Māori DNA rates are higher than non-Māori in all hospitals. The differential between Māori and non- Māori also appears the greatest in Taumarunui and Te Kuiti hospitals.
DNA rates are higher for male patients. The differential between Māori and non-Māori patients is similar for male and female patients.
Māori DNA rates are higher than non-Māori in all age groups. Differential rates appear to be greatest for patients over 65 years of age.

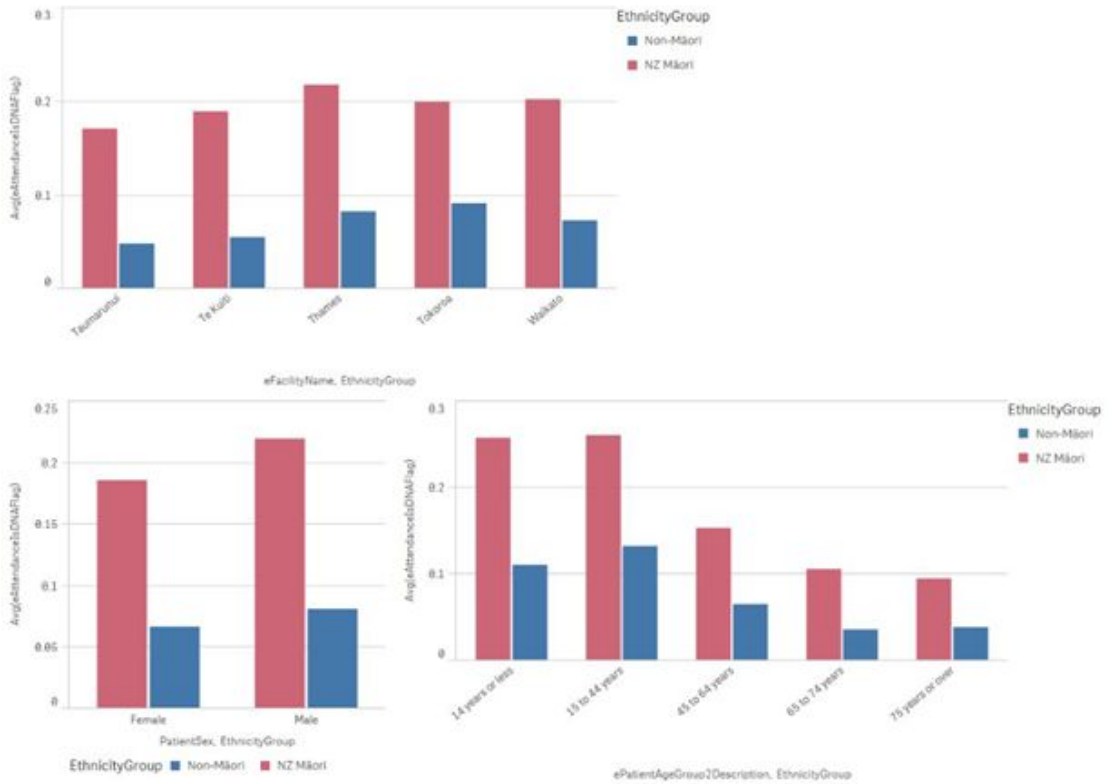


Figure 2: Outpatient DNA Rates by Location, Gender and Age (2014 – 2018 data)

3. By specialty:

In Figure 3 each specialty has a measure where the left indicates non-Māori OP DNA rates and the right indicates Māori OP DNA rates. OP DNA rates are higher for Māori in all specialties.

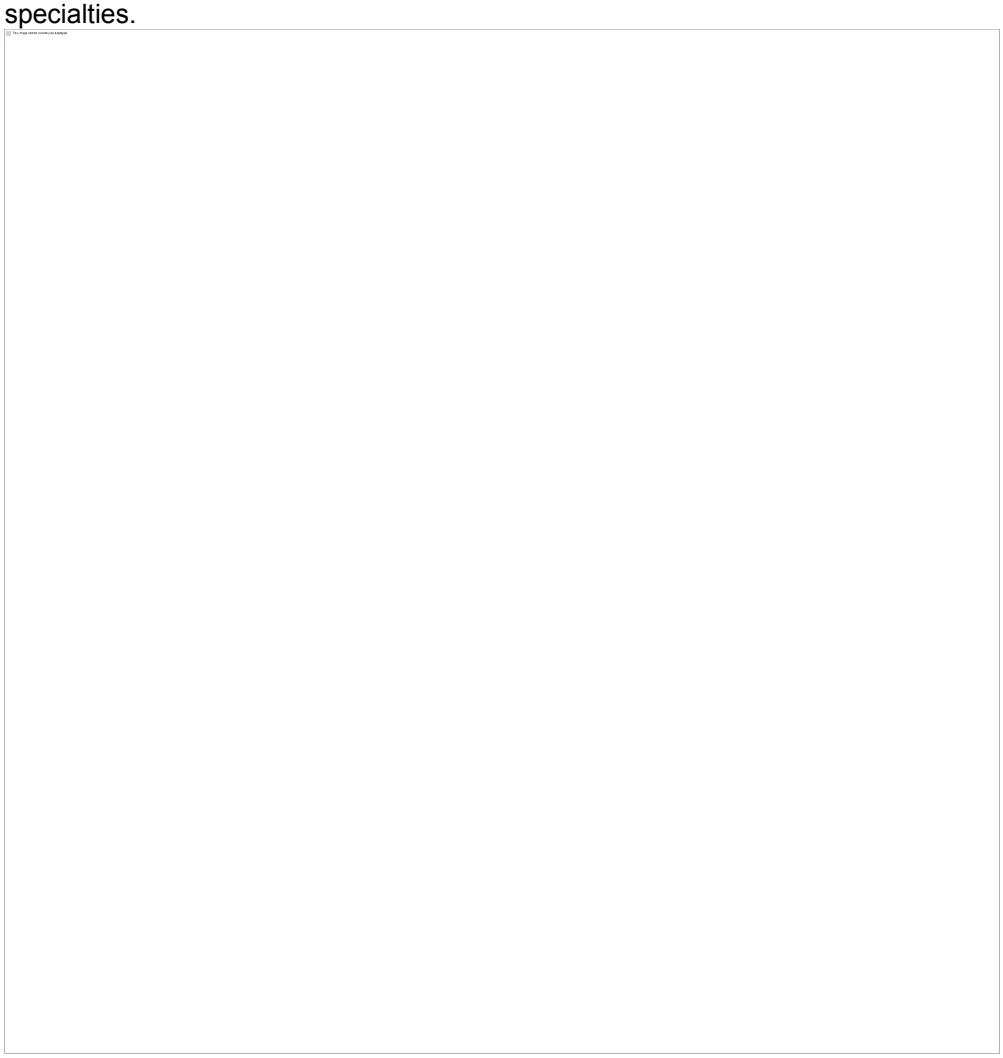


Figure 3: OP DNA Rates by Speciality (2014 – 2018 data)

Table 1: OP DNA Rates and Count by and Specialty (2014 -2018 data)

	Non-Māori		NZ Māori	
	Count	DNA Rate	Count	DNA Rate
Cardiology	17,593	5.6%	4,400	18.1%
Cardiothoracic Surgery	2,412	1.8%	721	10.1%
Dermatology	17,027	10.3%	4,170	25.0%
Diabetology	9,591	12.2%	2,777	24.6%
Endocrinology	11,784	5.2%	3,947	16.3%
Gastroenterology	10,636	10.4%	1,657	22.0%
General Medicine	4,273	9.3%	729	24.6%
General Surgery	36,392	5.3%	8,839	15.2%

Gynaecology	18,834	7.8%	6,699	17.5%
Haematology	17,690	5.5%	3,168	15.4%
Infectious Diseases	1,527	9.0%	300	17.3%
Neurology	15,522	7.9%	3,460	23.9%
Neurosurgery	6,115	5.3%	1,872	13.1%
Oncology	48,372	3.7%	10,398	8.5%
Ophthalmology	74,474	5.8%	14,789	18.1%
Orthopaedic Surgery	77,108	6.4%	20,538	20.8%
Otorhinolaryngology (ENT)	27,656	8.0%	11,658	22.2%
Paediatric Medicine	21,077	11.1%	8,965	25.1%
Pain Management	7,258	16.4%	1,063	20.9%
Plastic Surgery Non Burns	64,684	9.3%	13,498	28.4%
Renal Medicine	11,425	7.2%	5,920	17.6%
Respiratory Medicine	19,398	10.0%	6,377	23.0%
Rheumatology	17,761	5.7%	2,262	17.5%
Specialist Paed Oth Surg	8,190	17.2%	3,185	32.8%
Urology	6,264	8.4%	934	18.8%
Vascular Surgery	10,874	4.4%	2,042	14.8%
Total	**563,937**		**144,368**	

Priority Programme of Work - Progress August 2018

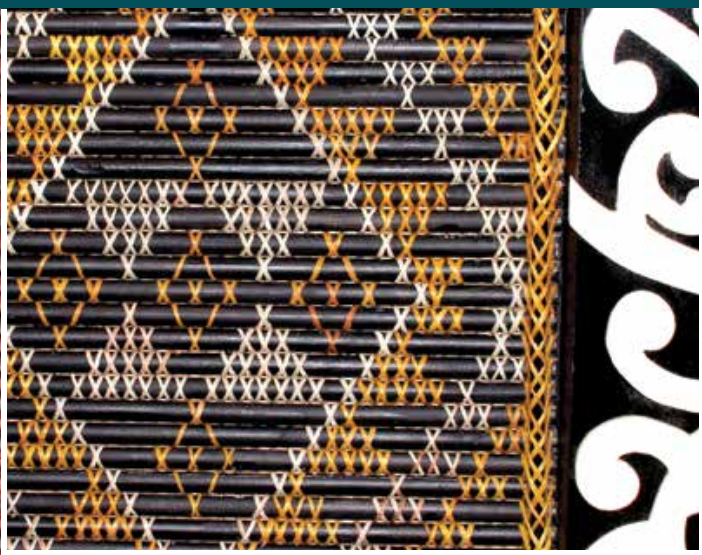
Programme of work – PART ONE		Status 2018								
	Proposed Activity	May	June	July	Aug	Sep	Oct	Nov	Dec	Comment
1	**Community Development Projects - Hauora/Wellness focus** Community development projects with a specific focus on hauora/wellness in Māori communities. Two projects developed and implemented in 2018/19 increasing number of projects and learnings each year.									Care in the Community Plan includes a series of wananga - TPO advice is that these should be targeted in high needs communities with a focus on solutions. If adopted by EY/Strategy & Funding these could be the beginning of the community development projects. Discussions are currently taking place with potential partners
2	**Community Development Projects - High need community focus** Community development projects with a specific focus on high need Māori communities. Six projects developed and implemented in 2018/19 increasing number of projects and learnings each year.									
3	**Puna Waiora - Māori rangatahi and whānau** Targeted programme to pipeline Māori rangatahi into health workforce. This is complemented wrap around services to support rangatahi and their whānau.									2/5 Endorsed by Operations Executive Group 16/5 Endorsed by Māori Strategic Committee with amendments 27/6 Approved by Waikato DHB Board
4	**Puna - Māori strategic capability** Securing high level Māori strategic capacity and capability to support the leadership required to drive the implementation of the Māori strategic plan.									Progressing with the appointment two strategic leaders with the intent to appoint a further two FTE at a later date.
5	**Oranga Kaimahi** A support for Māori health workforce across the Waikato DHB.									Establishment of Facebook page, going live August 2018.
6	**Harti Hauora – Stage 2 implementation** Targeted wrap-around service for priority groups accessing Waikato DHB services. For example, frequent flyers and those with chronic conditions. This programme links patients and whānau with the appropriate primary and community services.									Focussing on Harti Mama programme to link with Hapu Wānanga (exceeding planned outcomes)
7	**Special projects** Projects to be determined as strategy is developed.									
Programme of work – PART TWO		**Status 2018**								
	Proposed Activity	**Indicator**								**Comment**
1	**Tikanga best practice** In partnership with the University of Waikato, this is a specific compulsory training for all Waikato DHB employees to be actioned at induction. The training package will enable high quality culturally appropriate and clinically effective services as stipulated by the Waikato DHB Māori health policy and as required by national practicing bodies. The training will also be open to other providers for their staff. It is envisioned that this activity will: • Provide baseline tikanga best practice knowledge across all staff. • Strengthen key stakeholder engagement: Strategic relationship building with both University of Waikato and other health providers. • Link with existing funding and development schemes such as Māori Provider Development Scheme, Kia Ora Hauora.									• Business case in final stages of development • Joint Iwi/Board hui agenda for Sept will include Tikanga Best Practice training (pilot) • Board Institution racism workshop scheduled for June 2018
2	**Equity focussed reporting** Mandatory collection and reporting of ethnicity data across the organisation.									• 24/4 Ethnicity based KPI reporting presented to board from April 2018. • Supporting equity reporting by Midland Trauma Team
3	**DNAs (Did Not Attend)** A coordinated system for the follow up and support for patients who do not attend an outpatient appointment. Possible models: a. Centralisation at the Waiora Waikato Hospital with booking clerks. b. Locality/community based Equity Clinical Nurse Specialists. c. Te Puna Oranga managed service.									• Current analysis identifies long term consistent inequity between Māori and non-Māori. A coordinated organisational response is required. • TPO is currently developing a business case to address Maori health inequities in DNA rates • TPO are currently engaged in projects in the T-Hospitals to eliminate DNA inequities.
4	**Māori health plans** Every ward and service has a dedicated Māori health plan specific to their service contributing toward radical Māori health improvement.									• Review of clinical service plan drafts underway. Process to integrate MHPs to be agreed with COO.
5	**Audit** a. Internal monitoring processes against Māori accountabilities (i.e, Māori health plans, ethnicity data, induction training, hiring policies) b. External auditing to ensure alignment with strategic priorities, specifically as they pertain to Māori and radical Māori health improvement (Māori auditors with te reo Māori).									• Ethnicity Data collection Policy included in Internal audit plan for 2018-19
6	**HR policy, procedures, workforce leadership, and KPIs** Improve responsiveness in the organisation and workforce.									• Coordinating responses on the new PDs, especially regarding HR • KPI framework for IEAs (delegation to level 5) in progress as advice for Executive Management team
7	**Proactive recruitment of Māori** Enabling the recruitment process and setting KPI's to attract and employ Māori staff in all areas including medical, nursing, allied health, management. These staff would be supported with empowered career pathways.									• 100% Māori gateway students on board

Key	Colour
Not started	
In development	
In progress	
Deferred/On hold	
Delayed/Action Required	
Completed	
Ongoing	

MEMORANDUM OF UNDERSTANDING

BETWEEN
WAIKATO DISTRICT HEALTH BOARD
AND IWI WITHIN ITS DISTRICT






Waikato District Health Board

INTRODUCTION

1.0 The Parties

1.1 The Waikato District Health Board is a statutory corporation established under the New Zealand Public Health and Disability Act 2000.

1.2 The Iwi (Ngāti Maniapoto, Hauraki, Waikato-Tainui, Raukawa, Ngāti Tuwharetoa, Whanganui), Te Rūnanga O Kirikiriroa (Urban Māori Authority) and Kaunihera Kaumātua represent the interests of Māori within the area of the Waikato DHB.

2.0 Definitions

2.1 Board means the Waikato District Health Board.

2.2 The Iwi and Te Rūnanga O Kirikiriroa means Ngāti Maniapoto, Hauraki, Waikato-Tainui, Raukawa, Ngāti Tuwharetoa, Whanganui, and Te Rūnanga O Kirikiriroa, Kaunihera Kaumātua (Council of Māori Elders from within the area of the Waikato DHB).

2.3 Statutory committees mean committees as required under the Act and any other newly formed statutory committees.

2.4 Council means the Iwi Māori Council.

2.5 The Act means the New Zealand Public Health & Disability Act 2000.

2.6 The Provider-arm means services that are directly delivered by the DHB, these are not contracted services.

2.7 The Kaunihera Kaumātua representatives are the appointed Chair of the Waikato DHB Kaunihera Kaumātua and one other member of the Kaunihera

3.0 The Act

3.1 The Act provides for mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

3.2 These mechanisms include:

- A prescribed function of establishing and maintaining processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement.
- A prescribed function of fostering the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori.
- Providing for Māori representation on the advisory committees required by the Act.

THE BOARD AND IWI MĀORI COUNCIL AGREE AS FOLLOWS:

4.0 The Values

4.1 People at heart – Te Iwi Ngākaunui

4.2 Give and earn respect – Whakamana

4.3 Listen to me – talk to me – Whakarongo

4.4 Fair play – Mauri Pai

4.5 Growing the good – Whakapakari

4.6 Stronger together - Kotahitanga

5.0 Relationship

5.1 Te Tiriti o Waitangi (The Treaty of Waitangi) shall guide the relationship between the Iwi Māori Council and the Waikato DHB Board. This relationship is founded on the principles of:

Partnership – working together with iwi, hapū, whānau and Māori communities to radically improve Māori health outcomes and reduce Māori health inequities, and to develop appropriate health and disability services.

Participation that requires Māori to be involved at all levels of the health and disability sector, including in decision-making and planning and development roles and the delivery of health and disability services.

Protection which requires the Government to safeguard Māori cultural concepts, values and practices, and to ensure that Māori have at least the same level of health as non-Māori.

5.2 That their relationship shall be built on good faith, honesty and integrity, shall be maintained in a spirit of commitment and cooperation and shall be recognised as developing over time on the basis of mutual trust.

5.3 That the cultural norms and values of the Waikato DHB on the one hand and the Iwi on the other shall be acknowledged, preserved and promoted in their relationship.

5.4 That Iwi, Te Rūnanga O Kirikiriroa are legitimate representatives of Mana whenua and maata waka and that Kaunihera Kaumātua are recognised as contributors to the maintenance and upkeep of tikanga and kawa within the district of the Waikato DHB and that the Waikato DHB is the body appointed to ensure the provision of health and disability services within its district.

5.5 That no party to this agreement shall take any action or participate in any activity that may adversely affect this Statement and associated documents, or any party to them.

5.6 To endeavour in good faith to meet the Board's obligations with respect to Māori under the New Zealand Public Health and Disability Act 2000.

5.7 To be committed to work collaboratively at a strategic level to achieve the goals pertaining to the impact of health and disability services on Māori.

5.8 To consider the appointment of representatives nominated by the Council to the statutory committees.

5.9 To acknowledge that consultation by the Board with the Iwi shall occur through the Council but without restricting the Council's right to suggest more extensive consultation with third parties.

6.0 Goals

6.1 The overarching goal of this collaborative relationship is to radically improve Māori health outcomes, and to reduce health inequities.

6.2 The Council and the Board will give effect to this overarching goal by jointly supporting the following Māori health strategic priorities:

- Radical improvement in Māori health outcomes by eliminating health inequities for Māori.
- Promoting the implementation of the philosophy of Whānau Ora.
- Radical improvement of mainstream responsiveness to Māori health needs.
- Ensure the growth of sustainable Kaupapa Māori health services.
- Remove barriers for Māori experiencing disabilities.
- To increase and build a sustainable Māori workforce to contribute to the delivery of excellent culturally appropriate services.
- To grow future Māori leadership in the Health and Disability Sector at governance, and service delivery levels.

7.0 Roles and Responsibilities

7.1 The Board and Council will work together on activities associated with planning of health services in the Waikato DHB district.

7.2 The Board and Council will take responsibility for the activities listed below.

7.2.1 The Board will:

(a) Involve the Council in matters relating to the development and planning of significant health initiatives in the Waikato DHB district.

(b) Involve the Council in decision making processes that may have a significant impact on Iwi Māori within the Waikato DHB district.

(c) Feedback information to the Council on significant matters that may impact on the health of Māori within the Waikato DHB district.

(d) Move towards ensuring every provider and employee who receives DHB funding will actively contribute to and be accountable for achieving radical improvements in Māori health outcomes, and eliminating Māori health inequities. These requirements will be stipulated in provider contracts and employee key performance indicators.

7.2.2 The Council will:

(a) Recognise the Board as the body appointed to ensure the provision of health and disability services and Māori representation under the Act.

(b) Acknowledge that consultation aligned to the Treaty of Waitangi, by the Board with the Iwi shall occur through the Council and that the Board shall be deemed to have discharged any obligation to bring matters to the attention of Iwi in requesting that such matters be placed on the agenda of the Council.

(c) Maintain a Council to undertake those responsibilities set out in the terms of reference.

(d) Operate the Council in accordance with the requirements set out in the terms of reference.

(e) Involve the Board in matters relating to the development and planning of Māori health.

(f) Ensure that the Board is informed of decisions that are made by the Council that may have an impact on the Board.

(g) Feedback information to hapū / iwi o Tainui, Tuwharetoa, Whanganui and maata waka on matters which may impact on the health of Māori living within the Waikato DHB district.

(h) Assist the Board, in conjunction with the Kaunihera Kaumatua, in any matters relating to Māori customs and Tikanga (rules of conduct).

(i) Nominate representatives for appointment to the statutory advisory committees to be rotated every three years.

8.0 Ngā Hui / Joint Meetings

8.1 The parties will give effect to the Memorandum of Understanding through the following:

(a) At least 2 meetings per annum between the Board and IMC.

(b) The relationship between the Board and the Council will be reviewed by June of each year as an agenda item to either of the agreed meeting per annum.

(c) A relationship between the Council Chair, Deputy Chair and the Board Chair and Chief Executive Officer based on quarterly meetings between them.

(d) The Board Chair is expected to attend Iwi Māori Council meetings (where possible).

(e) The Chair of the Iwi Māori Council is able to attend Waikato DHB Board meetings as an ex-officio member.

8.2 All meetings shall observe the appropriate Tikanga and Kawa and be conducted according to the protocols and procedures of the host party.

8.3 When required, the parties may nominate and engage independent meeting facilitators selected by mutual agreement.

8.4 Written record of the resolutions of these meetings shall be kept and when required, circulated as an action list to each party's principal representative. Resolutions will be mutually agreed by both parties.

8.5 Subject to the provisions of the Official Information Act 1982, no record of these meetings shall be circulated beyond the representatives of the parties without prior approval of the respective principal representatives.

8.6 The parties shall provide secretarial services for meetings from their own resources as required.

8.7 Each party shall be entitled to adjourn meetings by simple verbal notification for the purpose of holding a "caucus" meeting, but no such adjournment shall exceed one hour.

AMENDMENT OF AND WITHDRAWAL FROM MEMORANDUM

9.0 Review of Memorandum

9.1 This Memorandum shall be amenable to amendment by agreement of all parties to it at the time amendment is proposed. Review should occur every three years from the date it is given effect.

9.2 The parties to this memorandum shall be free to withdraw from it upon giving three months' notice to the other parties.

10.0 Signatories

Waikato District Health Board	Maniapoto Māori Trust Board
Hauraki Māori Trust Board	Te Rūnanga O Kirikiriroa (Urban Maori Authority)
Tuwharetoa Māori Trust Board	Waikato Tainui Te Whakakitenga o Waikato Inc
Raukawa Charitable Trust	Ngā Tāngata Tiaki o Whanganui Trust

Kaumātua Kaunihera Representative

Date: _____

TERMS OF REFERENCE OF THE IWI MĀORI COUNCIL

Purpose

The purpose of Iwi Māori Council in conjunction with Waikato DHB Board will provide strategic leadership and oversight on all matters pertaining to the impact of health and disability services on Māori. The Memorandum of Understanding between the Board and Iwi Māori Council articulates the intent and contribution of both parties.

Specific responsibilities

- The Iwi Māori council membership: Iwi means Ngāti Maniapoto, Hauraki, Waikato-Tainui, Raukawa, Ngāti Tuwharetoa, Whanganui, and Te Rūnanga O Kirikiriroa (Maata Waaka) and the Kaunihera Kaumātua (Council of elders)
- So far as this is practicable, to affirm the Iwi Māori Council's position as a primary advocate for Māori at the strategic level in relation to the Board, and to do this by maintaining a strategic overview of the Board's activities and advising where these activities are not considered to reflect the interests of Māori
- To respond to the Board, either directly or following the completion of consultation undertaken by the Council itself, on all matters in respect of which the Board seeks advice collectively from Iwi, Te Rūnanga O Kirikiriroa and the Kaunihera Kaumātua.
- To raise with the Board at its own initiative any matters relating to the other specific responsibilities of the Council including the need to obtain further information as a prerequisite to effective decision making.
- To advise on an appropriate process of consultation where such consultation is proposed to extend beyond consultation with the Council itself.
- To maintain a strategic overview of the Board's programme in respect of identifying and addressing particular areas of concern in relation to Māori health.
- In relation to the responsibilities mentioned above, to maintain a strategic overview of, and provide comment on and input to the Board on its Strategic Plan, Annual Plan and Statement of Intent.
- To nominate persons to represent Māori on the statutory committees of the Waikato DHB.
- To actively participate in the induction and orientation of newly appointed Board and Iwi Māori Council members and the priority given to Māori health gain within the Waikato DHB district.
- To review from time to time in conjunction with the Board these Terms of Reference.

Operational requirements of the Iwi Māori Council

1) The Iwi Māori Council shall comprise two members from each of the Iwi, two representatives from the Kaunihera Kaumātua and two representatives from Te Rūnanga O Kirikiriroa.
2) The Iwi, Te Rūnanga O Kirikiriroa and the Kaunihera Kaumātua shall be free to appoint their respective members to the Iwi Māori Council as they see fit.
3) The Iwi, Te Rūnanga O Kirikiriroa and the Kaunihera Kaumātua shall advise the Board of their members appointed to the Iwi Māori Council and of any subsequent change to their members.
4) The Iwi, Te Rūnanga O Kirikiriroa and the Kaunihera Kaumātua may send a replacement(s) should their members on the Iwi Māori Council be unable to attend a meeting of the Council so long as the total number of attendees does not exceed two.
5) The Iwi Māori Council shall appoint a Chair from within its membership, by any manner deemed appropriate and utilise a rotational option of three years with a maximum of 6 years total or two terms maximum.

6) The Iwi Māori Council shall appoint a Deputy Chair from within its membership, by any manner deemed appropriate and utilise a rotational option of three years with a maximum of six years total or two terms maximum

7) The Iwi Māori Council shall not meet less frequently than once every three months and shall have a maximum of 10 paid meetings per annum except with the consent of the Board. This shall not, however, preclude the Council holding informal (that is unpaid and not reimbursed) meetings as often as it requires.

8) The members or replacements shall receive a fee for the attendance of their members at meetings of the Iwi Māori Council of $250 per meeting per person. This fee will be paid to the individual unless specified by their representing entity (in which case the fee will be paid directly to the representing entity).

9) The Chair shall receive an annual payment of $12,500.00 and the Deputy Chair shall receive an annual payment of $6,240, paid on a monthly basis.

10) Members of the Iwi Māori Council shall upon submission of a claim form be reimbursed for expenses incurred in attending meetings of the Iwi Māori Council at the same rate as Board members. Payment of any additional actual and reasonable expenses incurred by the Iwi Māori Council or its members e.g. training expenses shall be approved by the Chief Executive of the Waikato DHB.

11) The point of origin for determining the reimbursement of expenses shall be the member's normal residential address.

12) The Iwi Māori Council shall meet at a location determined by the Council within the district of the Board.

13) The Iwi Māori Council shall be serviced by Te Puna Oranga.

14) The Board will receive the minutes of the Iwi Māori Council.

15) The Iwi Māori Council shall set its own agendas. However, the Board through the Te Puna Oranga secretariat, request that specific items be considered by the Council.

16) For each of the statutory committees the Iwi Māori Council shall recommend one person (who may or may not be a member of the Council) to be a member. The term should not exceed three years.

17) The persons recommended by the Iwi Māori Council to the membership of the statutory committees shall be chosen having regard to the skills and expertise required by the committees as advised to the Iwi Māori Council by the Board at any time that a vacancy arises.

18) In making recommendations for the appointment of persons to the statutory committees, the Iwi Māori Council shall recognise that the Board has authority, in law, to determine who shall be appointed and cannot restrict its responsibility to do so in favour of another party.

19) Where a recommendation of the Iwi Māori Council is not appointed by the Board, the Council shall have the opportunity to make a further recommendation.

Constraints

The Council shall not concern itself with the following:

(1) Decisions of Waikato DHB, Māori providers and other private providers to the extent that such decisions concern business planning, the welfare of individual patients or groups of patients or operational management.

(2) Employment matters arising in relation to Waikato DHB, Māori providers and other private providers to the extent that such matters concern individual employees or positions. Except where a key management position for Te Puna Oranga is being considered.

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
8 AUGUST 2018

AGENDA ITEM 6.4

WAIKATO DHB TOBACCO CONTROL ACTION PLAN

Purpose	For information

At the joint June Community and Public Health Advisory Committee and Disability Support Advisory Committee meeting it was agreed that Strategy and Funding would strengthen the Tobacco Control Action Plan with respect to Māori, maternal smoking, and those who experience mental health issues. It was also agreed to focus on the reduction of smoking initiation across the district. The attached Tobacco Control Action Plan includes amendments to address the above.

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

WAYNE SKIPAGE
SENIOR PLANNING MANAGER
STRATEGY AND FUNDING

Waikato District Health Board

Tobacco Control Action Plan

2018-2025

1.0 Overview – The Waikato DHB Population

The Waikato District Health Board (DHB) plans, funds and provides hospital and health services to more than 417,000 people in a region covering 8% of New Zealand's population, stretching from Coromandel's most Northern point almost reaching down to Mt Ruapehu in the south, from Raglan on the West Coast right across to Waihi on the East Coast. It takes in the city of Hamilton and towns such as Thames, Huntly, Cambridge, Te Awamutu, Matamata, Morrinsville, Ngaruawahia, Te Kuiti, Tokoroa and Taumarunui. There are 10 territorial local authorities within our boundaries – Hamilton City, Hauraki, Matamata-Piako, Otorohanga, (part of) Ruapehu, South Waikato, Thames Coromandel, Waikato, Waipa, and Waitomo.

We have a larger proportion of people living in areas of high deprivation than in areas of low deprivation. Ruapehu, Waitomo and South Waikato territorial local authorities have the highest proportion of people living in high deprivation areas.

The Māori population (estimated to be 22% of our population for 2013/14) is growing at a slightly faster rate than other population groups and is estimated to be 23.3% by 2026. The Māori population is significantly impacted by many chronic conditions such as diabetes and smoking related diseases and show up disproportionately in adverse health statistics. These statistics together with our embedded strategic priority to reduce Māori health inequalities cement our commitment to partner with Māori in local health service development.

Pacific people represent an estimated 2.5% of our population and are a group that requires targeted health initiatives.

Approximately 40% of our population live in rural areas, and 60% live outside Hamilton city. This represents diverse challenges in service delivery, health promotion and community development. Waikato DHB (wherever possible) partners with local councils, community groups and community pharmacies to access priority populations.

Overall, our population statistics hide significant variations across the large geographical area we cover. Documents such as the recently developed Territorial Authority health profiles and Māori / Pasifika health profiles provide some in-depth analysis of our populations, their health status and the significance for strategic health planning and for prioritisation of programmes at an operational level.

2.0 Introduction – Why Tobacco Harm is a Key Issue for the Waikato DHB

Smoking prevalence in Waikato DHB is higher than all other DHBs in New Zealand. A significant contributor to this is the smoking rate equity gap between Māori and non-Māori. Among adults, 17% are smokers as compared to 15% across New Zealand. Of concern, youth smoking rates are higher than adult smoking rates (18% vs.17%).

Impact of Smoking on our Community's Health

A number of groups are disproportionally burdened with poor health outcomes as a result of these high rates of smoking. In our district these include:

- Māori and Pacific peoples - 35% of Māori and 24% of Pacific adults are smokers as compared to 13% of the wider adult population;
- Those living in the most deprived communities, who are nearly four times more likely to be regular smokers than the populations living in the most affluent parts of society;
- Waikato has a higher rate of maternal smoking for Māori women, resulting in poorer outcomes for their kids; and
- Mental Health and Addiction Service (MH&AS) users smoke at almost twice the rate of the wider population, and MH&AS staff smoke at higher levels than the wider health workforce. 84% of people using addiction services and 47% of mental health service users smoke.

With those priority groups in mind, this plan sets out to address smoking rates for the following groups:

- Māori
- Pregnant mums who smoke
- Those experience mental health issues

The actions within this plan have a particular focus on these priority groups. The DHB acknowledges that these groups are often the hardest to reach and the least likely to quit through mainstream programmes. Over the coming year, Strategy and Funding will work with core partners to identify new services, and to better target these clients. Additionally, through our settings-based public health services, we will increase reach into our youth communities to reduce smoking initiation.

The plan aligns with Waikato DHB Strategy and Smokefree Policy, Tobacco Position Statement, District Annual Plan, Waikato Plan, Public Health tobacco strategy 2017-2020, and Primary Health Care Plans (Midland Health Network 3 year Strategic Review).

We expect to update this Strategy early 2019 with even stronger focus on priority groups.

3.0 Alignment to National and Regional Objectives

National

Approximately 15.5% of adults in New Zealand aged over 15 years smoke daily. Māori and Pacific people are more likely to smoke (37% and 23% respectively). Smoking during pregnancy affects the baby and can cause health problems such as a low birth weight, an increased risk of losing the baby (miscarriage or stillbirth), pneumonia, asthma and glue ear; and for the child's health after birth (including but not limited to increased rates of Sudden Unexpected Death of an Infant (SUDI), high blood pressure and respiratory disease.

The prevalence of smoking remains high for all Māori populations and people who live in low socio-economic areas. Rates of smoking are not decreasing as much as previous years; we are not on track to reach the Smokefree goal in 2025 of less than 5% smoking prevalence, especially for Māori and low socioeconomic groups. Inequalities in health status exist for populations in particularly Māori, Pacific and lower socioeconomic groups and smoking can be seen as a symptom of health inequalities as people who smoke are more likely to have less access to the key determinants of health. Smoking can also be seen as a cause of health inequalities as people who smoke tend to have less disposable income, which in turn affects the key determinants of health. DHB/MoH has as priority, Smokefree pregnancies and better access to smokefree services for people enrolled in mental health and addiction services. Māori are highly represented in these groups.

In March 2011, in response to the Māori Affairs select committee tobacco inquiry the Government adopted a Smoke-free 2025 goal for New Zealand - making New Zealand essentially a smoke-free nation by 2025.

Achieving <5% smoking prevalence by 2025 appears feasible but will require large increases in cessation among Māori (20% per annum), accompanied by strong reductions in initiation to half or quarter current rates. The DHB will continue to support and advocate for well-established evidence-based tobacco control interventions e.g. continuing the current pattern of annual tobacco tax increases, as well as supplementary interventions for population groups with highest smoking rates e.g. intensive mass media campaigns, enhancing intensive smoking cessation support that is both targeted and culturally appropriate.

DHB Leaders will continue to partner with Primary Care (including Pharmacies), Non-government Organisations (NGOs), TLAs and local communities to address ethnic inequalities in smoking for Māori which require interventions that address both the "broader determinants in health (eg, improving income, housing, employment and access to healthcare) as well as tobacco control specific measures".

Leadership in Tobacco Control by DHB must be meaningful and visible at the national and local levels. Support and promotion of major new endgame approaches such as a sinking lid on tobacco supply, tobacco retail outlet licensing, a phase-down of nicotine levels in tobacco, and Smokefree cars must be supported by the DHB.

Regional

On the 2nd of March 2012, the Waikato District Health Board signed the Midland District Health Boards Smokefree Midland Vision Statement. In the Statement, all five Midland District Health Boards (Waikato, Bay of Plenty, Lakes, Tairawhiti and Taranaki) committed strong leadership toward achieving the vision of a smokefree Midland by 2025.

4.0 Understanding Our Smoking Population – Current State for Waikato DHB

The most up-to-date and accurate picture of the smoking population has been taken from the recently released 2013 Census data. This creates a detailed picture across the district showing varying smoking rates across and within different population groups. Census data shows that there were approximately 44,000 regular smokers in the Waikato DHB area on census night. This equates to a 17% smoking rate of reported status.

Health of Older people 60 to 89 years – smoking data relating to chronic health conditions is available via InterRAI and has the ability for trending to be tracked over time. Clinical Action Protocols (CAPs) triggered by assessment outcomes for tobacco and alcohol demonstrate for Midland benchmarking of the frail and complex elderly population - Midland 7% compared to 9% for Waikato for Quarter 2.

Māori

Māori are a priority for Waikato's Stop Smoking Service delivery. Midlands Heath Network is Waikato District Health Board's Stop Smoking Service Provider, who has a significant relationship with Tainui working towards closing the equity gap for Māori who smoke. Midlands Health Network has contracted with a number of Māori providers to increase engagement with this demographic.

Maternity services

Smoking during pregnancy affects the baby and can cause health problems such as a low birth weight, an increased risk of losing the baby (miscarriage or stillbirth), pneumonia, asthma and glue ear; and for the child's health after birth (including but not limited to increased rates of Sudden Unexpected Death of an Infant (SUDI), high blood pressure and respiratory disease. The smoking rate for mothers when they first register with a Lead Maternity Carer (LMC) is 19.9%[1]. The DHB average smoking rate for women aged 15-44 is 21%. Although no analysis has been undertaken, it is likely that the difference is due to women either stopping prior to trying to conceive, or quitting between finding out they are pregnant and registering with their LMC.

Only 2% of smoking mothers stopped smoking during pregnancy[2]. This has already been identified as an area of concern by The Maternity Quality and Safety Governance Board of Waikato DHB.

DHB and Midlands Health Network are collaborating to increase the number of referrals from LMCs to the Stop Smoking Service and to identify LMCs who may wish to become Stop Smoking practitioners.

Better support for Mental Health and Addiction Service Users

Smoking related harm accounts for much of the reduced life expectancy of people with serious mental health disorders.

A strong historical culture of acceptance and tolerance of tobacco use across the mental health and addiction services (MH&AS) sector has contributed to the treatment of tobacco dependence remaining a low priority. These views and practices persist despite growing evidence that people with experience of mental health disorders do want to be Smokefree and stopping smoking may improve MH&AS treatment outcomes.

DHB has a transformational culture change programme is underway with NGO partners aiming to;

- target vulnerable populations with high smoking prevalence;

[1] Waikato DHB Maternity Annual Report July 2013 to June 2014

[2] Waikato DHB Maternity Annual Report July 2013 to June 2014

- help people with experience of mental health and addiction issues who are less likely to receive stop smoking advice despite being typically more dependent and to smoke more heavily that the general population; and
- negate the strong historical culture of acceptance of tobacco use across MH & AS which in turn has influenced their 47% prevalence rate.
- create sustainable smokefree best practice and systems across the continuum of Mental Health & addiction services.

5.0 Current service response

Waikato DHBs tobacco control activities occur across the service continuum, and maintain a focus on priority groups. Broadly those activities fit into 4 categories:

1. Leadership
2. Reducing Smoking initiation
3. Increase quitting
4. Reduce exposure to second hand smoke

The Waikato District Tobacco Control Steering Group meets regularly with partners including public health, Primary Health Organisations (PHOs), secondary care, community groups, and other Non-government Organisations (NGOs). The intention of this group is to maintain momentum in respect to:

- de-normalising tobacco smoking
- reducing access to tobacco
- reducing individuals starting smoking initiation
- significant increasing cessation rates to meet the Smokefree 2025 goal.

6.0 Public Health Regulatory Role

The Waikato DHB Public Health service is contracted to provide regulatory (enforcement of the Smoke-free Environments Act 1990) and health improvement services for tobacco control. Through this role Public Health Waikato DHB, is responsible for implementing several smokefree activities as described below and in the Public Health Tobacco Strategy, 2017 – 2020 (see Appendix).

Regulation and Enforcement of the Smokefree Environments Act 1990
The Public Health, health protection service is responsible for enforcing the Smoke-free Environments Act 1990 (SFEA) across the Waikato DHB region. This involves investigating breaches and providing advice on the SFEA. Specific areas of focus include:

- Tobacco sales to minors, with controlled purchase operations
- Informing tobacco retailers of their responsibilities under SFEA;
- Investigating complaints of smoking in licensed premises;
- Advising licensed / other premises (e.g. cafés) on where smoking areas are permitted within the licensed premises;

Health Improvement and advocacy
The health improvement team and the advisory and development within Public Health, support tobacco control activities provided through a number of settings.

- Supporting national legislation through advocacy/submissions to strengthen policy responses to ensure we are working towards Smokefree Aotearoa 2025
- Work with Local Government to develop and extend Smokefree policies/by-laws. Encourage those without any formal tobacco control response to develop Smokefree polices/by-laws
- Facilitate Smokefree health improvement strategies for priority populations in Māori, Pacific, Sport, Workplaces, Local Government and Education settings.

7.0 Planning Linkages

This plan reflects and aligns with the following plans from the Waikato DHB tobacco control sector:

- Waikato DHB's District Annual Plan 2017 – 18
- Waikato DHB Smokefree Co-ordination plan
- Waikato DHB Public Health Unit Tobacco Strategy 2015 – 18
- Primary Health Organisation (PHO) Tobacco Control plans. (Midlands Health Network, National Hauora Coalition and Hauraki PHO)

- Waikato DHB Smokefree Maternity Group (Maternity Quality and Safety)
- Waikato District Health Board Mental Health Smokefree group
- Waikato Community Pharmacy Group

8.0 Performance Measures

- Maintain the number of frontline clinical and administration staff in hospitals who are ABC trained either during orientation; face to face or ad hoc.
- Maintain the number of frontline clinical and administration staff in primary care who are ABC trained.
- Maintain the number of Waikato DHB-wide staff who access e-learning training for ABCs
- A staff cessation incentive programme is developed
- Increase the number of tobacco control sector staff across the district by 10% for the next three years who attend national Stop Smoking training.
- Increase the number of LMCs/midwives trained in ABCs and Stop Smoking training by 10% for the next three years
- Increase the number of hospital and primary care referrals to quit providers by10% for the next three years
- Report on Waikato DHB utilisation of NRT products from secondary pharmacy services (by ward/NHI)
- Update policy status across the district (where applicable).
- Report on numbers of TLAs that are working collaboratively towards Smokefree Environments (such as parks)
- Report on numbers of Marae/Iwi that are working collaboratively towards Smokefree Environments
- Waikato District Health Board Tobacco Control Steering Group Terms of Reference and membership is agreed and updated
- System level measure – proportions of babies who live in a smokefree household at six weeks postnatal.
- Achieving <5% smoking prevalence by 2025 in the 65+ population (measured nationally through interRAI)

Actions for 2018-2025

The following table outlines the DHB's planned activity to reduce smoking prevalence over the next 7 years. It should be noted that on-going discussions between Strategy and Funding, Population Health and our Primary and Community Care partners are continuing as means to add to, and strengthen this mix.

Waikato District Health Board Tobacco Control Action Plan

No	National Tobacco Control objectives	Deliverables/actions	Timeframe	Performance commitments	Lead	17/18 deliverables	Funding source (new/existing) 17/18	18/19	19/20
1	**Leadership**	a) Membership Midland Regional Tobacco Integration Network (TIN)	Quarterly	Meetings attended and actions achieved	Ministry of Health	WTCSG Terms of Reference and membership is agreed Narrative reports – strategies/achievement	Ministry of Health – existing Smokefree DHB	Yes	
		b) Active Waikato DHB Tobacco Control Steering Group (WTCSG) meetings Maternity Smokefree Leadership group Mental Health Smokefree Leadership group.	Bi-monthly	Terms of reference and membership is agreed and updated to reflect changing environment	Strategy and Funding and WTCSG	Waikato District Health Board smoking policy updated.			
		c) Waikato DHB commitment to creating smokefree environments	Ongoing	Smokefree environments implemented across the Waikato DHB and staff supported to become Smokefree.		1 FTE SF Co-ordinator Plus proposed: 0.5 FTE Maternity 0.5 FTE Mental Health Number of recommendations implemented from the Smoking on Waikato DHB grounds and Staff report accepted by the Waikato DHB Executive Group.			
				Smokefree Co-ordinator will support the development of the DHB Smokefree Policy by giving Stop Smoking support to staff.	Waikato Hospital /Rural Hospitals	Number of Smokefree areas/grounds implemented within the Waikato DHB.			
				Maintain the number of frontline clinical and administration staff in hospitals who are ABC trained		Evidence that numbers have been maintained			
				Maintain the number of Waikato DHB staff who access e – leaning training for ABCs	Waikato Hospital/Rural Hospitals	Evidence that numbers have been maintained			
				Maintain the number of frontline clinical and administration staff in primary care who are ABC trained		Evidence that numbers have been maintained 0.5 FTE employed by Midlands Health Network – Waikato 0.5 FTE employed by Hauraki PHO (including National Māori Coalition			
				Report on numbers of	PHOs				

No	National Tobacco Control objectives	Deliverables/actions	Timeframe	Performance commitments	Lead	17/18 deliverables	Funding source (new/existing) 17/18	18/19	19/20
				TLAs that are working collaboratively towards smoke free environment	Public Health	Report completed and available on intranet and DHB website			
2	Reducing Smoking Initiation	a) Regulation and Enforcement b) Partnership with Schools to increase risk education c) Partnership with other community organisations to increase reach of risk messaging	Ongoing To be initiated To be initiated	Smoke free environments and de-normalising smoking.	Public Health Service - Waikato District Health Board Strategy & Funding and Public Health Service Strategy & Funding and Public Health Service	Percentage of tobacco retailers compliant with SFEA. Report available to board Number of partnership schools Number of community organisations engaged	Ministry of Health – Public Health Group - existing	Yes	Yes
3	Reduce exposure to second hand smoke	a) Work constructively with local government to introduce bylaws or policies to create smokefree areas in public places not currently covered by the SFEA 1990 b) Engage key settings in smokefree environments/policy development		Smoke free environments and de-normalising smoking.	Public Health Service - Waikato District Health Board Strategy & Funding with PHOs and Tamariki Ora Well Child providers	Number and type of settings engaged in smokefree environment/policy development. Report available to board System Level Measure – portions of babies who live in a Smokefree household at six weeks postnatal. Reports available to Strategy and Funding and WTCSG			
4	Increase Quitting	a) Stop Smoking Services, with a particular focus on reaching Maori, Pregnant Mums and Mental Health Consumers	Ongoing	A staff cessation incentive programme is developed Increase the number of hospital and primary care referrals to quit providers by 10% during the term of the plan Increase the number of tobacco control sector staff across the district by 10%, , who attend Stop Smoking	Waikato DHB Waikato Hospital /rural Hospitals and general and PHOs Stop smoking Service provider (Midlands Health Network)	Results reported to Ministry of Health directly Copied to Waikato District Health Board Strategy and Funding	Ministry of Health		

No	National Tobacco Control objectives	Deliverables/actions	Timeframe	Performance commitments	Lead	17/18 deliverables	Funding source (new/existing) 17/18	18/19	19/20
				training during the term of the plan					
				Increase the number of LMCs/midwives trained in ABCs and Stop Smoking by 10% during the term of the plan	Maternity Quality and Safety Programme, Birthing Centres Waikato Hospital	Reports available to WTCSG			
				Report on Waikato DHB utilisation of NRT products from secondary services by ward /NHI	Waikato Hospital pharmacy Services	Reports available to WTCSG and Waikato Hospital COO and Rural Hospitals managers			
				Achieving <5% smoking prevalence by 2024 in the 65+population measured nationally through InterRAI		Reports available to WTCSG an Agewise forum			
		a) Support enrolment to Stop Smoking Services with an emphasis on reducing the equity gap for Māori who smoke. b) Tupeka Kore Framework c) Resource Pregnancy lead d) Mental health sector support	Ongoing	Increased referrals to SSS	Whole tobacco control sector - Waikato District Health Board wide	Number of referrals to SSS (Waikato Hospital)	Ministry of Health – existing Smokefree DHB	Yes	Yes
				Tupeka Kore framework goals achieved. FTE available to support tobacco control initiatives in specified areas of maternity and mental health		Consider incentives for pregnant women to be smokefree – process to be agreed by WSFSG. Consider supporting workforce development for 3rd party smoking cessation providers i.e. pharmacists (if enabled) and LMCs Consider the purchase nicotine inhalators and smokealysers for smoke free programme in mental health and resources/incentives for staff quit programme (dependent on Pharmac approval)	Maternity and Mental health FTE resource – possible new funding One off funding	?	?
				Effective engagement with Midlands Health Network to achieve shared outcomes	Strategy and Funding				
				Update Policy status across the district as applicable	Public Health				
					Strategy and Funding	Transitioning Long Term Conditions cessation approach with Pharmacies to focus on Māori and report change			
				Report on numbers of	Te Puna Oranga	Establish baseline in 18/19 and report in 19/20			

No	National Tobacco Control objectives	Deliverables/actions	Timeframe	Performance commitments	Lead	17/18 deliverables	Funding source (new/existing) 17/18	18/19	19/20
				marae that are working collaboratively towards smoke free environment	(Māori Health Service)				

Smoking statistics 2006-2013

Waikato DHB

15

Data sources

- **Statistics NZ Census 2013:**
  - Cigarette smoking behaviour by age group and sex, for the census usually resident population count aged 15 years and over, 2006 and 2013 Censuses (RC, TA, AU)
  - Cigarette smoking behaviour and ethnic group (grouped total responses) by age group and sex, for the census usually resident population count aged 15 years and over, 2006 and 2013 Censuses (RC, TA, AU)
- **Ministry of Health:** National Maternity Collection 2011 & 2015

Technical note:

Adults = 15 years and over

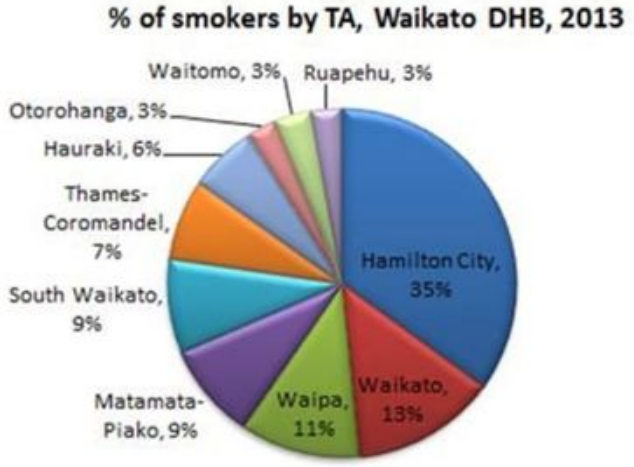
Youth = 15-24 years

Regular smokers (15+ years) in Waikato DHB, 2013

Number and proportion of regular smokers (15+), by Territorial Authority, Waikato DHB, 2013

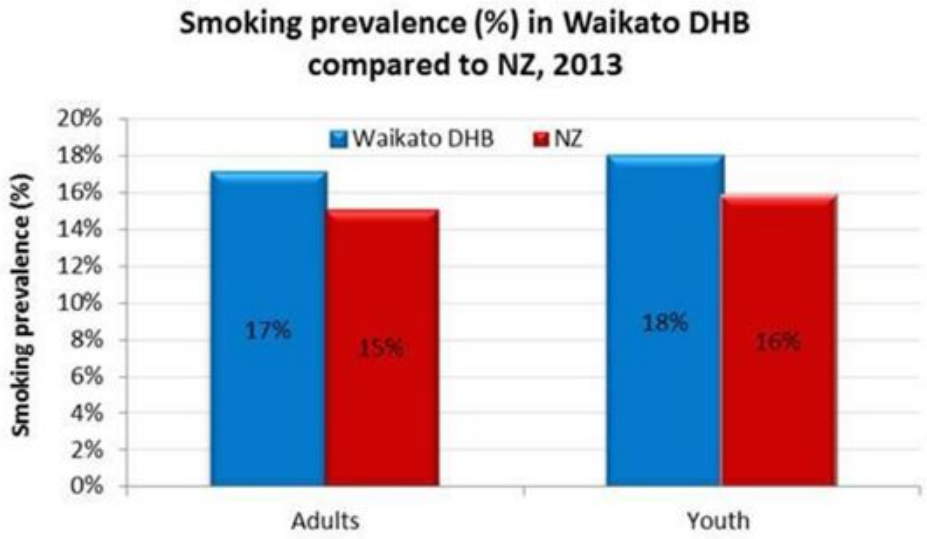
Territorial Authority	Number of smokers	% of total smokers in Waikato DHB
Hamilton City	15327	35%
Waikato District	5859	13%
Waipa District	4887	11%
Matamata-Piako District	3948	9%
South Waikato District	3807	9%
Thames-Coromandel District	3273	7%
Hauraki District	2736	6%
Otorohanga District	1182	3%
Waitomo District	1506	3%
Ruapehu District	1257	3%
Waikato DHB	**43782**	**100%**

Data source: Statistics NZ 2013 Census



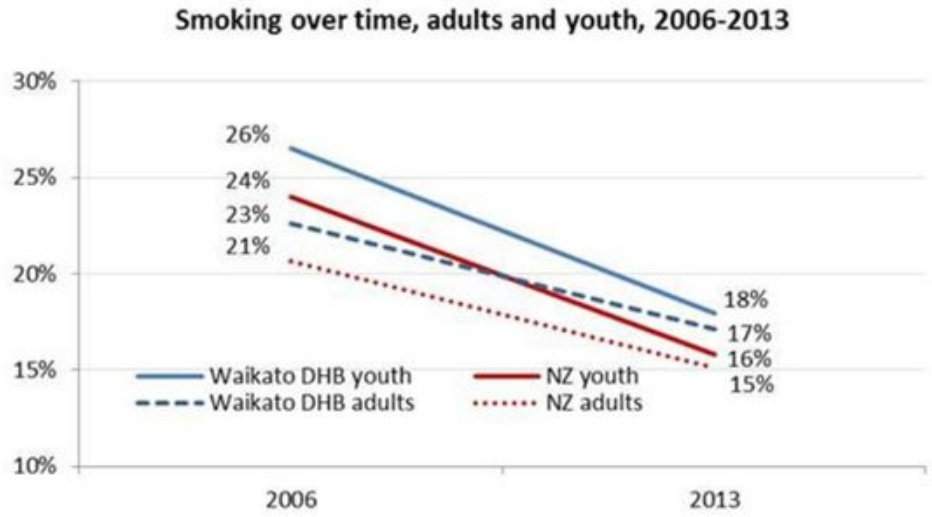
Interpretation: Waikato DHB has 43,782 adults aged 15 years and over who are regular smokers. 35% (n=15,327) of those live in Hamilton City.

Smoking in Waikato DHB compared to NZ



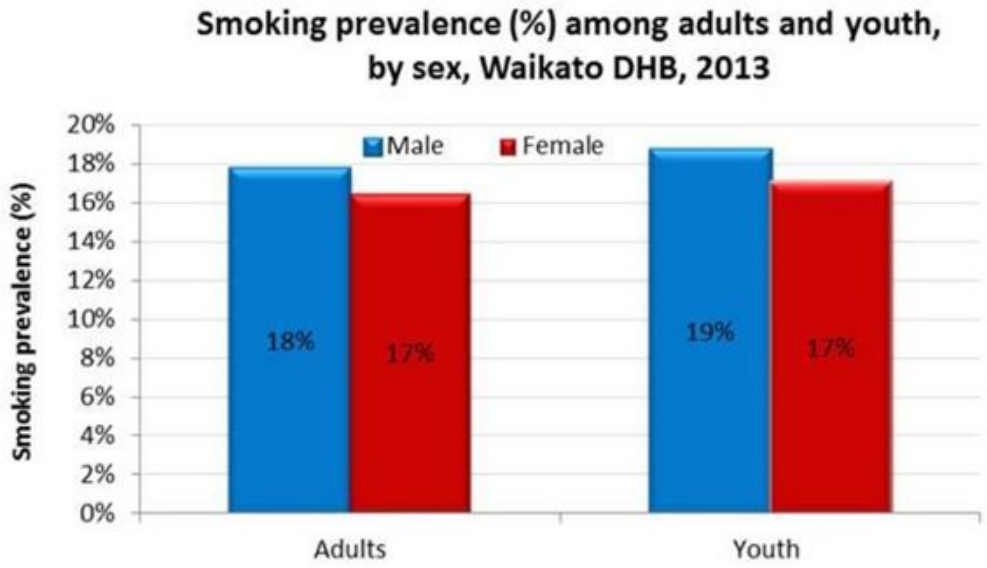
Interpretation: The smoking prevalence in Waikato DHB is higher compared to the overall NZ (statistically significant). Among adults 17% are smokers compared to 15% in NZ. Youth smoking rates are higher than adult smoking rates (18% vs. 17%, statistically significant).

Smoking— time trend 2006-2013



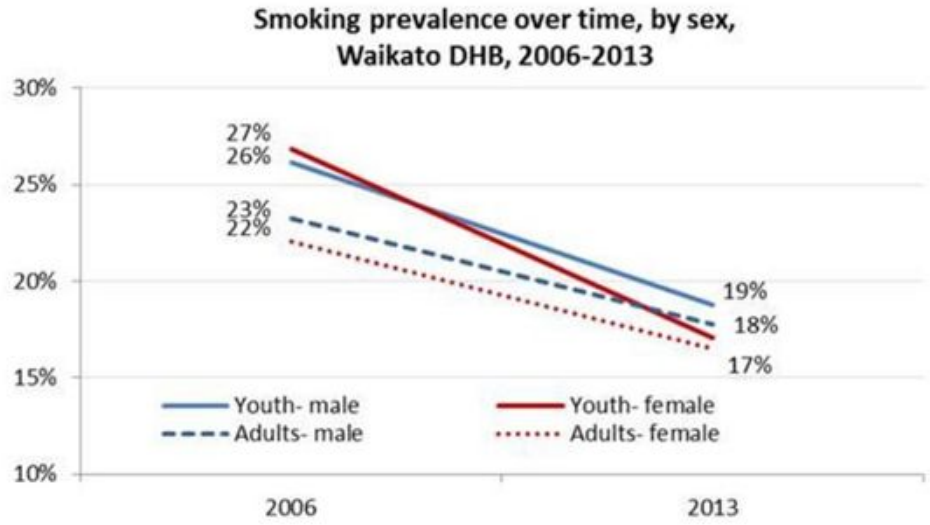
Interpretation: The smoking prevalence for both youth and adults has decreased in New Zealand as well as in Waikato DHB 2006-2013. Among youth the smoking rate decreased from 26% to 18% 2006-2013 (statistically significant).

Smoking prevalence, by sex



Interpretation: The smoking prevalence for males is higher than for females (statistically significant). Among youth, 19% of males and 17% of females are smokers.

Smoking by sex— time trend 2006-2013



Interpretation: 2006-2013 smoking rates decreased for both males and females. Female youth had the steepest decrease from 27% in 2006 to 17% in 2013.

Smoking and ethnicity

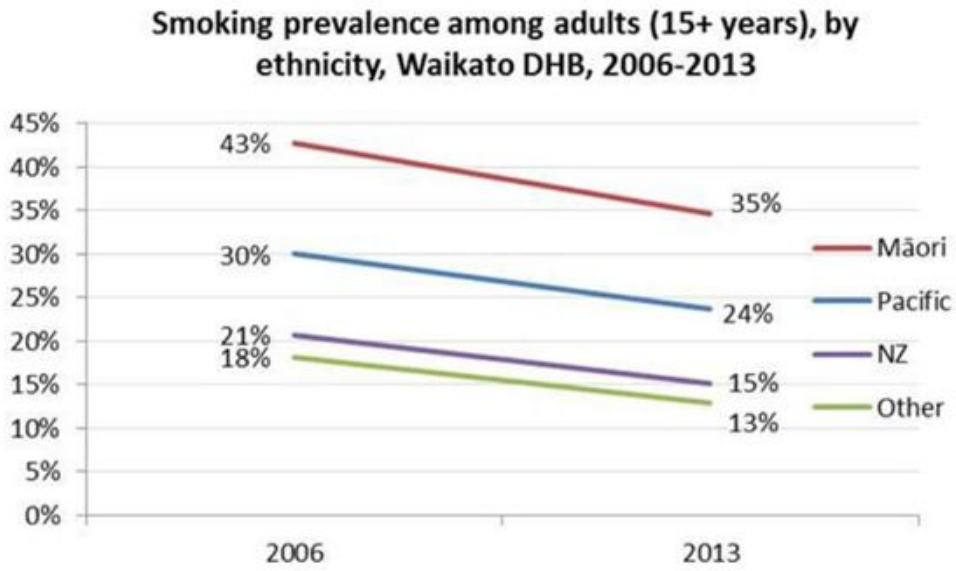
Smoking prevalence among youth and adults, by etnicity, Waikato DHB, 2006-2013

	2013		95%
Youth (15-24 years)	**Number**	**Prevalence (%)**	**Confidence Interval**
Māori	3966	31.3%	(30.5-32.1)
Pacific People	492	20.6%	(19.0-22.3)
Other	3642	12.1%	(11.8-12.5)
Waikato DHB	8100	18.0%	(17.6-18.3)
NZ	82896	15.8%	(15.7-15.9)
Adults (15+ years)			
Māori	15852	34.7%	(34.3-35.1)
Pacific People	1764	23.7%	(22.7-24.7)
Other	26166	12.9%	(12.8-13.1)
Waikato DHB	43782	17.1%	(17.0-17.3)
NZ	463194	15.1%	(15.1-15.2)

Data source: Statistics NZ 2013 Census

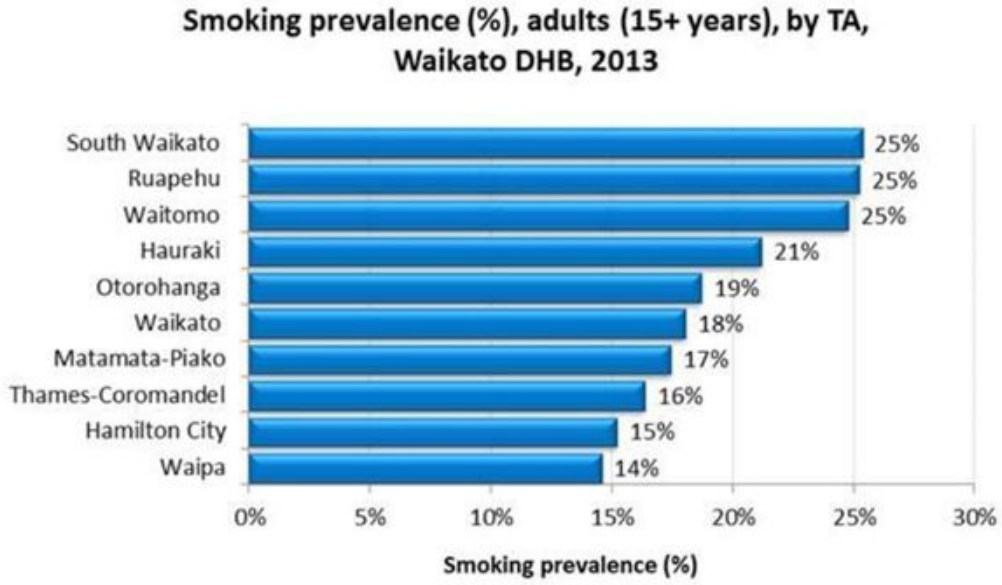
Interpretation: In adults and youth alike, smoking rates are higher for Māori and Pacific peoples compared to Other (2013). 35% of Māori, 24% of Pacific, and 13% of Other adults are smokers (statistically significant)

Smoking and ethnicity— time trend 2006-2013



Interpretation: 2006-2013 smoking rates decreased across all ethnic groups. In 2013, 35% of Māori adults were smokers compared to 43% in 2006.

Smoking prevalence, by Territorial Authority



Interpretation: The smoking rate vary greatly across the Territorial Authorities. The highest smoking prevalence rates are in South Waikato (25%), Ruapehu (25%), Waitomo (25%), and Hauraki (21%). Waipa (14%) and Hamilton City (15%) have the lowest rates.

Smoking prevalence, by Territorial Authority and sex

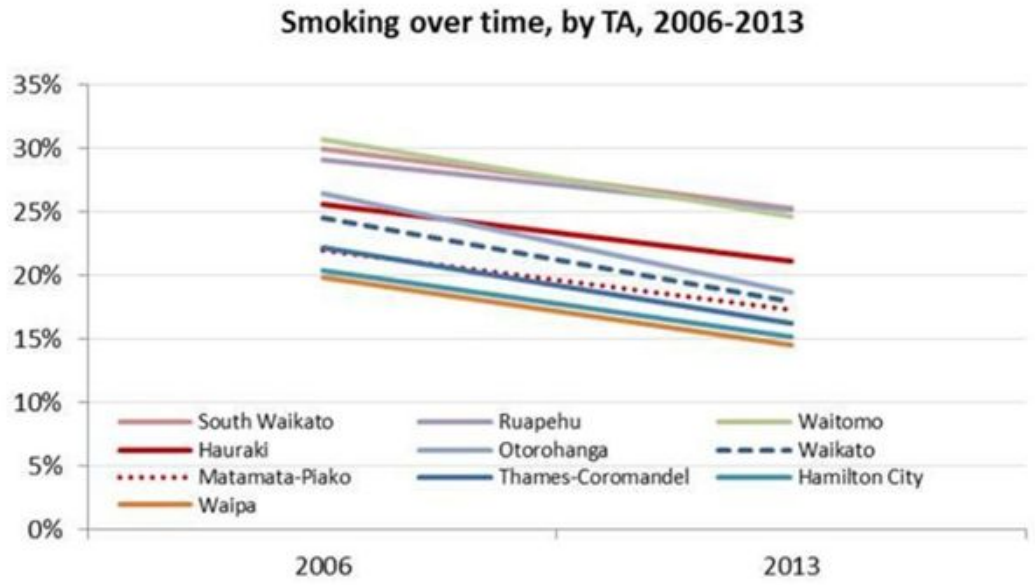
Smoking prevalence for adult (15+ years) males and females, by TA, Waikato DHB, 2013

	Total		Male		Female	
Territorial Authority	**Prevalence**	**95% CI**	**Prevalence**	**95% CI**	**Prevalence**	**95% CI**
South Waikato	25%	(24.5 - 25.9)	24%	(23.3 - 25.3)	26%	(25.1 - 27.1)
Ruapehu	25%	(23.9 - 26.3)	25%	(23.4 - 26.9)	25%	(23.6 - 27.0)
Waitomo	25%	(23.6 - 25.7)	24%	(22.0 - 25.1)	26%	(24.2 - 27.3)
Hauraki	21%	(20.4 - 21.8)	22%	(20.6 - 22.7)	21%	(19.6 - 21.5)
Otorohanga	19%	(17.6 - 19.6)	19%	(17.5 - 20.1)	18%	(17.0 - 19.8)
Waikato	18%	(17.5 - 18.3)	18%	(17.6 - 18.8)	18%	(17.0 - 18.2)
Matamata-Piako	17%	(16.8 - 17.8)	18%	(17.5 - 18.9)	17%	(15.8 - 17.1)
Thames-Coromandel	16%	(15.7 - 16.7)	17%	(16.1 - 17.6)	16%	(14.9 - 16.3)
Hamilton City	15%	(14.9 - 15.3)	16%	(15.8 - 16.5)	14%	(13.9 - 14.4)
Waipa	14%	(14.1 - 14.8)	15%	(14.5 - 15.6)	14%	(13.4 - 14.4)
Waikato DHB	**17%**	**(16.9 - 17.2)**	**18%**	**(17.5 - 17.9)**	**17%**	**(16.3 - 16.7)**

Data source: Statistics NZ 2013 Census

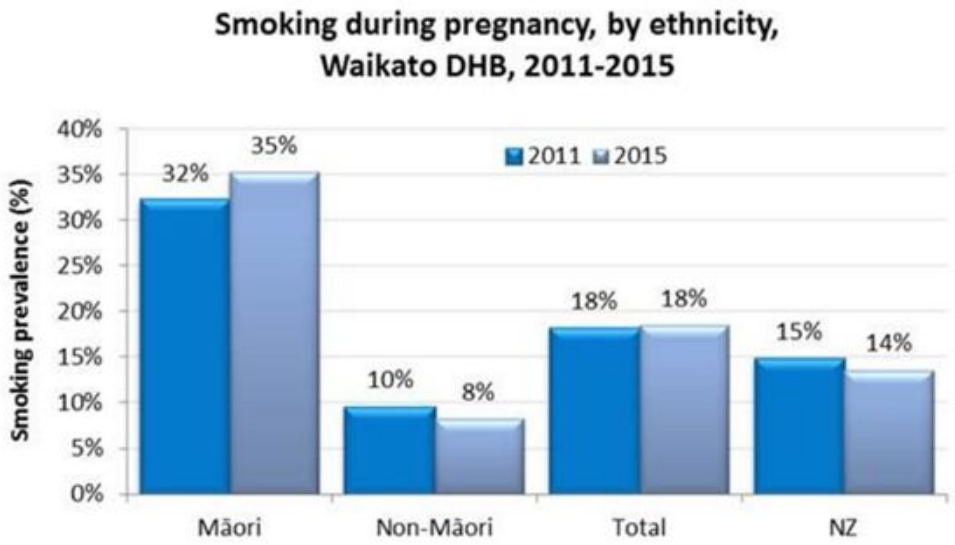
Interpretation: South Waikato, Ruapehu, Waitomo, Hauraki, Otorohanga and Waikato have significantly higher rates than overall Waikato DHB (the confidence intervals are not overlapping).
The highest prevalence rates are among females in South Waikato (26%), Ruapehu (25%) and Waitomo (26%) (not statistically significant). However, in the overall DHB females have lower rates than males.

TA time trend 2006-2013



Interpretation: Smoking rates have decreased across all Territorial Authorities 2006-2013.

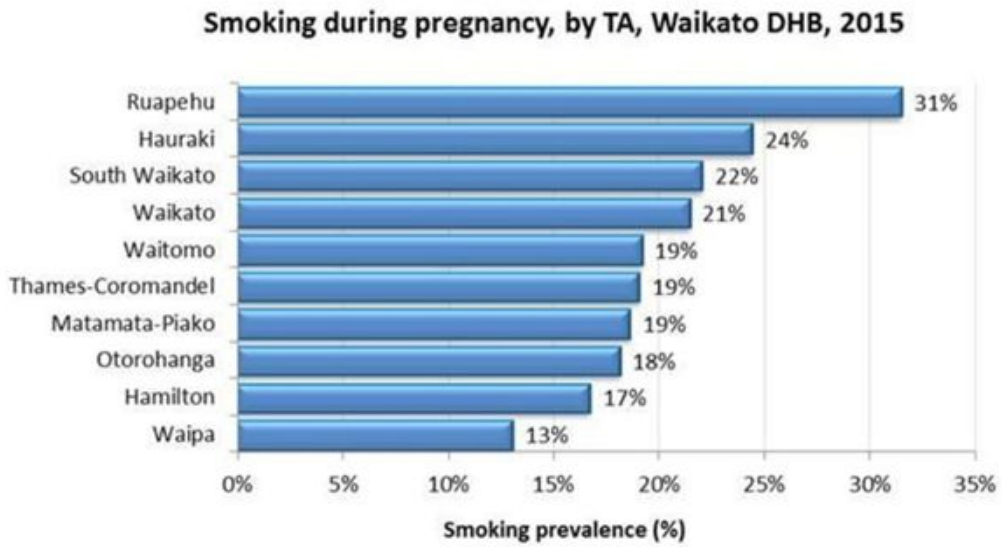
Smoking during pregnancy



Data source: Ministry of Health, National Maternity Collection

Interpretation: Smoking during pregnancy is more common in Waikato DHB (18%) than in overall NZ (14%) (statistically significant). A larger proportion of Māori women than non-Māori women smoke during pregnancy (35% vs. 8%). The prevalence has not changed significantly 2011-2015.

Smoking during pregnancy – by TA



Interpretation: The highest prevalence of smoking during pregnancy is in Ruapehu (31%), Hauraki (24%) and South Waikato (22%). In Ruapehu 1 in 3 women smoke during pregnancy (31%).

Appendix 3
Deprivation - The NZDep2013 index

Waikato DHB Deprivation

Deprivation

The NZDep2013 index is used to rank areas by relative deprivation, with 1 being the least deprived areas and 10 the most deprived areas.

The table below shows significant variation in smoking rates with those living in the most deprived communities nearly four times more likely to be regular smokers than the populations living in the most affluent decile. It should be noted that as a District Health Board we serve a relatively deprived population. More of the Census Area Units in the District are defined at the more deprived end of the spectrum, compared to the national distribution, which will see 10% of areas in each deprivation decile.

NZDep2013 index	Number of regular smokers	Percentage of regular smokers
1	1,122	8%
2	1,893	9%
3	1,974	13%
4	1,806	14%
5	4,386	15%
6	5,985	17%
7	4,467	16%
8	10,587	19%
9	8,958	23%
10	10,545	29%

Statistics New Zealand, Census 2013, Usually resident population, selected ethnic group

29

30

Presentations

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
8 AUGUST 2018

AGENDA ITEM 7.1

ORAL HEALTH SERVICES UPDATE

Purpose	For information

Introduction

The attached paper has been provided by the Community and Southern Rural Health Service as an overview of Waikato Oral Health Services, and their current performance.

A presentation by Katie Ayers and Jill Dibble will be provided at the Committee meeting.

Points to note in the Report

- The number of children (75,000+) enrolled in the Community Oral Health Service (COHS) has increased mainly due to the population increase and improved data collection with new IS systems;
- The Ministry of Health target for 2017 for arrears[1] (when children are not seen within 12 months) was not achieved. There are a number of reasons for this outlined in the update. Mitigations are included;
- COHS referred 1,100 children for dental treatment under general anaesthetic (GA) during the last 12 months with a shortfall of 226 children/adolescents still on the waiting list. Workforce and theatre availability along with the increased complexity of care required are some of the reasons for this. Mitigations are included in the paper;
- The average percentage of caries free 5 year olds has continued a steady improvement year on year;
- Year 8 children also show significant improving oral health statistics in terms of caries free and lowering DMFT rates;
- There are a number of successes and innovations outlined in the paper;
- While the number of adolescents attending the dentist has increased each year, the Waikato adolescent population has increased by approximately 2000 since 2013, resulting in a relatively stable overall utilisation rate. There have been minimal changes though in adolescent utilisation by ethnicity. Māori and Pacific continually have utilisation rates that are unacceptably lower than those for non-Māori;

[1] Arrears is a measure of children who
- have not had their oral health assessment appointment and
- don't have an appointment for this booked

- Opportunities to improve on existing services have been outlined.

Recommendation
THAT
The Committee discuss the content of the report.

JILL DIBBLE
DIRECTOR
COMMUNITY & SOUTHERN RURAL HEALTH SERVICES

Waikato Oral Health Services

A Service Delivery and Performance Overview by the Community and Southern Rural Health Service of Waikato DHB

1. Community Oral Health Services (COHS)

Coverage

Waikato Community Oral Health services provide coverage across 21,000km with eight fixed clinics in schools (Frankton, Peachgrove, Fairfield, Crawshaw, Matamata, Morrinsville, Tokoroa, Cambridge) ranging from 1 chair to 6 chair facilities.

The service also has 12 mobile dental units and 3 assessment units.

The age of the enrolled population ranges from pre-schoolers to high school aged youth (see later section in this paper for adolescent specific information). The service is provided through universal entitlement.

In the 2018-19 financial year Community Oral Health operate with funding of $10,441,000.

Enrolments to 30 June 2018

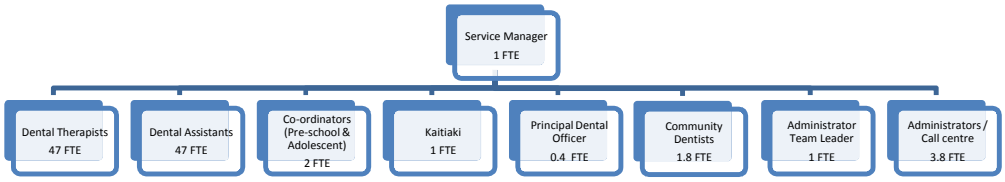
Total	76026
Maori	24073
Other	48892
Pacific Islander	3061

Schools

Approximately 255 schools are visited by a mobile unit, or are seen in local facilities across the district.

Strategy and Funding also provides funding to Sport Waikato to include oral health education as part of the Early Child Education programme. This involves 121 early childhood education centres at a cost of $20,122.00.

COHS Staffing Model (current):



Recruitment is currently underway for a 1 FTE operations manager. A business case is in progress for a 1 FTE systems administrator for the Titanium client management system.

Service Challenges

Arrears

ArrearsTarget: 10%	Results: 18%	Not achieved
a) 95% preschool enrolment, (population denominator 28,230) b) arrears at 10%	20431 or 77% 12,584, 18%	Not achieved Not achieved

The Ministry of Health (MoH) target for 2017 for arrears[1] (when children are not seen within 12 months) was not achieved. Contributing factors for this include:

- Implementation of new Titanium software programme and the impact of staff training on performance;
- The service was scoped to provide 1.8 appointments per child, however to ensure timely interventions and oral health education, the service does an average of 2.0 appointments per child;
- Vacancy factors, particularly in rural areas; and
- Offering enrolled pre-schooler appointments from nine-months of age.

Mitigation plans to address Challenges:

- Low risk patient groups to be seen on 15 month rotation to provide additional time; and resource for high risk groups to be seen 6 monthly for fluoride applications;
- Saturday and evening clinics in selected locations with high arrears;
- Promotion of Waikato DHB to under-graduate dental therapists; and
- Work progressing on changing MECA agreement allowing therapists to work eight hour days and enable staff to work through school holidays to increase capacity.

Dental GA waitlist

All dental surgery needs to comply with MoH Elective Surgery Performance Indicators (ESPI) and be treated within 4 months of being accepted onto the inpatient waitlist. For Thames and Te Kuiti patients, this is from point of referral. Waikato hospital patients are required to attend an FSA appointment prior to acceptance onto inpatient waitlist.

Capacity of scheduled theatre sessions for dental surgery at the three DHB facilities is approximately 850 children per annum. The did not attend (DNA) rate ranges between 12 – 22%. COHS referred 1,100 children for dental treatment under general anaesthetic (GA) during the last 12 months with the shortfall shown in table below (includes over 18 years age patients).

Sustainability by Clinician

	Last 12 Months			Last 90 days			Delivery Capability		
Clinician	Total Added	Total Removed	Net Movement	Total Added	Total Removed	Net Movement	Historic removal Rate	Total currently Waiting	Shortfall
Dental Surgery	1405	1134	271	413	286	127	170	396	226
Grand Total	1405	1134	271	413	286	127	170	396	226

[1] Arrears is a measure of children who

- have not had their oral health assessment appointment and
- don't have an appointment for this booked

Reasons for increased referrals / reduced capacity:

- Increased number of enrolled children (75,000+) in COHS due to increased population and improved data collection with new IS systems;
- Reduction in number of children seen in full day theatres at Thames and Te Kuiti from 6 to 5 due to workforce availability and complexity of treatment required;
- Restriction of acceptance criteria for patients onto Waikato Hospital GA waitlist resulting in significant increase of numbers referred to Te Kuiti and Thames;
- Decrease in the number of scheduled theatres for Waikato department from 3 to 2 lists per fortnight; and
- Increased complexity of care required for high need groups. Some of this could be attributable to poor lifestyle choices including food selection.

This is being mitigated by the following activities:

- Large number of preventative initiatives successfully deployed by COHS;
- Reduction in DNA rates in rural facilities;
- Thames providing first choice for free theatre time to dental;
- Outsourcing theatre sessions to Braemar and Anglesea facilities.

Current dental GA waitlist numbers as at June 2018:

Te Kuiti – 100
Thames - 160
Waikato Inpatient (under 18 years) - 100
Waikato Outpatient (under 18 years) - 100

Delivery capability without increase theatre capacity and access to anaesthetists will result in increasing delays to access care and breaching as shown in below graph as at June 2018.

Sustainability by Clinician

	Last 12 Months			Last 90 days			Delivery Capability		
Clinician	Total Added	Total Removed	Net Movement	Total Added	Total Removed	Net Movement	Historic removal Rate	Total currently Waiting	Shortfall
Dental Surgery	1405	1134	271	413	286	127	170	396	226
Grand Total	1405	1134	271	413	286	127	170	396	226

Planned outsource sessions to reduce waiting list numbers will be an ongoing waitlist management strategy.

Successes and Innovation

Nitrous Oxide Sedation (NOS)

- Nitrous Oxide sedation facilities in Fairfield clinic has successfully treated 48 children since being established in the four months from March 2018. These children would have otherwise required dental surgery under GA.

Co-ordinator Activities

- Fluoride applications in Primary Schools with high risk / non fluoridated water
- Oral Health education delivered in Early Childhood centres (not visited by Under 5 Energize), primary and high schools, wharekura, teen centres, Hapu Wananga and parent groups.
- High success rate with Hapu Wananga with approximately 1350 referrals per annum for 0 to life into oral health (community and private providers)
- Advising Tamariki Ora well child providers on access to service

Tooth Brushing Programmes

- Once a day brushing programmes at high need schools. Currently at 2 schools in Waikato with 2 more to shortly come on board. Provision of tooth paste and brushes, train the trainer sessions with educational staff and follow up and support.

Under 5 Energize

- Provision of education and workshops with staff, children and whanau on oral health in 126 early childhood centres across Waikato working closely with COHS

Promotional Days / Activities

- Multi community based events tailored to group need with education, fluoride application, enrolment and triage checks etc.
- Home Visit Programme – working with Plunket to provide home visits with dental therapist plus co-ordinator alongside Plunket nurse to provide oral health checks in homes of those who would not visit clinic setting.
- Liaison with contracted dentist providers for adolescent enrolments and attendance.

Titanium System Quality Improvement

- In considering mobility of families and the associated risk of children missing out on needed care when they relocate, the service developed a notification to other DHBs when children relocate from Waikato and into their area including contact information and when the patient was last seen within Community Oral Health.

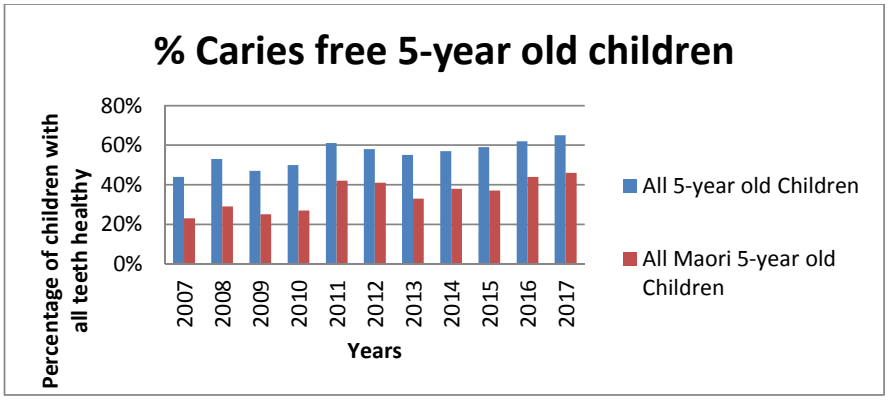
Kaitiaki

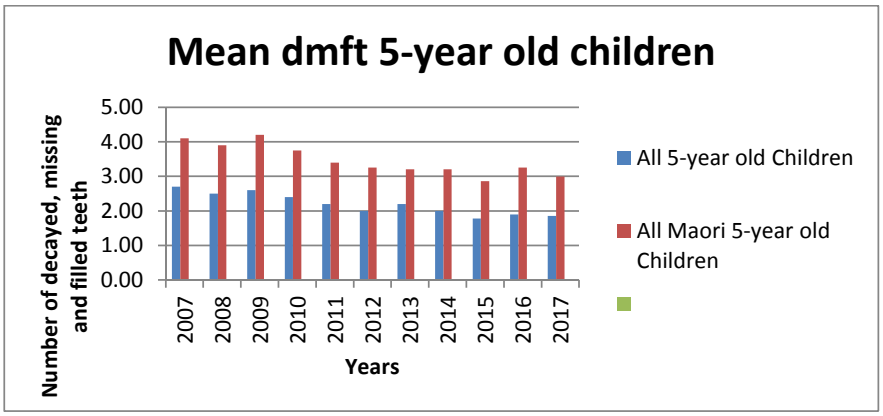
- 0.8 FTE of Kaitiaki services to help reduce inequalities in particular Maori children in high need areas. Include assistance with consent forms signed, distribution of resources as needed, referrals for high DNA patients and health promotion

Oral Health of Waikato Children

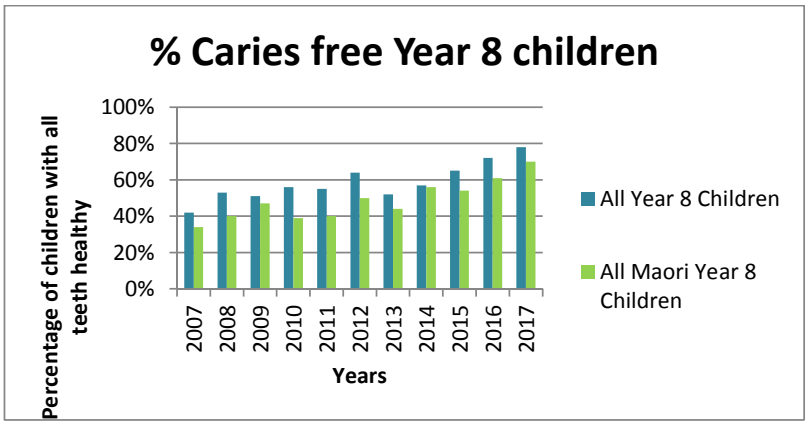
Children who identify as Maori are less likely to be caries free and are more likely to have decayed, missing and/or filled teeth (DMFT) however the inequalities gap is reducing.

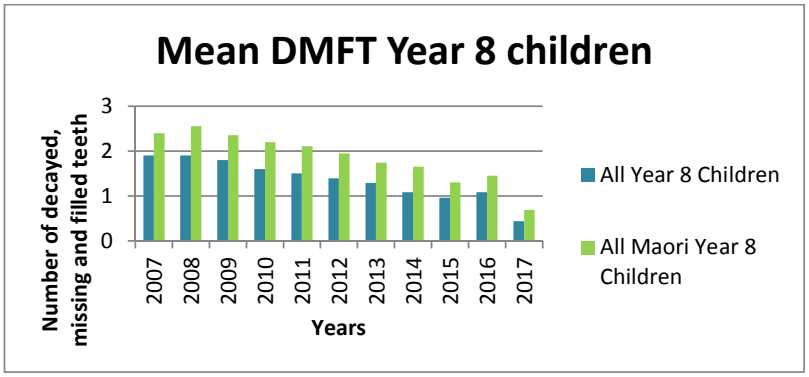
5 YEAR OLD STATISTICS: The average percentage of caries free 5 year olds has continued a steady improvement year on year. The mean DMFT of 5 year old children also improves with lowering figures





YEAR 8 CHILDREN STATISTICS: Year 8 children also show significant improving oral health statistics in terms of caries free and lowering DMFT rates





See Appendix 1 for areas of Community Oral Health Focus 2018-19

2. Adolescent Oral Health Services

Free adolescent dental services are available from Year 9 until the day preceding an individual's 18th birthday. This is not conditional upon an adolescent attending school.

The critical importance of this service is that if adolescents are dentally fit by age 18 they are likely to have good teeth for life and not face substantial bills in future years. Once the eligible population in NZ are over 18, the only service some DHBs cover (including Waikato District Health Board) is dental care for the relief of pain or infection for people with CSC cards. There is limited support from WINZ.

In the Waikato, adolescent services are provided by 79 Combined Dental Services Agreement providers. These are mostly private dentists operating within the region. Six of these contractors offer a mobile service attending local secondary schools. The preschool and School Service delivered by Rural and Southern Community Health Services (Waikato District Health Board) outlined in Section 1, provides a 'safety net service' aiming to treat adolescents who would not otherwise access dental care (e.g. those in rural/remote areas).

Uptake

The greatest challenge we have is to increase access and utilisation by Maori and Pacific adolescents. Although almost all adolescents are enrolled with a dentist or mobile provider when they enter secondary school, getting adolescents to attend dental services, even when they are free and close to where they live, remains stubbornly difficult.

The numbers of adolescents accessing care by ethnicity are presented in Table 1 below.

Note these figures refer only to adolescents attending the dental surgery on at least one occasion, not necessarily those completing all required dental treatment. Each year adolescents are entitled to a free examination, X-rays, clean, preventive treatment (such as fluoride varnish and fissure sealants) and other required general dental treatment. Some specialist services are funded on a case-by-case basis.

Table 1: Number of adolescents accessing dental care by ethnicity, population statistics, and utilisation rate by calendar year – combined dental agreement.

Calendar Year:	2017 (Estimate)	2016	2015	2014	2013
Adolescents seen					
Maori	4012	3843	3718		
Pacific	529	502	492		
Other	12959	13056	13295		
TOTAL	17500	17401	17505	17355	16995
Population					
Maori	8230	8185	8155	7950	
Pacific	940	935	915	910	
Other	15305	15465	15795	15970	
TOTAL	24475	24585	24865	24830	23830
Utilisation rate (%)					
Maori	48.7	47.0	45.6		
Pacific	56.3	53.7	53.8		
Other	74.7	84.4	84.2		
AVERAGE	71.5	70.8	70.4	69.9	71.3
Annual expenditure ($000s)	$3,234	$3,499	$3,454	$3,336	$3,378

Notes –

1. *Claim data by NHI did not commence until 2015 so ethnicity breakdown is not available prior to this.*
2. *Confirmed figures for 2017 are not yet available and have been estimated.*

While the number of adolescents attending the dentist has increased each year, the Waikato adolescent population has increased by approximately 2000 since 2013, resulting in a relatively stable overall utilisation rate. There have been minimal changes in adolescent utilisation by ethnicity; Maori and Pacific continually have utilisation rates that are unacceptably lower than those for non-Maori.

Where mobile dental vans visit secondary schools Maori utilisation is very high. There are however other issues in respect to mobile dental services. For example, duplication of claims is an issue when students visit both their own dentist and the mobile service, resulting in the Waikato District Health Board paying twice. In addition, there is on-going concern within the dental community that some mobile providers don't provide best-practice treatment, or complete treatment for all adolescents, leaving local dental practices to manage urgent treatment that arises between mobile visits. Waikato District Health Board continues to try to address this through clinical advice and audit.

Annual (informal) analysis is undertaken to better understand adolescent uptake. Interim results for 2017 indicate an estimated coverage (uptake as a percentage of the school role figures reported to Ministry of Education each July) as follows, where a mobile provider is the predominant service:

College/High School	Location	% access
Huntly College	Huntly	89.6%
Te Kauwhata College	Te Kauwhata	94.0%
Te Wharekura o Rakaumanga	Huntly	92.8%
Nga Taiatea Wharekura	Hamilton	100.0%
Hamilton Boys High School	Hamilton	98.9%
Tai Wananga	Hamilton	82.6%

College/High School	Location	% access
Hamilton's Fraser High School	Hamilton	85.4%
Melville High School	Hamilton	71.7%
Fairfield College	Hamilton	65.5%

The Ministry of Health has set an annual adolescent utilisation target of 85% so we have further work to do in this area, particularly in reducing inequities in access, and the associated inequalities in oral health status. Data is not routinely collected on the oral health of adolescents as it is for 5-year-old and year 8 children. This is being considered at a national level.

Mitigations to address uptake challenges:

Previous attempts at offering incentives for adolescents to attend the dentist or dental therapist have not been particularly successful. Some providers offer incentives such as $10 gift cards for adolescents who attend for dental treatment, but Waikato District Health Board does not incentivise adolescent attendance at present.

There is interest in the idea of establishing/ promoting private providers to offer a mobile dental service that is designed with adolescents in mind (appealing branding, availability of Wi-fi on site, young enthusiastic staff, public-private partnership opportunities such as free mobile data for attending) but of course funding will need to be made available for this, and there would need to be a particular focus on Maori and Pacific Island groups.

Waikato District Health Board also holds a number of special contracts to enable children and adolescents with unique needs to access specialist dental services which are not included under the Combined Dental Services Agreement and are not available from the Health Waikato Dental Department. These include endodontic services for children and adolescents (2 providers, estimated annual expenditure $52,100 plus GST), and orthodontic and complex restorative dental services for adolescents (4 providers, estimated expenditure $46,310.56).

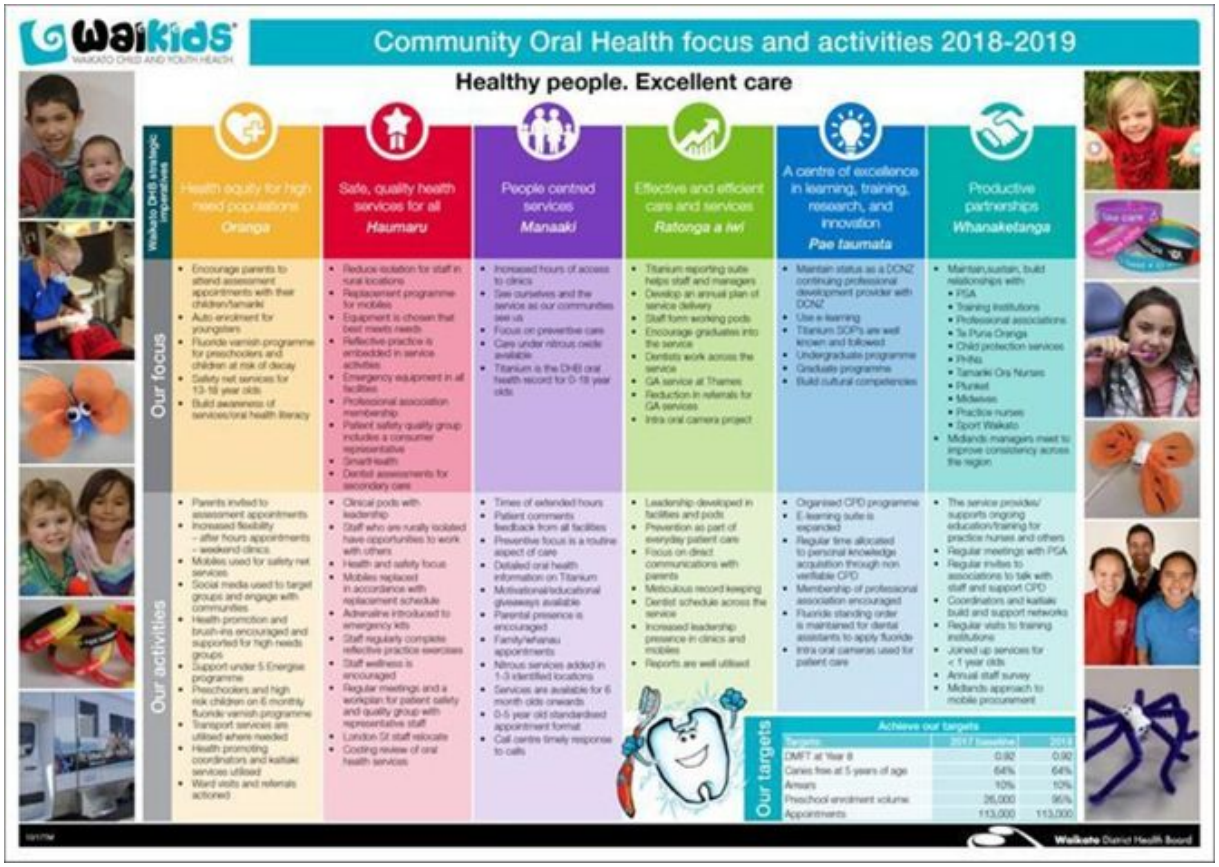
Opportunities to improve on existing services

- Smoke-free training for child and adolescent oral health providers – encourage referral of adolescents and whanau to smoking cessation services
- Investigate opportunities to include oral health in the educational curriculum, perhaps at year 9 or 10 level
- Encourage schools, sport teams and marae to adopt and implement water-only policies
- Increase engagement with adolescent providers – e.g. provide free continuing development sessions, incentives for increasing numbers of patients completing treatment, annual thank-you for continuing to provide valuable services
- Extend role of adolescent coordinator within COHS to provide adolescent dental contractors details of their enrolled patient group annually (instead of only for the Year 9 cohort), aiming to promote attendance and reduce duplication.
- Investigate possibility of using social networking platforms to encourage dental attendance e.g. ads on Instagram and/or Spotify reminding adolescents to get their dental check-up
- Investigate possibility of public-private partnerships to improve utilisation (e.g relationship with a mobile phone company to offer adolescents free data for attending dental services)

Recommendations:

- Conduct focus group research with adolescents, particularly those who are Maori/Pacific/low income to help determine what measures could be put in place to improve adolescent enrolment and completion of dental treatment
- Include the story / importance about utilising free dental care by adolescents in the Care in the Community Plan

Appendix 1


Waikids
WAIKATO CHILD AND YOUTH HEALTH
Community Oral Health focus and activities 2018-2019
Healthy people. Excellent care
Waikato DHB strategic imperatives
Health equity for high need populations
Oranga
Safe, quality health services for all
Haumaru
People centred services
Manaaki
Effective and efficient care and services
Ratonga a iwi
A centre of excellence in learning, training, research, and innovation
Pae taumata
Productive partnerships
Whanaketanga
Our focus
Our activities
Our targets
Achieve our targets
Waikato District Health Board

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
8 AUGUST 2018

AGENDA ITEM 7.2

PROJECT ENERGIZE UPDATE FROM SPORT WAIKATO

Purpose	For information

Background

Project Energize has been funded by Waikato DHB for over 13 years and is the flagship programme of Sport Waikato. It is nationally recognised for its success in getting our children engaged in exercise, and is a significant health investment initiative of the DHB.

The attached paper has been prepared by Sport Waikato to provide CPHAC with a progress update on Project Energize, and to discuss programme development opportunities.

The paper should be considered in conjunction with a presentation to be provided at the August Community and Public Health Advisory Committee meeting by Sport Waikato.

Recommendation
THAT

1) The Committee **notes** the report and presentation.

2) The Committee **notes** the evaluation currently being developed.

3) The Committee **notes** the gaps in the current approach and opportunities for increased impact through expansion of the programme.

TANYA MALONEY
EXECUTIVE DIRECTOR
STRATEGY, FUNDING AND PUBLIC HEALTH

PROJECT ENERGIZE

A report prepared by Sport Waikato for the Community and Public Health Committee of the Waikato District Health Board

1. Purpose

This report provides an overview of the Project Energize Programme including the history of the Sport Waikato-Waikato DHB partnership, results of the programme to date, and the future aspirations for Sport Waikato and Project Energize to continue to enhance the health and wellbeing of Waikato Tamariki.

2. Sport Waikato Overview

Sport Waikato is a charitable trust that has been in operation for 32 years. Our vision is 'everyone out there and active' and we have been achieving this vision through targeted programmes and initiatives that aim to improve the health and wellbeing of our community. We rely on strong partnerships and have built our capability and success through relationships with organisations such as the Waikato District Health Board, Ministry of Health and Sport NZ over many years.

In 2016, Sport Waikato initiated the partnered development of a region-wide strategy for sport, recreation and physical activity for the Waikato– Moving Waikato 2025. We are the lead regional agency in delivering on the outcomes of this strategy and our current focus is on increasing the percentage of people meeting the physical activity guidelines with an emphasis in our first 18 months of this ten year strategy on the priority populations of women and girls and young people.

As an organisation Sport Waikato's funded programme areas cover some form of targeted physical activity for health outcomes across all ages of the life spectrum. From Under 5 Energize (Ministry of Health funded) through Project Energize in primary schools, right through to Green Prescription as an intervention for adults.

3. Project Energize Overview

Project Energize has been a flagship programme of Sport Waikato for over 13 years and a national rollout of this approach was listed as a policy within the new Government's manifesto in 2017, having previously been in Labour's manifesto in 2014.

Project Energize is an intervention based programme which initially was introduced to 63 primary schools in 2004. Energize is now delivered into all 240 primary and intermediate schools in the Waikato Region including adaptation into Te Reo to all kura kaupapa.

The main aim of Project Energize is to increase the amount and quality of physical activity and improve the nutritional status of primary and intermediate school aged children in the Waikato. The key tagline is 'Eat Healthy, Be Active, Have Fun!'. To achieve this a team of Energizers work with each school to increase teacher and child knowledge around physical activity and healthy eating using a through-school and into the wider community approach. This includes taking sessions in schools with educators and parents to help build the capability of educators to deliver the Health and Physical Education Curriculum where appropriate.

The following outlines the Energize approach in the two key focus areas of nutrition and physical activity:

Healthy Eating

- Promote water and milk as the best choice of drink
- Have water available to children in the classroom
- To encourage the consumption of milk and high calcium foods every day.
- To increase the consumption of daily consumption vegetable and fruit

- To educate and advocate for an increase in availability of healthy food at school and bought to school.

Physical Activity

- To encourage a minimum of 20 minutes of daily physical activity
- To encourage and advocate for 'home play' every day.
- Reduction in screen time
- Raise the awareness and importance and learning fundamental movement skills and physical literacy.

Each school has a designated Energizer who takes them through a needs analysis with all staff, which then turns into an action plan to work through across the year. An Energizer acts as the catalyst, facilitator, co-ordinator, ideas person who assists teachers, students and parents with physical activity and healthy eating initiatives within the school community.

Nutrition messages to parents are sent home through nutrition nuggets in the school newsletters and tip sheets which have a different topic each term.

A Home Play Challenge is developed each year to support the goal of reducing sedentary time after school.

In 2017 total deliveries by Energize into the Waikato school community can be summarised as follows:

- 923 Nutrition Sessions delivered to children
- 4987 Physical Activity Sessions delivered to children
- 978 Teachers attending Workshops/PD's
- 8,182 Parents attending an Energize supported Event/Delivery/Nutrition Presentation

Waikato DHB invests approximately $2,000,000 in Project Energize each year ($45 per tamariki) which has proven to be a low-cost intervention when compared to other primary school initiatives. This funding essentially helps place an agent of DHB healthcare into every village/community within the Waikato Region.

Energize is currently also operating in Northland through Sport Northland/Northland DHB and in Wellington through the Heart Foundation/Capital Coast DHB. Sport Waikato has also had discussions with other areas of New Zealand and internationally regarding the potential licensing and adaption of the programme.

4. Results

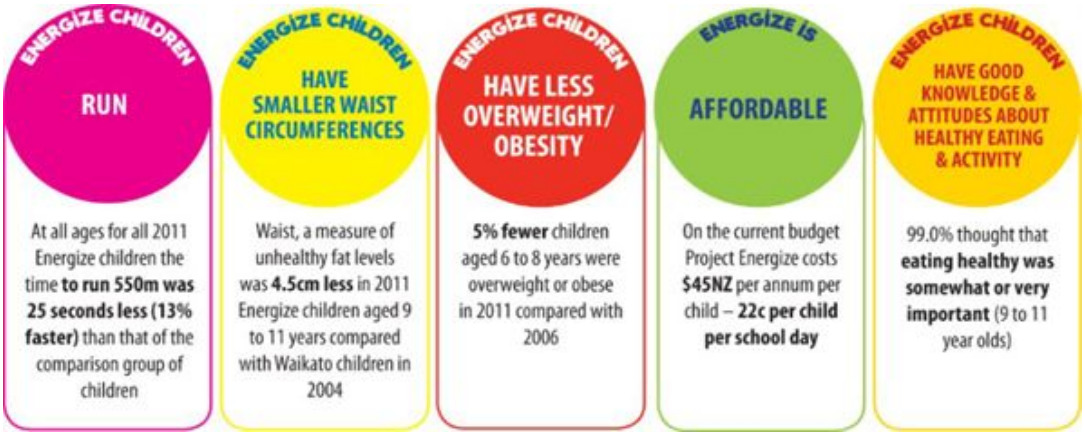
Project Energize has been extensively evaluated in the past by Auckland University of Technology (AUT) and evidence produced of the positive difference experienced in both the physical activity and healthy eating habits of Energized primary school students. The most recent evaluation occurred in 2011 and discussions are underway for a 2019 evaluation.

The following evaluative measures were undertaken in 2011:

- Height, weight, waist circumference
- Blood pressure
- BMI
- 550m run
- Knowledge and attitude survey

- Home survey
- School stock take

Broadly the results illustrated:



It is important that an evaluation is undertaken in 2019 to ensure that success of the programme continues and to allow for reflection and adjustment in delivery where required. Currently a partnership is forming between Sport Waikato, Waikato DHB, Waikato University and Auckland University of Technology (AUT) (the lead evaluators through Elaine Rush and Erica Hinckson) which will formulate the evaluation piece. Discussions to date have raised the potential to undertake a longitudinal study into the long term effectiveness to Project Energize given the longevity of the project. For an evaluation and a longitudinal study to occur further funding would be required from Waikato DHB.

5. <u>The Future</u>

Gaps
There is an opportunity for a stronger focus to be developed around the Project Energize work within intermediate schools. For many students transitioning into this bracket from primary school it is often their first opportunity to have their own money to purchase food both on the way to/from school and at the canteen. The opportunity would be for Energize to work more intensively with intermediates around canteen options, student nutrition and healthy fundraising options. A link could also be made through to age appropriate physical activity options outside of school and an introduction into more structured sport to assist with transition into secondary school/teenage years which traditionally has been a high drop off zone in terms of participation. For this to be addressed Sport Waikato would require further funding toward a full time equivalent to enable delivery to occur.

A similar undertaking could occur within the Waikato secondary school system and we would welcome further discussions with Waikato DHB around how to achieve health outcomes within this age bracket.

Nationally
There is a national lens over what is occurring in the Waikato currently with regard to Project Energize. Sport NZ are partnering with Sport Waikato to introduce the principles of Play.Sport into Hamilton to enhance the impact of Energize. Play.Sport focuses more on the development of the teaching workforce to enable champions within schools to be more proficient in delivery of the Physical Education and Health Curriculum.

Sport Waikato Leadership Team recently met with Minister for Sport and Recreation, the Honourable Grant Robertson, who mentioned that Project Energize is being discussed in health, sport and education circles in Wellington as the Government looks to wellbeing initiatives for the population.

Project Energize is able to be adapted to each region or school's specific needs and ultimately an aligned national programme would have great impact in improving the current obesity statistics in the country.

6. Conclusion

Sport Waikato believe that together with our partners in the Waikato DHB, Project Energize has taken a leading role in improving the health and wellbeing of all Waikato tamariki through a primary school intervention focussing specifically on increased amount and quality of physical activity and healthy eating.

We are thankful for the ongoing support of Waikato DHB and hope that in 2019 some form of partnered in-depth evaluative analysis can occur, as well as a move toward 'filling the gaps' of our physical activity and nutrition delivery into the school setting.

General Business

Date of Next Meeting
10 October 2018