Community and Public Health Advisory Committee / Disability Support Advisory Committee Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	10 April 2019	**Time:**	12:30 pm

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

Next Meeting Date:	12 June 2019	
Contact Details:	Phone: 07 834 3622	Facsimile: 07 839 8680

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Community and Public Health Advisory Committee / Disability Support 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 and Disability Support Advisory Committee; 13 February 2019 3.2 Lakes DHB Community and Public Health Advisory Committee; 18 February 2019 3.3 Lakes DHB Disability Support Advisory Committee; 18 February 2019 3.4 Bay of Plenty DHB Community & Public Health and Disability Services Advisory Committee; 7 February 2019
4.	**DISABILITY SERVICES** 4.1 No papers
5.	**PAPERS AND PRESENTATIONS** 5.1 Health System Plan – Goal, Actions and Activities 5.2 Waikato DHB Annual Plan 2019-2020 (draft) 5.3 Draft Public Health Annual Plan 2019-20 5.4 Te Pae Tawhiti Feedback 5.5 Waikato Drinking Water Assessment Service 5.6 Urgent and Emergency Care 5.7 REACH (Realising Employment Through Coordinated Healthcare)
6.	**WORK SCHEDULE** 6.1 Work Schedule for 2019/20
7.	**GENERAL BUSINESS**
8.	**DATE OF NEXT MEETING** 8.1 12 June 2019

Apologies

Interests

SCHEDULE OF INTERESTS AS UPDATED BY COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEMBERS TO APRIL 2019

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	

Note 1: Interests listed in every agenda.

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

Sally Webb

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

Crystal Beavis

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

Pippa Mahood

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

Note 1: Interests listed in every agenda.

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

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			

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	Non-Pecuniary	None	Refer Notes 1 and 2
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,			

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

both of which receive health funding **Disability issues blogger (opticynic.wordpress.com)**			

Te Pora Thompson-Evans

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

Rob Vigor-Brown

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

Mark Arundel

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB **Board member, Bay of Plenty DHB** **Member, Pharmaceutical Society of NZ** **Trustee, TECT (Tauranga Electricity Consumer Trust)** **Wife is an employee of Toi Te Ora (public health)**	Non-Pecuniary	None Potential	Refer Notes 1 and 2

Judy Small

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

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

Minutes
and
Matters Arising

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Community & Public Health and Disability Support Advisory Committee held on 13 February 2019 commencing at 12.30pm

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

In Attendance: Ms T Maloney, Executive Director, Strategy, Funding & Public Health
Dr D Tomic, Clinical Director Primary and Integrated Care
Mrs MA Gill, Waikato DHB Board member
Mr M Gallagher, Waikato DHB Board member
Prof M Wilson, Deputy Board Chair
Mr W Skipage, Strategy and Funding
Ms R Poaneki, Strategy and Funding
Dr F Dumble, Medical Officer of Health
Dr R Vipond, Medical Officer of Health
Dr R Wall, Medical Officer of Health
Mr G Morton, Strategy and Funding
Prof R Lawrenson, Population Advisor

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

Ms S Webb joined the meeting via teleconference.

ITEM 1: APOLOGIES

No 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

3.1 Waikato DHB Community & Public Health and Disability Support Advisory Committee; 12 December 2018

The Committee requested that a rec-cap of the discussion of the minutes regarding item 7.1 "Review of Waikato DHB Position Statements on Tobacco Control, Alcohol Harm, and Psychoactive Substances" be brought back to the April Committee meeting to better reflect the Committees desire for the DHB to be pro-active and show strong leadership around achieving the 2025 target of a smoke free Aotearoa.

It was also requested that an overview of the diabetes service be included in the Work Schedule under the topic "Prevention and Management of Long Term Conditions".

Resolved
THAT
The minutes of a meeting of the Waikato DHB Community and Public Health and Disability Support Advisory Committee held on 12 December 2018 be confirmed as a true and correct record, subject to further discussion at the 10 April 2019 meeting regarding the Smokefree target.

3.2 Lakes DHB Community and Public Health Advisory Committee

No minutes available. Next meeting 18 February 2019.

3.3 Lakes DHB Disability Support Advisory Committee.

No minutes available. Next meeting 18 February 2019.

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

Minutes for 7 February 2019 meeting are to be brought to the next Waikato DHB CPHAC/DSAC meeting.

ITEM 4: DISABILITY SERVICES

4.1 Disability Responsiveness Plan Update

Ms R Poaneki joined the meeting for this discussion.

A community stakeholder meeting had been held at the end of January 2019 to develop the aspirations of the Disability Responsiveness Plan. Attendance at the hui included Committee members, Mr D Slone and Ms J Small.

Key directions would be formally shared with all forum participants and incorporated into planning documents.

Members highlighted the importance of defining who should be invited to represent the disability sector, noting the intellectual impairment group was often not well represented. Management acknowledged that "Disability Sector" representation needed ongoing consideration.

Hui invitations had been extended in consultation with co-chairs of the Consumer Council. Ms TP Thompson-Evans highlighted that a Rural Group from Matamata had not been extended an invitation.

It was also highlighted that the focus should be on access to services rather than focussing on a disability.

Resolved
THAT
The Committee received the report.

ITEM 5: PAPERS FOR DECISION

5.1 Review of Position Statements on Immunisation, Urban Environments Housing and Land Transport

It was agreed that all future Waikato DHB Position Statements should include a statement regarding how health inequities for Māori will be eliminated to ensure the radical improvement in Māori health outcomes.

Immunisation
Presented by Dr F Dumble, Medical Officer of Health this position statement remains largely unchanged with an equity focused approach to improve immunisation.

Dr F Dumble highlighted there have been 12 confirmed cases of measles in 2019 and that further outbreaks of Measles, Mumps and Rubella (MMR) would continue without herd immunity (95% of population).

The increasing equity gap remained a concern, and work alongside the Strategy and Funding and Te Puna Oranga Units was underway to look at ways to decrease this gap. This included a review of messaging and investigating who and where else the vaccine could be administered.

It was acknowledged that whilst the current immunisation messages were working for part of the population, more work needed to be done on appropriate message for the communities the DHB are not reaching. Some Committee Members noted that the Position Statement did not adequately address the needs of Maori.

Members requested that information on the uptake of the HPV vaccine be included in the CPHAC work schedule. The vaccine had recently been extended to the male population.

Urban Environments

Dr R Wall attended for this agenda item.

This position statement has been strengthened with a view to ensure health is considered in the planning, build and renewal of urban infrastructure; alongside recognition of the effects of climate change and natural hazards.

It was requested that the Position Statement be strengthened by:

- The specific inclusion of Health Equity Tools in line with the Ministers Letter of Expectations around inequities.
- Additional information being added to the "Key information" section regarding the DHB being pro-active in the decision making of other community organisations such as schools, licensing trusts and district planning. For example when local schools fenced off public school fields, or unhealthy food was sold in schools.

The Waikato DHB had provided comment as part of the Ministry Of Health Submission on Gambling, which would be circulated to committee members. Further opportunities had recently opened up and it may now be possible for the DHB to provide its' own submission. Timeframes would also be circulated to committee members.

Housing

Dr R Vipond attended for this agenda item.

The updated Housing Position Statement had been strengthened to reflect the government's priority to ensure New Zealander's have access to warm, dry homes that are affordable and secure.

Committee members asked for the Position Statement to be modified by:

- Strengthening the section regarding "affordability of owning and running the house". Correction of spelling from "owing" to owning".
- Include a set of principles reflecting a "Waikato" flavour and how we advocate for Waikato's "patch". This should include social housing.

It was acknowledged that further discussion was required on the role of Public Health, with a more proactive approach needed to influence the areas that impact on people's health.

Land Transport
Dr R Vipond presented this Position Statement.

The updated Land Transport Position Statement places a stronger emphasis on the value of collaboration in land transport planning and advocates for post-crash care to be embedded into road safety policy as the fifth pillar of the Safe System approach to road safety.

Resolved
THAT
The Committee approved the position statements with the noted modifications.

ITEM 6: PAPERS FOR INFORMATION

6.1 Rural Health – A Waikato Perspective

Presented by Professor R Lawrenson, members were provided with an update of the issues facing rural communities within the Waikato DHB area. A copy of the presentation would be circulated to members.

Points highlighted included:

- The largest population of rural Māori are young whereas the larger population of rural pakeha are in the older age bracket.
- People with disability do better in urban areas. Increasing migration to rural population due to housing cost will have an impact on this.
- There is no provision for access to out of hours for areas between Hamilton and Middlemore. Management highlighted that a review of urgent care is currently underway which included GP requirements for after hours care.
- New government subsidy for community card holders should provide greater access and targeted the high needs population.
- The building of the initial Waikato DHB car park building sent a message that communities were to come to Waikato Hospital rather than being managed locally.
- Challenges existed with rural workforce recruitment. This was exacerbated by there being no Waikato DHB rural doctors training programme. The placement of PGY1 and PGY2 in rural hospitals had been introduced over the last 3-4 years but further work is to be done to look at making rural runs available for junior doctors.
- Rural health is more than just the identified gaps. What outcome do rural communities want and how do we develop communities to take care of their own health?
- Two of the six Care in the Community Plan (CCP) goals are; “partnering with Māori, and support community aspirations and address determinant of health”. A workshop on the CCP is to be held with the Board in late February. The Plan will then be brought to a future committee meeting.
- Rural mental health needs to be incorporated into the Mental Health Strategy and needs to address out of hours services for acute mental health.

Resolved
THAT
The Committee noted the presentation.

6.2 Waikato DHB Annual Plan Update 2019-20

Mr G Morton attended for this agenda item, and provided a brief update on the process for the development of the Annual Plan and the Statement of Intent along with the key points of the Minister's Letter of Expectation.

Further guidance is still awaited from the Ministry and will be incorporated into the planning process once received. An update will be provided to the April Committee with the final draft being presented to the June CPHAC meeting.

It was highlighted that the Ministers Letter of Expectations is very clear regarding achieving equity for Māori; these expectations and the need for conversations/discussion with Iwi Māori Council should be reflected in the planning process.

Resolved
THAT
The Committee noted the report.

6.3 Te Pae Tawhiti Update

Committee members provided feedback on the draft "Framework for change for Waikato Mental Health, Alcohol and Other Drug Services 2018 -2030" which was released to the sector for feedback in late 2018. Further refinement of the framework will be undertaken to incorporate the feedback as follows:

- The framework incorporates the Te Pae Tawhiti models of care and the Creating our Futures Plan. There were a number of models of care (MoC) underpinning the framework. The MoC have more detail about services. "Disability" had not been one of the original models of care and therefore was not specifically included. However it was agreed to note the need for improvement to services for those with Intellectual disability and mental health needs.
- Forensic services needs to be considered as part of the planning.
- It was highlighted that autism spectrum disorder (ASD) has consequences in Mental Health but with a different funding stream.
- Māori feedback on the Mental Health Inquiry has been summarised and may be useful in informing Te Pae Tawhiti.

Collated feedback on Te Pae Tawhiti will be brought to the next committee meeting alongside the Creating our Futures update.

Resolved
THAT
The Committee noted the report and provided feedback.

ITEM 7: PRESENTATIONS

7.1 Mental Health and Addictions System

Presented by Ms T Maloney, hard copies of the presentation Mental Health and Addictions System Draft System Map were tabled, and is appended to the minutes. The draft system map clarified on a single page what the DHB mental health and addictions should look like.

The starting point should be the social determinants of well-being, which included a focus on whānau and would also be addressed in the next steps of Te Pae Tawhiti work.

Resolved
THAT
The Committee noted the presentation.

ITEM 8: WORK SCHEDULE

Members requested the following changes be made to the 2019/20 Committee Schedule.

April
- Te Pae Tawhiti feedback to be included with Creating our Future

June
- The status of Oral Health be included with the Dental Health Services Overview

August
- HPV update to be included with Immunisation discussion

December
- Palliative care

Resolved
THAT
The Committee received the 2019/20 schedule with the above inclusions.

ITEM 9: GENERAL BUSINESS

Members acknowledged the recent appointment of Ms Adri Isbister to the role of Deputy Director General – Disability.

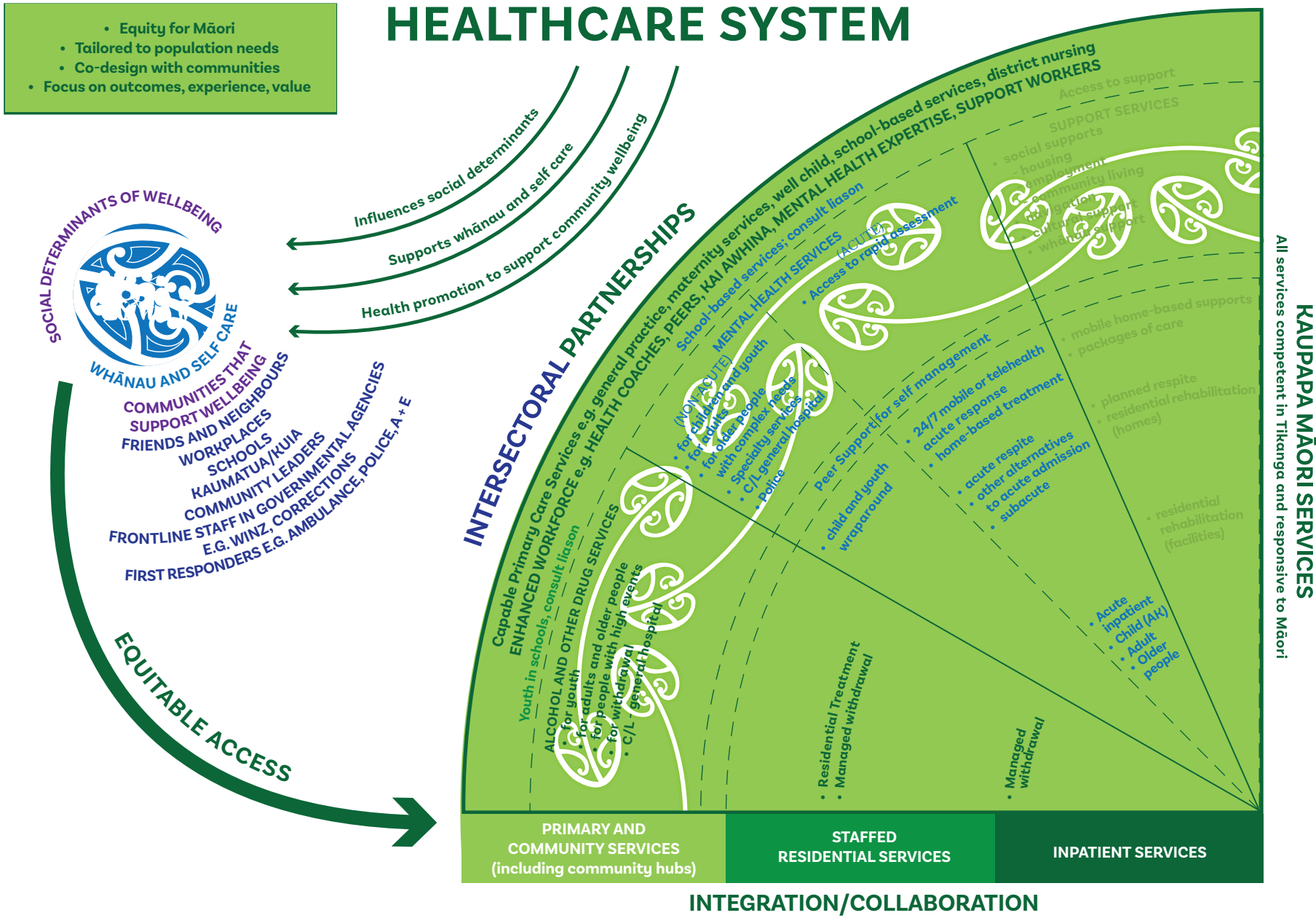
ITEM 10: DATE OF NEXT MEETING

10 April 2019

Chairperson: _____

Date: _____

Meeting Closed: 3:15 pm


• Equity for Māori
• Tailored to population needs
• Co-design with communities
• Focus on outcomes, experience, value
HEALTHCARE SYSTEM
Influences social determinants
Supports whānau and self care
Health promotion to support community wellbeing
SOCIAL DETERMINANTS OF WELLBEING
WHĀNAU AND SELF CARE
COMMUNITIES THAT SUPPORT WELLBEING
FRIENDS AND NEIGHBOURS
WORKPLACES
SCHOOLS
KAUMATUA/KUIA
COMMUNITY LEADERS
FRONTLINE STAFF IN GOVERNMENTAL AGENCIES E.G. WINZ, CORRECTIONS
FIRST RESPONDERS E.G. AMBULANCE, POLICE, A+E
EQUITABLE ACCESS
INTERSECTORAL PARTNERSHIPS
Capable Primary Care Services e.g. general practice, maternity services, well child, school-based services, district nursing
ENHANCED WORKFORCE e.g. HEALTH COACHES, PEERS, KAI AWHINA, MENTAL HEALTH EXPERTISE, SUPPORT WORKERS
Youth in schools, consult liason
ALCOHOL AND OTHER DRUG SERVICES
• for youth
• for adults and older people
• for people with high events
• for withdrawal
• C/L - general hospital
(NON-ACUTE)
• for children and youth
• for adults
• for older people
with complex needs
• Specialty services
• C/L general hospital
• Police
MENTAL HEALTH SERVICES
School-based services; consult liason
(ACUTE)
• Access to rapid assessment
Peer Support for self management
• child and youth wraparound
• 24/7 mobile or telehealth acute response
• home-based treatment
• acute respite
• other alternatives to acute admission
• subacute
Access to support
SUPPORT SERVICES
• social supports
• housing
• employment
• community living
• mobile home-based supports
• packages of care
• planned respite
• residential rehabilitation (homes)
• residential rehabilitation (facilities)
• Residential Treatment
• Managed withdrawal
• Managed withdrawal
• Acute inpatient
• Child (AK)
• Adult
• Older people
PRIMARY AND COMMUNITY SERVICES (including community hubs)
STAFFED RESIDENTIAL SERVICES
INPATIENT SERVICES
INTEGRATION/COLLABORATION
KAUPAPA MĀORI SERVICES
All services competent in Tikanga and responsive to Māori

LAKES DISTRICT HEALTH BOARD

MINUTES OF A MEETING OF THE COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE
HELD MONDAY 18th FEBRUARY 2019 at 1.00pm
TAUPO HOSPITAL CONFERENCE ROOM, KOTARE STREET, TAUPO

Meeting: **[148]**

Present: L Thurston (Chair), W Webber, D Shaw, M Raukawa-Tait, D Epp, J Morreau (from 1.10pm), P Mahood, B Edlin, A Morgan and A Pedersen

In Attendance: J Hanvey, K Stone, M Grant, D Oldershaw, N Saville-Wood, P Tangitu, K Evison, C Foley, M Grant, T Chapman, P King, L Pritchard (presenter) and B E Harris (Board Secretariat)

1.0 MEETING CONDUCT

The Chair welcomed everyone to the meeting asking P Tangitu to lead the opening karakia. Advice regarding early departure were registered by P Mahood & B Edlin. M Raukawa-Tait asked to be excused in light of an expected conference call during the meeting.

1.1 Apologies: T Te Akau and Dr J Miller
Resolution:
THAT the apologies be received.
L Thurston : P Mahood
CARRIED

1.2 Schedule of Interests Register
The register was circulated during the meeting with an entry made by A Pedersen's interest in AP Consultancy – Holistic Health Coach.

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

1.4 Items for General Business : Nil

1.5 Presentation by
Leonie Pritchard on Community Oral Health Service
Review, outcomes and recommendations

P King introduced L Pritchard, Manager of Population Health. The presentation covered:-

- Population Health Service Vision
- Oral Health Service Review
- Current Issues
- What does the oral health team say?
- Management structure options
- Team approach
- Key service directions
- Utilising resources
- Geographical spread
- The future

Congratulations were offered to L Pritchard on the considered approach to the Community Oral Health Service Review. Points made from the presentation were:-

- Focus placed on where concentration needs to be and flow down to the provision of service to schools
- The need to reduce the excessive DNAs– critical to get fundamentals
- Provision of free oral health –focus on addressing the inequalities – how can this be

integrated into other child health primary care services? Have dental care in primary for ease of access to service
- Prevention work rather than drilling and filling
- Looking at successful models in other places
- As many services as possible being offered from the hub during school holidays
- Wellbeing services could be placed within kura kaupapa
- Who are the most vulnerable?

It was suggested at the 10 June 2019 meeting an update on integration of oral health service and inequalities – inequity be provided, the results of the review and how any new structure will improve the outcomes

2.0 SIGNIFICANT ISSUES

2.1 **Integration**

2.1.1 Children's dental – examples – issues - opportunities
This item was included in the above discussions.

2.2 **Primary Health**

2.2.1 Pinnacle MHN report
D Oldershaw spoke to the report which he took as having been read. He briefly touched on the Lakes extended care team integration across the community to successfully deliver the Lakes DHB and general practice long term condition management plan and support child health in Taupo and Turangi.
Resolution:
THAT the Pinnacle MHN report be received.
L Thurston : M Raukawa-Tait
CARRIED

2.2.2 RAPHS report
K Stone took the RAPHS report as having been read. Issues brought up included:-
- Interest in feedback on the community services card initiative – barriers for those who need it most and what could be practically done to help people in a seamless way to support added advantage in health
- National Patient Experience Survey – an electronic survey MoH sent to patients
- Of concern was the high number of people reporting their inability to obtain prescriptions because of the cost involved
- Support for Advanced Care Planning – becoming more critical is the ageing population with many people suffering from chronic conditions
- Agreement to have domicile enrolment data to replicate report for Board Chair, D Shaw

Resolution:
THAT the RAPHS report be received.
K Stone : J Morreau
CARRIED

2.2.3 Te Arawa Whanau Ora report
Highlights were:-
- New initiative with Police – two Paearahi working with perpetrators of crime
- Collective Impact Whaimua – Respiratory initiative – a two year programme available for 60 whanau to improve quality of life by addressing the management of long-term conditions relating to respiratory disease
- TPK Housing – Te Arawa – housing repairs initiative for 26 whare in the areas of Te Arawa, Rotorua, Turangi and Taupo. This project targets kaumatua and those with health conditions
- Healthy Maori Women breast screening – National target 70%. In 2018 Lakes DHB Maori women rated 64.3%
- Cervical screening - support for all the "Smear your Mea" initiatives

Resolution:
THAT the Te Arawa Whanau Ora report be received.

M Grant : J Morreau
CARRIED

2.3 **Maori Health**

2.3.1 Maori Health report
Some of the points raised were:-

- Good engagement with iwi primarily around Lakes DHB Strategy and working with iwi governance at the front end
- Lakes DHB Annual Plan currently in draft form
- Community initiatives over the last six months – "Smear your Mea" campaign, wahakura programme and hapu wananga Tuwharetoa

2.3.2 Healthy Families Panui : December 2018
Resolution:
THAT the Maori Health report be received.
D Shaw : W Webber
CARRIED

2.4 **Public Health**

2.4.1 Toi Te Ora Public Health Service

2.4.1.1 Public Health Services report
The report gave updates on:-

- Kai Rotorua and Ka Pai Kai
- Sugar drinks in school, a significant issue for oral health of children
- Housing quality work in conjunction with cobalt

Resolution:
THAT the Public Health Services report be received.
J Hanvey : L Thurston
CARRIED

2.4.1.2 Public Health Medical Officer report
Members were all aware of the heat issue being experienced and noted that Tauranga had not had significant rain for five weeks. The heat guidelines raised awareness of the risks of hot weather to health with the best advice to avoid getting dehydrated on hot days.
Resolution:
THAT the Medical Officer report be received.
L Thurston : J Morreau
CARRIED

2.4.2 Influenza Vaccination – Increasing Lakes Uptake Rates
Discussion ensued with some of the points noted being:

- 2018 rates for the uptake of the influenza vaccination
- On-going low rates of coverage in the Lakes population
- Range of proposals to improve the uptake
- Consultation with key stakeholders
- Reviews utilised to inform the recommended proposals
- Particular attention paid to increasing influenza vaccination rates among priority population groups – Maori, pregnant women and the vulnerable
- Can implement most of the recommendations but need to address accuracy of performance – offer from Dr J Miller to help with data analysis and barriers to collecting information – over 80% inconsistent with information reported in NIR – need to be able to have cohesive view of immunisation provided – a systems incompatibility issue

Resolution:
THAT the committee receives the report
W Webber : J Morreau
CARRIED

3.0 SECRETARIAL

3.1 Minutes of Community and Public Health Advisory Committee meeting 8th October 2018

Resolution:
THAT the minutes of the Community and Public Health Advisory Committee meeting of 8th October 2018 be confirmed as a true and accurate record.
W Webber : J Morreau
CARRIED

3.2 Matters Arising : Nil

3.3 Schedule of Tasks:-
P King to provide B Harris with a date for the "stop/quit smoking" and community initiatives presentation.

3.4 Copy of presentation slides – Kia Wana Breastfeeding Services and The threat of antimicrobial resistance (AMR) : Noted

4.0 REPORTS

4.1 Community representative reports :

A Pedersen
- Marae restructure undertaken
- Met with M Ranclaud regarding Mental Health & Addiction Service for Mangakino

T Chapman
- Consideration of three Tuwharetoa representatives for Lakes DHB Advisory Committees
- Communication problem within iwi with its people and GPs
- Cancer focus group

A Morgan
- Tairawhiti Kuwatawata Programme – TRHOTA endorse programme and would be happy to roll out to Rotorua and Tuwharetoa
- Met on an informal basis with Acting CE, N Saville-Wood
- TRHOTA held a successful planning day on 16th February 2019 with P Tangitu and K Evison being involved
- Two resolutions were taken 1) support re-introduction of Lakes DHB Strategic Plan and 2) support re-introduction of Maori Strategic Plan
- Working on behalf of TRHOTA with N Saville-Wood, K Evison & P Tangitu on the Lakes DHB Annual Plan

Resolution:
THAT the community representatives' reports be received.
L Thurston : D Shaw
CARRIED

5.0 INFORMATION AND CORRESPONDENCE

5.1 Draft public Bay of Plenty DHB DSAC/CPHAC minutes 3rd October 2018

5.2 Draft public Waikato DHB CPHAC/DSAC minutes 12th December 2018

Resolution:
THAT the draft public BoP DHB DSAC/CPHAC minutes 3rd October and draft public Waikato DHB CPHAC/DSAC minutes 12th December 2018 be received.
M Raukawa-Tait : D Epp
CARRIED

5.3 Consumer Engagement

K Evison advised that in going forward, Strategy, Planning and Funding:-
- Will compile a list of where consumers are currently being used in the hospital and community
- What the process is for this and
- Where the gaps are

The list will help to identify what is currently working well and what needs improvement. Once the list is completed, Lakes will find the best way forward and find a suitable process for Lakes DHB as a whole.

The importance to clarify the purpose of consumer involvement and how Lakes financially supports any consumer participation and maintains support for anything established was noted.

Resolution:
THAT the committee notes this report. Strategy, Planning and Funding will update once the stock-take is completed later this year.
L Thurston : M Grant
CARRIED

6.0	**PUBLIC EXCLUDED**
6.1	Confidential minutes of CPHAC meeting held 8th October 2018
6.2	MURIAL Team minutes 6th September 2018
6.3	Team Rotorua minutes of ALT meeting held 13th September & 8th November 2018

Resolution:
THAT the committee move into Public Excluded at approximately 2.34pm
W Webber : L Thurston
CARRIED

Chair ..... 8th April 2019
L Thurston QSO JP

PUBLIC

LAKES DISTRICT HEALTH BOARD

SCHEDULE OF TASKS: COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

18th February 2019

Agenda Item	Action	Responsibility of	Timeframe
Presentations:			
Media campaign "stop/quit smoking and community initiatives this year	Presentation by Lakes DHB	Pip King	P King to advise Secretariat of presentation date
Hapu Hauora	Presentation on Hapu Hauora	Toi Te Ora	10th June 2019
Tasks			
Community Oral Health Service	An update be provided on integration of the oral health service and inequalities – inequity be provided , the results of the review and how any new structure will improve the outcomes	L Pritchard	10th June 2019

LAKES DISTRICT HEALTH BOARD

MINUTES OF THE DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD IN THE TAUPO HOSPITAL CONFERENCE ROOM, KOTARE STREET, TAUPO MONDAY 18th FEBRUARY 2019 AT 10.00AM

MEETING: **[No. 143]**

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

IN ATTENDANCE: K Stone, T Chapman, N Saville-Wood, V Russell, (from 10.29am - apologies for lateness from P Tangitu and K Evison) & B E Harris (Board Secretariat)

1.0 MEETING CONDUCT *(Agenda Item 1.0)*

The Chair welcomed everyone to the first DSAC meeting for the year. Introductions from around the table were made with T Chapman, Tuwharetoa representative advising that there will be a Tuwharetoa appointment to each of the three Lakes DHB advisory committees. The appointees identified were herself, Tania Te Akau and Ngatiterangi Smallman.

1.1 **Apologies** *(Agenda Item 1.1)* : D Sorrenson
Resolution:
THAT the apologies be received.
D Shaw : P Mahood
CARRIED

1.2 Schedule of Interests Register – This was circulated during the meeting with an amendment made by S Westbrook that she is a Trustee/Contractor for Te Whare o Kenehi.

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

1.4 General Business
Items submitted by the Chair included:-

1. Suicide Prevention Plan for Lakes DHB
2. Suicide Prevention co-ordinator
3. Possible invitation to New Zealander of the Year to present – Mike King
4. Mental Health and Addictions report to Government Inquiry

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

2.0 WORKPLAN : DISABILITY SUPPORT ADVISORY COMMITTEE

2.0.1 Disability Support Advisory Committee Work Plan 2018

2.0.2 2016-2026 NZ Disability Strategy – feedback from committee
Working group (J Horton, D Epp, S Westbrook, M Barnett) progress update report outlined areas where disabled people may find engaging with our services difficult and a need to look more closely at health literacy. A follow up meeting is to be held 22nd February with Kelly Thompson, CNM of Outpatients to develop an action plan.

2.1 **~ Disability Support Services**

2.1.1 Access Taupo Minutes 19th December 2018

Colin spoke to the minutes, highlighting the following points:-

- Draft Transport Strategy and draft public consultations expected mid-2019
- The new CCS App to find disability parking sites requires users to import photo/information on parking area size which initially will be time consuming but considered useful. Also being promoted in Rotorua.

Resolution:
THAT the Access Taupo Minutes 19th December 2018 be received.
C Cockburn : B Edlin
CARRIED

2.1.2 Carers NZ and Carers Alliance Newsletter – January 2019

Members' noted the above information.

2.2 **~ Health of Older Persons**

2.2.1 Health of Older Persons & Disabilities update

Some of the highlights from the meeting were:-

- ACC Falls and fracture Prevention programme data showing positive trends
- Lakes DHB purchase of 2,000 "Cancer Korero" booklets for distribution to cancer support services and other health promotion organisations to support early detection and access to treatment for Maori
- ARC Occupancy Survey – November 2018 capacity and occupancy data will be electronically sent to members
- Influenza vaccination rates for people over 65 – national target of 75%. 2017-18 rate in Lakes was approximately 40%. K Stone advised there is a data capture issue between primary care and national immunisation team currently being addressed
- Lakes Q2 interRAI assessed older population (226 people) revealed:-
  - 74% older people assessed have not had a dental exam in the last year
  - 42% have no Enduring Power of Attorney – challenge is costs attached to EPOA for some people.
- Using the interRAI information and developing a case management approach to support the most frail is used in many DHBs to reduce risk of hospitalisation and permanent out of home care
- Health Navigator and Healthpoint websites continue to be developed with Lakes providers

Resolution:
THAT the report be received.
D Epp : J Horton
CARRIED

2.3 **~ Mental Health**

2.3.1 Midland Mental Health & Addiction Newsletter – Issue 7

The appointment of Robyn Shearer to the MoH Deputy Director-General, Mental Health & Addiction was noted.

3.0 SECRETARIAL

3.1 Public minutes of previous meeting held 5th November 2018

Resolution:
THAT the public minutes of the DSAC meeting held 5th November 2018 be approved as a correct and accurate record.
B Edlin : J Horton
CARRIED

3.2 Matters Arising

It was noted that:-

- Both BoP and Waikato DHBs had suicide prevention action plans and suicide prevention co-ordinators
- BoP had an extremely high suicide rate with young people 16-18 year olds
- There is a BoP and Lakes DHB wide programme in place with P Tangitu and M Ranclaud leading for Lakes DHB

3.3 Schedule of Tasks :

- NZ Disability Strategy update at next meeting
- Remove task - additional charges in age-related residential care
- Te Ara Tauwhiroranga Summary – N Saville-Wood to follow through once M Ranclaud returns from leave. Full report submitted to 15th February Board meeting – need to work balance of information for advisory committees. Committees receive the detail and summary elevated to the Board. Remove task from schedule – future papers can be submitted for information.

4.0 REPORTS

4.1 Community representative reports

K Stone

- Bowel screening
- Hospital ED & pharmacy staff can access last 90 days of patients GP record. However, GPs cannot access DHB patient management systems until further development of IT platforms

C Cockburn

- St John Ambulance Taupo – considering new Health Shuttle – public survey recently held
- Muscular Dystrophy submission on Nusinersen to Pharmac – deferred decision until further clinical trials completed
- Hospital Disability Advisory Reference Group current issues
- Access Taupo – footpaths not suitable for power chairs
- Whanau support group for people with disability in Taupo
- Difficulty finding replacement carers at short notice under individualised funding package

T Chapman

- Met with Pihanga Health – work in progress with new ambulance station
- Recently held meeting with P Tangitu and E George – three community representatives have been appointed to the Lakes DHB advisory committees
- Y Rogers invited to Tuwharetoa Sport for promotion of National Bowel Screening programme
- Turangi disability access to be investigated

B Edlin

- Key points from BoP Minutes 3.10.18 were First 1000 days and reducing tobacco
- Linking of services around issues and focussing on outcomes

M Barnett

- National changes to DSS funded services funding
- EPOA & PPPR Act process to support formal guardianship for people with disability can cost $1500 to $3000 and need renewing every three

years
- Hamilton has free bus transport for people with disabilities
- Footpaths in rural towns not being maintained
- Cost of Taxi Mobility Vouchers prohibitive with increasing rental costs. Some areas Maori Wardens are providing transport assistance

S Westbrook
- Attended youth drama group – Rebel in Me suicide prevention annual tour – very relevant to young people
- Reporoa Hauora Community Day held a whanau focussed event in February – positive social gathering
- Kaingaroa interested in suicide prevention information
- TRHOTA planning session held with K Evison and P Tangitu participating
- TRHOTA Chair attended the National Bowel Screening programme launch on 15th February 2019
- Te Arawa games 13-24 March 2019

P Mahood
- Te Kuiti Maternity Resource Centre recent opening. Meeting isolated rurual health professionals highlighted need to understand where to access services in an emergency
- Te Kuiti Whanau Ora Centre opening week of 25th February
- Consumer council highlighted need to keep language simple

5.0 INFORMATION AND CORRESPONDENCE

5.1 BoP CPHAC/DSAC minutes 3rd October 2018
Resolution:
THAT the BoP CPHAC/DSAC minutes 3rd October 2018 be received.
B Edlin : S Burns
CARRIED

5.2 Waikato CPHAC/DSAC Minutes 12th December 2018
Resolution:
THAT the Waikato CPHAC/DSAC minutes 12th December 2018 be received.
P Mahood : D Shaw
CARRIED

5.3 Heat Health Plan guide : Noted

1.4 General Business
Discussion on Lakes DHB Suicide Prevention services – R Vigor-Brown

1. Lakes DHB Suicide Prevention Plan recently reviewed is in draft. N Saville-Wood to send to the Chair (R Vigor-Brown).
2. Suicide Prevention Co-ordinator : Due to complexity and individual situations, it is not expected to have one specific role. Currently two staff cover postvention co-ordination. Multi-agency working group planned for late March.
3. Suggestion to invite Michael King, New Zealander of the Year to present in Lakes. Group considered less value to present to DHB committees – may be more beneficial to community groups.
4. Mental Health & Addiction report to Government Inquiry : P Tangitu to give an overview summary of the Inquiry to the next meeting

6.0 PUBLIC EXCLUDED

Resolution:
THAT the committee move into Public Excluded at 12.15pm
J Horton : B Edlin

CARRIED

Chair …….. ……Dated 6th May 2019
R Vigor-Brown – Chair

PUBLIC

LAKES DISTRICT HEALTH BOARD

SCHEDULE OF TASKS: DISABILITY SUPPORT ADVISORY COMMITTEE
18th February 2019

Agenda Item	Action	Responsibility of	Timeframe
Presentations:			
Tasks			
2016-2026 NZ Disability Strategy	An update be provided to the next meeting	J Horton, D Epp, S Westbrook, M Barnett, V Russell	6th May 2019
Te Ara Tauwhiroranga Summary ***(Minutes 5th November 2018 - item 2.3.1)***	Follow through once M Ranclaud returns from leave	N Saville-Wood	a.s.a.p
Lakes DHB Suicide Prevention Plan	Draft Lakes DHB Suicide Prevention Plan to be sent to R Vigor-Brown	N Saville-Wood	a.s.a.p
Mental Health & Addiction report to Government Inquiry	An overview summary of the Inquiry be provided to DSAC	P Tangitu	6th May 2019

Minutes

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

Venue: 889 Cameron Road, Tauranga
Date and Time: 7 February 2019 at 10.30 am

Board: Bev Edlin (Chair), Sally Webb, Ron Scott, Mark Arundel, Mary-Anne Gill (Waikato DHB Rep), Paul Curry (Community Rep), Marion Guy (11.00 am)

Attendees: Pete Chandler (Acting Chief Executive), Simon Everitt, (GM Planning & Funding), Sharlene Pardy (Planning & Funding Planning and Projects Manager), Hugh Lees (Chief Medical Advisor)

Item No.	Item	Action
	The meeting opened with the Karakia.	
1	**Apologies** Apologies were received from Janine Horton, Judy Turner and Marion Guy (for lateness) **Resolved** that the apology from J Horton, J Turner and M Guy Moved: R Scott Seconded: S Webb	
2	**Interests Register** B Edlin advised of a new interest with Western Bay of Plenty District Council, which will be recorded	
3	**Minutes** 3.1 Minutes of Previous CPHAC/DSAC Meeting **Resolved** that the minutes of the meeting held on 3 October 2018 be confirmed as a true and correct record. Moved: S Webb Seconded: P Curry 4.2 Lakes DHB CPHAC Meeting - 8.10.18 The minutes of the Lakes DHB CPHAC meeting of 8.10.18 were received by the Committee 4.3 Lakes DHB CPHAC Meeting - 5.11.18 The minutes of the Lakes DHB CPHAC meeting of 5.11.18 were received by the Committee. BOPDHB rep advised the meeting discussed the importance of not having presentations for presentations sake and when there are presentations, consider what can be done with the knowledge and whether it aligns with the SHSP.	

4	**Matters Arising** There were no outstanding Matters Arising	
5	**Presentation** 5.1 <u>Provider Engagement – Home and Community Support Services Alliance</u> Erica Amon (Reg Mgr, Healthcare NZ), Trudy Ake (Nga Mataapuna Oranga), Bronwen Foxx (CE, Disability Resource Centre), Ian Yost (Nat GM, Home Healthcare, Vision West) and Rita Blade (BOP Service Mgr, Vision West). P&F members Stewart Ngatai, Brent Gilbert De Rios, Sarah Davey and Sarah Nash. Erica presented the new BOP Responsive Service model, its intents and challenges. The model differs from other models around the country. It required a lot of change to systems and processes, at quite a cost. There were still some matters to be finalised at implementation. Differences have been realised in East versus West in the BOP region eg provision and preparation of meals in the West which are not available in the East, community support differences and demographics. The long transition period has some negative impacts. Erica outlined future opportunities. Questions were requested from the floor. • Does earlier intervention result in better care? Evidence indicates it does. • Has there been consumer feedback to the new model? Feedback had been that because of the change from the "hour" system, it was considered that there could have been better communication to that change. New referrals are finding it easier than those who had previously received help. The quality of the relationship with carers has been important. • Are young people being attracted to the workforce? There is a groundswell in the education sector, however education is also required for older patients to accept young people as carers. GMPF advised that P&F works with home based carers through the Alliance which is helpful. From a funding perspective BOPDHB are looking at a cluster model and relativities, also looking at high needs Maori. There has been some work done with a specific provider in the East. The cluster model doesn't recognise higher needs. BOPDHB is opening up online learning modules to Community providers through the Clinical School.	

	Request was made for BOPDHB to lead discussions with Home Care providers and Primary Care. GMPF advised of the intention to include a rep on the BOP Alliance Leadership Team. The Committee Chair thanked the presenters for attending and for the informative presentation.	GMPF
6	**Items for Discussion** 6.1 <u>Overview on progress towards implementing actions within Strategic Objective 2 of the BOPDH Strategic Health Services Plan</u> 6.2 <u>Health Care Homes Update</u> 6.3 <u>Bay of Plenty Community Care Co-ordination Update</u> GMPF advised of delivering on the 3 Strategic objectives which are aligned with the direction of the organisation and through the BOP Evolution work. There is also connection with the presentation this morning regarding short term care to long term care. Sarah Davey, P&F Service Development & Delivery Manager, gave an overview. Projects are interlinked. There is a bundle of integrated care initiatives which builds off the base of Health Care Homes, supporting integrated teams and programmes. It's not quite there yet, however there are advancements being made. Care Co-ordination is a concept that supports the interface between Hospital and Health Care Homes. An evaluation of Community Care Co-ordination has been carried out, the purpose of which was to determine what community Care Co-ordination could look like. What are the benefits for the wider scope. Care Co-ordination is managed through Support Net and they are located in the Kollective, the Social Sector Hub. The Referral Centre has 2 FTE triage Registered Nurses, Admin Support and an Operations Manager. They are operating under extended hours including Saturdays. Referrals are predominantly from the Hospital, 65%, the rest from Primary Care and a small number of self- referrals. Query was raised as to how General Practice knows where to refer. The same referral system as previously, (BPAC) is being used. Query was also raised on how quickly we are able to respond with provision of care. A process has been introduced of triaging and grading. There is still some work to do on that process. There is a percentage where care is required to be provided same day, others in 2-5 days and then 5 days onwards. The provider is able to respond to the care intended. One of the findings was that a better service could be provided if it was more targetted. As more data is collected, progression will be made with this. A challenge has been to change the messaging that patients receive which does take time to filter through. Communication is being worked on to inform patients and providers, looking towards a single point of entry.	

	BOPALT has approved the service going forward. The Committee considered the project was a good step forward towards envisaged goals. 6.4 <u>Keeping me Well – An Integrated Community Enablement Approach</u> Sarah Nash P&F Project Co-ordinator, advised that Keeping Me Well is a Strategic Objective 2 initiative and arose from a need for integration of BOPDHB's community services. Once endorsement had been received from the Executive team, P&F wanted to conceptualise what a model of care might look like. It is a concept at this time. It is a response to BOPDHB's population who have a short term need, and assists with prevention of hospital admissions. There are 10 main elements of the model of care which includes care within the home setting. People get better sooner in their homes. Integration including how to work together as one of a virtual team. Focus is with Allied Health Workforce. There is a need to look at moving some of that workforce into the community. 6.5 <u>Mental Health Update – Govt Inquiry into Mental Health Outcomes and Addictions</u> GMPF advised that the report has been released from the National Consultation process that was undertaken. The Government is to respond to the report in March and the priorities to focus on. From a BOPDHB perspective there are areas where we could do better. A BOPDHB stocktake of all MHA services has been undertaken. There are a lot of different providers. How easy they are to navigate and who provides what is not always clear within the community. It is intended to have a strong consumer voice in the way forward. Patients need to be at the centre of all we do. Query was raised with regard to MHAS as to how whole of system would be applied. GMPF advised that Mental Health does involve many other sectors, justice, education etc. COO advised that a start would be to look at the care currently provided through the Provider Arm and consider expansion for best effect through co-designing practice. CMA advised of a Grand Round presentation on Tuesday 5 February which had talked about three times as many teenagers being alone as older people. The Committee requested a link to the session be circulated to the Committee. Query was raised as to whether the work being visualised would conflict with the Government's response in March. GMPF advised it would not. It is such a vast area that creating discussion and awareness can only assist the way forward.	Board Secretariat

	Query was also raised as to whether it was considered Autism and ADHD should move out of the Mental Health label. It was considered that they perhaps should, however would need applied resource. 6.6 CPHAC/DSAC Coversheet template questions. A sheet of questions was circulated to the Committee which is put forward to be applied to presentations and submitted papers, to assist the Committee to focus on its objectives. The Committee requested that the fifth question on Equity be elevated to the top which aligns with the Board's intent for its two key priorities, Equity and Whole of System approach.	
7	***Matters for Noting:*** 7.1 Draft Work Plan 2019 The Committee agreed the Plan as final. 7.2 TTHW – Toi Te Ora Monthly Report The Committee noted the report.	
8	**General Business** There was no general business	
9	**Next Meeting –** Thursday 1 May 2019	
	Resolution to Exclude the Public **Resolved** that Pursuant to S9 of the Official Information Act 1982 and Schedule 3, Clause 33 of the New Zealand Health and Disability Act 2000 the public be excluded from the following portions of the meeting because public release of the contents of the reports is likely to affect the privacy of a natural person or unreasonably prejudice the commercial position of the organisation: Confidential Minutes of last meeting: That the following persons be permitted to remain at this meeting, after the public have been excluded, because of their knowledge as to organisational matters or for the purpose of legal records. This knowledge will be of assistance in relation to the matter to be discussed: Pete Chandler Simon Everitt Hugh Lees **Resolved** that the Committee move into confidential. Moved: S Webb Seconded: R Scott	

The meeting closed at 12.15 pm
The minutes will be confirmed as a true and correct record at the next meeting.

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

Disability Services

Papers and Presentations

MEMORANDUM TO COMMUNITY & PUBLIC HEALTH AND DISABILITY ADVISORY COMMITTEE
10 APRIL 2019

AGENDA ITEM 5.1

HEALTH SYSTEM PLAN – GOALS, ACTIONS AND ACTIVITIES

Purpose	For information

Background

The Health System Plan (HSP) sets a direction and focus for the whole sector that will enable the strategic imperatives of the DHB's strategy *Healthy People Excellent Care* to be achieved. This direction guides specific service and planning initiatives, priorities and decisions for investment and disinvestment.

The intent of *Healthy People Excellent Care* is to shift the health system focus from specialist services to the community. Specialist services are vital and will continue to be funded to provide safe and high quality care, but we need a greater focus on preventing people becoming ill, intervening earlier when people do get ill, treating people in the community and for those with complex needs; helping them to recover, manage their illness and live independently in their communities.

The draft goals, actions and activities for the Health System Plan (HSP) have been developed through an engagement process including consumers, community members, providers and other stakeholders. The process commenced with a focus on the Care in the Community Plan, where Māori, consumers and stakeholders gave us their broad perspectives and experiences with the health system as a whole, not confining their views to community services. People do not differentiate the system in the way people within the health system do (e.g. primary, secondary, rehabilitation etc) – they see health as a single system and want it to operate as one system. Thus, we have moved our focus to the HSP, and have used the Care in the Community content to inform the HSP and to provide a vision for the whole system. The engagement process included opportunities for the Board, Iwi Māori Council (IMC) and Consumer Council to contribute.

The Board approved the goals, actions, activities and enablers at their meeting of 27 March 2019. These will form a substantive part of the (draft) HSP document that the DHB will consult on.

The draft goals, actions, activities and enablers are attached as Appendix 1.

Next steps

The consultation on the HSP will commence in April for four weeks. Subject to the consultation feedback, approval of the HSP will be sought from the Board in June.

Recommendation
THAT

The Committee notes the goals, actions, activities and enablers for the draft Health System Plan which will be under consultation from April 2019.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

Appendix 1 – Health System Plan – Goals, Actions, Activities and Enablers

Health System Plan – Draft Goals, Actions, Activities and Enablers

Contents

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

The DHB and providers will have collaborative partnership arrangements with Māori. This goal underpins all the actions of the Health System Plan.

This will mean:

- *Māori are partners in the planning, delivery, monitoring, evaluation and improvement of health and social services across the Waikato*
- *All planning processes in the Waikato health system will give effect to He Korowai Oranga, and its goal of Pae Ora - healthy individuals, healthy families and healthy environments*
- *Partnerships operate at multiple levels of the system as well as across organisations. Partnerships will enable Māori to participate in all the multiple levels so that the perspectives of Māori consumers and Iwi can be prioritised.*
- *Quality data will enable differences in equity for Māori to be measured, and used as improvement indicators across multiple levels of the system, and to be shared widely including with the public, providers and practitioners.*
- *Tikanga Māori is normalised in the Waikato health system, and underpins the way we work*

Goal 1 Actions

1.1. DHB takes a lead by example approach to working in partnership with Māori

Rationale:

- The DHB as a Crown agent has a responsibility to uphold and protect Te Tiriti o Waitangi, this includes working in partnership with Māori.
- The DHB as the commissioner of health services and provider of hospital services has to reflect its responsibilities through the services it provides as well as through the providers it commissions
- The DHB can lead by example with respect to partnership ways of working with Māori at all levels of the organisation to achieve equity and support Māori development.
- Equity will require the identification and elimination of institutional and individual sources of racism in the contexts and situations in which people learn, work and live.

Activities:

- DHB works with Māori to develop an ongoing programme for the whole DHB that progressively:
  - Addresses structural, policy and procedural barriers to achieving Māori equity
  - Builds knowledge and awareness, shapes beliefs, and debunks myths and stereotypes
  - Supports staff with the right behaviour
- DHB develops policies and processes that enable Māori to participate in the planning, development, delivery, quality and performance of health services it provides and commissions

  Examples of this include:
  - Evidence of Māori involvement in governance processes such as clinical governance, project steering groups, system leadership groups
  - Evidence of the involvement of Māori whānau in the design of services
  - Practice oriented around Māori models of health
- Publication of performance information including movements to achieving equity
- DHB implements a strategy to increase the proportion of Māori in its workforce across clinical, non-clinical and management areas
- DHB enables a feedback process for Māori consumers to reflect on their experience that is supported by a service improvement programme and information to address improvement priorities.

1.2. Reorient commissioning to achieve equity

Rationale:

- Providers consistently criticise that service agreements with the DHB are based on inputs and activity rather than outcomes
- A focus on inputs and activity generally does not address health inequities, rather it risks worsening them due to inverse care and bias effects
- Kaupapa Māori providers would rather focus more on whānau wellbeing than output alone
- Longer-term service agreements allow for trust-based relationships to develop between providers and the DHB, and providers to reorient their services to focus on outcomes and inequities

Activities:

- Develop an outcomes performance framework for the Waikato health system that identifies inequity and unmet need and make performance information publicly accessible. The framework includes an intervention logic that enables different parts of the sector to understand their contribution to achieving equity.
- The DHB commissioning approach involves a progressive shift from focusing on throughput to outcomes, and requires extensive engagement and co-design with providers and Māori consumers. Māori participate in the monitoring and evaluation of the outcomes.
- Equity of outcome indicators are built into service agreements, with the DHB and providers sharing responsibility for improving these and freely sharing data to support this
- Service agreement duration is extended for providers meeting defined capability and performance standards.
- DHB supports providers to understand inequities in their patient populations and lends expertise to help with strategies to address them

1.3. Build requirements for partnership with Māori into provider service agreements

Rationale:

- Consumers do not make distinctions between DHB-provided and commissioned services – they view the 'health system' as a single entity
- Māori consumers want to see tikanga Māori valued and operationalised in all services they interact with
- As the commissioner in the Waikato health system, the DHB can exert both soft (relationships and leadership – direction-setting) and hard (contracts and funding) influences to ensure services are fit for Māori consumers

Activities:

- DHB progressively includes requirements for partnership-based ways of working in service agreements with providers.
  Examples of this include:
  - Evidence of Māori involvement in governance
  - Māori workforce participation to reflect population proportion
  - Practice oriented around Māori models of health
  - Evidence of contribution towards achieving equity
  - Evidence of the involvement of Māori whānau in the design of services
  - Ensuring services do not worsen inequities (e.g. through application of the Health Equity Assessment Tool)
  - Publication of performance information including movements to achieving equity
- DHB supports the sector to develop partnership based ways of working through sharing its own experiences, resources, networks and relationships.
- Provider service agreements include a requirement to enable Māori consumers to provide feedback and to demonstrate how improvements for priority areas have been made through process change and performance information.

Goal 2: Empower whānau to achieve wellbeing

Whānau are supported to define and achieve their wellbeing goals and can shape the services they require.

This will mean that consumers and whānau will:
- *Have access to assessment to identify whānau wellness priorities, plans to achieve those priorities, and services are resourced to support this*
- *Be supported by health and social services to care for their own whānau*
- *Have an online portal to access their health records and shared care plans, and other reliable health-related information as part of a digital strategy*
- *Be able to control who has access to their personal health records*
- *Have access to culturally-appropriate information and tools that support wellbeing*

Goal 2 Actions

2.1. Expand resourcing for Whānau Ora in the Waikato

Rationale:
- As it is currently structured, the health system is focused on illness rather than prevention, is difficult for consumers to navigate and services are poorly coordinated
- Whānau Ora is a successful model for addressing these issues as it involves holistic assessments, targets resources to whānau aspirations and wellbeing, and coordinates an intersectoral approach to keeping whānau well
- Whānau Ora is inadequately resourced in the Waikato, with the opportunity available to expand the programme's reach to more whānau

Activities:
- The Whānau Ora approach is resourced, and embedded as the wellness model of care for the Waikato district. A workforce development strategy is devised to support this expansion
- Whānau Ora expansion is closely linked with primary health care and other government agencies to ensure availability of the required services. This will ensure that needs assessments only occur once, that information is shared between relevant providers (controlled by whānau), and that whānau needs drive service capacity and development
- Prioritise the development of Māori and Pacific Whānau Ora provider capability and capacity to enable access by the whole population
- Monitor and review Whānau Ora approaches to inform improvements

2.2. Advance initiatives to better support whānau as carers

Rationale:
- The health system relies greatly on the care performed by whānau, particularly in Māori communities. More often than not, family and whānau are the first point of care.
- Whānau want to be well supported to look after the health needs of their whānau.
- Existing support mechanisms could be further developed to provide assistance, such as improved access to and flexibility of respite, virtual access to after-hours/urgent medical advice and peer support networks

Activities:
- Develop pathways that inform whānau at a locality level of where to go for advice and services
- When planning services that avoid the need for hospitalisation or enable people to be discharged from hospital earlier, consider the needs of carers and how their needs can be incorporated
- Support the development of peer support networks in communities of need
- Develop protocols for individualised care planning that consider the need to support both carers and whānau

2.3. Support whānau to make informed decisions regarding their health and wellbeing

Rationale:

- People want to be able to obtain, process and understand health information and services to make informed choices and self-manage their health and wellbeing.
- Health workers and organisations need training and resources to enable them to communicate effectively so that community members can make informed decisions and take appropriate actions to protect and promote their health

Activities:

- DHB partners with Māori to identify specific community health literacy issues to prioritise (e.g. discharge communication, medication information)
- Workforce is upskilled in health literacy to better support whānau and communities
- Health education and health promotion material is developed in conjunction with Māori and communities to be culturally appropriate, relevant, and accessible
- Whānau and consumers can access bilingual, culturally appropriate information to support health literacy and self-management
- An interagency approach is taken to coordinate health information and ensure consistency and accessibility of health messaging

Goal 3: Support community aspirations and address determinants of health

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

This will mean:
- *Iwi, the DHB, health service providers, other government agencies and non-governmental organisations form inter-sectoral collaborations to coordinate their efforts and provide local leadership*
- *These collaborations support community development activities that enable local communities to identify and address social and environmental determinants of health that are important to them*
- *Iwi in particular are supported to develop their own health environments, communities and institutions*
- *Māori models of health are used and further developed*
- *The DHB partners with other agencies in the implementation of the Health in All Policies approach to ensure health impacts and wellbeing are considered during policy development*

Goal 3 Actions

3.1. Work with communities to design solutions that address determinants of health

Rationale:
- Often health service providers become oriented around the needs of their service, rather than the needs of the community. Increased community participation in service review and planning would improve engagement and service responsiveness
- Communities are often experts on the unhealthy environments to which they are exposed, and are best placed to address determinants that affect them. The DHB has a wealth of data that can support communities to identify whānau that have poor access to positive health determinants
- Iwi are well advanced in developing long term health plans. DHB and providers must collaborate with Iwi to ensure alignment. These relationships also act as conduits for community development and health promotion activities
- Many hospitalisations and other episodes of health care utilisation are preventable with relatively simple interventions. These episodes present opportunities to improve access to holistic healthcare for whānau and communities

Activities:
- DHB and other partners work with Māori to understand locality priorities, the resources they have, and agree on a plan to support the localities.
- DHB resources and supports communities to facilitate community development and leadership
- DHB provides additional resources for health promotion
- Where there is evidence of health benefits, the DHB directly invests in population health interventions
- The DHB actively looks for co-investors for intersectoral solutions

3.2. Expand the inter-sectorial approach to address determinants of health

Rationale:
- Factors outside the health system such as income, housing, social support and education have large effects on the health of populations
- Evidence shows that population health interventions are highly cost-effective and can be equity positive. They also address acute demand by reducing the prevalence, severity and incidence of disease
- Responsibility for addressing the determinants of health is scattered across multiple government agencies, but the health system often bears the burden of unhealthy impacts. As health affects the determinants, a collective approach is required to redress this imbalance

- A health event provides an opportunity to improve health by actively engaging whānau with housing, educational, financial, community and other health and social services in a mana enhancing and culturally safe way.

Activities:

- The DHB works in collaboration with other health and social agencies (e.g. education, local government, transport, housing, police, and social development) to form coalitions aimed at addressing determinants of health in the Waikato, and supporting the effective delivery of Whānau Ora
- Coalition activities occur at district-wide and locality levels, and focus on determinants in both human and natural environments
- The coalition in collaboration with communities develops a multiagency outcomes framework focussed on equity
- Iwi and Māori are involved as partners in both governance and operations, and Māori-based analyses and frameworks for action are employed
- Support communities in their priorities to spread information and encourage change, with health education and promotion supported by health professionals

3.3. Collaborate with local and national agencies to ensure the wellbeing of the Waikato population is considered in policy decisions

Rationale:

- The Health in All Policies approach takes into account the health implications of policy decisions by public agencies. It aims to avoid unintended harmful health impacts in order to improve health equity and population health
- The DHB is well positioned as the district's health commissioner to lead the implementation of this approach, within the DHB and across other agencies when public policy is being developed

Activities:

- The DHB works in collaboration with other health and social agencies (e.g. education, local government, transport, housing, police, and social development) to implement the Health in All Policies framework during local public policy development. This is informed by priorities identified by the local communities and builds on the coalitions formed in each locality and the district.

Goal 4: Improve access to services

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

This will mean:

- *Cultural competence and safety underpin the way services are planned and provided particularly for Māori*
- *Equity in access to services is achieved for Māori*
- *A model of virtual primary health care, co-designed with consumers, communities and caregivers, operates to bridge geographic barriers*
- *Innovative community care approaches to improving access for priority populations are supported and evaluated*
- *Care is delivered in a range of settings that are accessible for consumers and their whānau (e.g. marae, homes, workplaces, schools, digital)*
- *Support is provided to improve access to organised screening programmes as well as unorganised screening*
- *Where feasible, services for people with long term conditions are decentralised*
- *Health and social service providers are inter-connected, ensuring 'every door is the right door' for consumers and whānau to simplify and enhance access to multiple health and social services*
- *Urgent care and after-hours services are affordable and accessible, particularly for rural whānau*

Goal 4 Actions

4.1. Develop the Waikato health system to be culturally competent and safe for Māori

Rationale:

- Culture describes the way members of a group understand each other and communicate that understanding. Cultural safety in health is how a consumer experiences a service from their perspective. Cultural competence focuses on the capacity of the health worker to improve health by integrating culture into the clinical context. Competence is therefore more about behaviour than recognition of culture.
- Identifying and eliminating institutional and individual racism is part of addressing cultural competence and safety.
- Our workforce does not reflect the multi-cultural profile of the communities they operate in, therefore cultural competence and safety is key to maximising the gains from a health intervention. While culture is often viewed from an ethnic perspective there are other groups that have their own culture e.g. youth
- Māori consumers and whānau consistently reported that they want services (both DHB and contracted providers) that are culturally safe and where tikanga Māori is consistently integrated into service delivery

Activities:

- Develop a coordinated strategic district wide approach to improve cultural competency and safety at an organisational level
- DHB strengthens its approach to tikanga and cultural competency through changes to its own practices and services, and assists commissioned providers with this also
- DHB takes a planned approach to improving cultural safety including initiatives that address structural and policy matters that lead to prejudice and discrimination and shares its learning with other providers
- DHB leads sector Māori workforce development by enhancing its own workforce plans to increase the proportion that are Māori across clinical and non-clinical areas in proportion to the population.

4.2. Collaborate in the development of district-wide service delivery models that enhance access for Māori and other priority populations

Rationale:

- Communities want service delivery models that improve access, are more convenient, are affordable (direct and indirect costs) and achieve equity for Māori and other priority populations
- Services are provided in community settings by the DHB and a diverse range of health and social service providers. They may coordinate their services for an individual but there is less coordinated and collaborative planning in a consistent approach to improving access and using the diverse expertise in community providers. Service delivery models need to include alternative settings and providers.
- Service areas of highest need and inequity: maternity/tamariki/children, rangatahi/youth, kaumātua/older people, mental health and addictions, cancer and long term conditions
- The DHB is unable to effectively decentralise all specialist services due to geographical and staff constraints. However, there are numerous facilities already available in communities, such as pharmacies and aged residential care facilities, that are underutilised by the health system as delivery settings
- Other health activities, such as health promotion, early intervention and self-management, could be suited to being delivered in community settings to improve engagement
- Cost and transportation are barriers for many people that limit access and outcomes. Many people say the cost of medicines is a problem particularly when the sickest use the most medicines

Activities:

- Develop system wide service delivery models for priority areas aligned with locality priorities to achieve equity of outcomes
- Develop a district-wide coordination framework to guide the practical coordination initiatives that care providers at a locality level put into place
- Develop alternative approaches to face-to-face services, as settings where services can be provided
- Explore co-location and collaborative service delivery with health and intersectoral partners
- Provide greater access to specialist care and/or expertise through use of mobile teams and technology delivered in different settings e.g. schools, marae, general practice led clinics, pop-up clinics
- Develop initiatives that address cost barriers for people with high and complex needs particularly general practice services and access to subsidised medicines
- Improve transport options for areas and people of highest need to facilitate access to specialist services including those provided outside of the district

4.3. Access barriers for people with disabilities are eliminated

Rationale:

- Disabled people encounter a range of barriers when they attempt to access health services. This includes aspects such as a physical environment that is not accessible, lack of relevant assistive technology (assistive, adaptive, and rehabilitative devices), negative attitudes of people towards disability/impairment, and services, systems and policies that are either nonexistent or that hinder the involvement of all people with a health condition in all areas of life. Often there are multiple barriers that can make it extremely difficult or even impossible for disabled people to function.

Activities:

- Improve access to health services for disabled people, and progressively integrate health and disability services
- Develop appropriate systems and policies to identify disabled people

4.4. Grow the capability and capacity of the workforce to enable district wide service delivery approaches

Rationale:

- The concept of health workers practising at the top of their scope provides the potential to utilise the diverse workforce in communities and localities
- The amount of activity in rural areas may not be sufficient to sustain a local workforce. A combination of local, mobile and centralised workforce linked by technology is most likely to be used for the provision of services particularly where the health care team is broad
- There are opportunities to provide local employment and getting people into health to grow a local workforce

Activities:

- Develop workforce plans that enable the service delivery models to be delivered in a sustainable way and builds a local workforce
- Following the development of service delivery models, establish programmes that give the workforce the appropriate skills, knowledge and competencies needed to meet quality standards or expectations
- Establish mobile specialist teams and locally-based clinical staff to support the service delivery approaches in community settings where feasible

4.5. Support district-wide service delivery models with technology and information

Rationale:

- Experience to date shows an appetite for using technology in the Waikato amongst consumers and providers that is broader than video interaction
- A decision arising from the HealthTap implementation assessment was that the DHB would work with primary health care providers to implement a virtual care platform capable of supporting virtual consults (including text, telephone, video and email)
- The development and integration of technology across the system is difficult for a number of reasons therefore providers including the DHB have followed their own strategies. In a constantly evolving industry, there are significant risks with over-planning. Therefore health providers only want to align high level directions. The strategic principle is inter-operability.
- The commissioning approach needs to be informed by information that provides a population perspective of quality and performance, and the outcomes being achieved

Activities:

- The DHB and its partners agree a model of health technology for the Waikato, which has alignment between primary and secondary approaches. The planning process and detailed design of the services to be implemented involve Māori and consumers for whom the services are for.
- The technology component of services will be expanded through trialling, evaluating and scaling up well-designed pilots with defined use cases (e.g. home monitoring, observed therapy for TB etc.)
- Equitable access to health technology for Māori and priority populations is explicitly prioritised
- Collaborate across the sector to share consistent and reliable information and to develop a district wide dataset with analytical tools that can be progressively used for needs analyses and the measurement of outcomes achieved.

4.6. Further enhance district-wide patient portals and integrated health records

Rationale:

- Shared, accessible patient records and care plans will improve coordination of care across providers
- Consumers currently have very little control over their own health information, and often have difficulty even accessing it.
- Reputable information can be hard to source, including what health care options are available to whānau A portal is a mechanism that could offer health and provider information, and self-management tools

- Embracing digitally enabled care allows health to take advantage of future technologies and capabilities

Activities:

- The Waikato health system agrees an action plan that improves the shared health record and care plans, collaborating with stakeholders within the district (and Midland Region where appropriate). This record is consumer-centred and gives consumers access to their information through patient portals
- All providers involved with a consumer's care have access to appropriate information to inform their service provision
- Waikato health stakeholders collaborate and coordinate with national stakeholders on a high level digital strategy including portals to ensure a consistent approach to consumer access, content and support for agreed initiatives

4.7. Trial personalised care using whānau care budgets

Rationale:

- The increasing prevalence and complexity of long term conditions means an increasing proportion of the population is living with multiple chronic diseases and relies on ongoing care and support, which is often very difficult to access and navigate or limited in what is routinely funded or available
- In the UK, personal health budgets (PHBs) are used in different health and disability areas to give people more choice and control over money spent on meeting their health and wellbeing needs. Personalised care and support planning is an essential part of PHBs where plans and budgets are agreed. In the UK, essential services such as accident and emergency, general practice, laboratory tests and medication are excluded from PHBs and continue to be funded in their usual way
- In New Zealand, the Enabling Good Lives pilot has shown that individualised budgets and purchasing is an effective means of empowering people with disabilities and their whānau to choose the services and support that are right for them
- Personal health budgets in the Waikato would be supplementary to existing services and facilitate people accessing services that they may not otherwise have easy access to

Activities:

- Enhance awareness of what services are available and how they can be accessed
- The concept of personalised care is advanced in the Waikato, with exploration of how people living with mental health or other long-term conditions can be empowered to determine their own care using whānau care budgets
- Establish a whānau care support team that assists people with planning and advice on where to allocate their budget, to approve personal care and support plans and monitor outcomes
- Establish an evaluation and research initiative to investigate short and long term outcomes, and benefits of whanau care budgets

4.8. Improve access to services after-hours

Rationale:

- Emergency services provided by DHBs are configured as a specialist service but are often used by the public as an urgent care and/or after hours care setting for low acuity conditions.
- Providers of urgent and emergency services operate independently of each other
- Some people will be referred to a hospital by primary health care due to a lack of options they can access
- After-hours primary care is generally unaffordable for the people who need to access it most. Consumers do not pay to attend services provided by DHBs while those provided by non-DHB services are more likely to have a patient cost.
- Travel time to after-hours services and ambulance response times can be an issue

Activities:

- Establish an urgent and emergency care network that shares information, provides oversight on service quality, workforce support and development, and coordination between services
- Develop a district wide service delivery model for the provision of urgent and emergency care services to meet future demand and reduce demand where feasible.

- Develop enhanced after-hours coverage and access through locality delivery models
- Link the urgent and emergency care service delivery approaches to the development and use of intermediate care options

4.9. Develop strategic approaches to sustainable hospital services

Rationale:

- Demand for hospital services often exceeds the capacity to provide them
- Communities want specialist services provided closer to where they live. Some services cannot be provided easily in local settings and other options need to be considered e.g. use of services in neighbouring DHBs, use of emerging technologies
- Rural communities want services close to where they live. The rural hospitals have underutilised capacity, their roles need to be clarified as long term service delivery models are developed and aligned
- The DHB is operating in a significant financial deficit environment. The value of any investment needs to contribute towards achieving equity and eliminating the deficit
- A planned approach to capital investment is needed to give confidence of the potential benefit and value, and alignment with strategic approaches

Activities:

- Address the capacity constraints for elective surgery and procedures
- Develop strategic service delivery models for priority hospital services. Identify potential investment needs (high level) and align with system service delivery models
- Instigate work to address efficiency and effectiveness to enable appropriate treatment and care delivery

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

Primary and community health care teams are an approach rather than a specific group of health workers. By focussing on how to work effectively together, primary and community health care service providers are able to focus on health and wellbeing in a seamless way

This will mean:

- *Primary health care providers give priority to eliminating barriers and lifting outcomes for Māori. Being responsive to Māori is embedded in primary and community health care services.*
- *An interdisciplinary team approach to community care is co-designed and implemented utilising shared care plans*
- *Patients and whānau participate in developing shared care plans when chronic and complex conditions arise, and have ongoing control over them*
- *Within the community care team, an optimised mix of regulated and non-regulated roles working to top of scope to make best use of the available professional workforce*
- *Collaborative development and implementation of a framework of minimum standards for an enhanced primary health care model*
- *Local communities shape the improvement of primary health care through co-design of services, regular feedback mechanisms, and access to provider performance result*
- *Primary health care are able to access NGO services directly rather than through referral to a specialist service*
- *Primary care clinicians have access to appropriate diagnostics (e.g. ultrasounds, cardiac investigations) through defined, resourced pathways*
- *Community care professionals have access to rapid specialist service advice (e.g. through defined locality-to-specialist relationships)*
- *Primary health care teams have access to additional initiatives to assist in managing acute hospital demand*
- *Co-design with communities of a Waikato community pharmacy model of care that incorporates wellbeing, with a one team focus*

Goal 5 Actions

5.1. Establish locality networks to encourage local collaboration and engagement in health services planning and delivery

Rationale:

- If health and social service providers would plan collaboratively to respond to needs in a local context, projected demands could be met in a more efficient and cohesive manner.
- By involving local communities in the operation and planning of local services, the health system will be more responsiveness to needs of these communities.
- As the health system leader, the DHB can act as an intermediary for locality-based collaboration in planning and service delivery
- Health systems tend to be service oriented therefore the locality voice needs leadership for operational and planning purposes

Activities:

- The DHB establishes a locality framework and appoints locality leadership roles to lead local planning and improvement of health services
- Establish locality networks with Māori, local providers and stakeholders to coordinate and improve health services and care. Locality networks are also established to address the determinants of health.
- Establish local priorities, stocktake of services and resources, and agree plans to address priorities
- Align DHB, PHO and NGO configuration to support effective locality planning and delivery of services

5.2. Develop expanded primary and community health care approaches with a focus on quality, equity and teamwork

Rationale:

- More proactive and better coordinated primary and community health care delivery carries benefits for consumer and whānau wellbeing, makes better use of the available workforce, and avoids hospital attendance and admissions.
- Within communities there is a wealth of expertise that can be used more effectively. The expertise can be used for the whole spectrum of health delivery from prevention, early intervention, assessment, treatment, reablement and palliative care of people
- General practice are a key component of expanded primary and community health care approaches. New models of enhanced general practice are spreading across the Waikato (and nationally) that can improve general practice effectiveness, efficiency and facilitate a path to achieve equity for Māori and other priority populations in collaboration with other health and social services
- There is the opportunity to bolster this innovation through effective use of care coordination functions, and an explicit commitment to achieving health equity and delivering for Māori whānau
- Expanded primary and community health care approaches include specialists and DHB provided community services as well as integrating essential services that address social needs such as whānau ora and other whānau focussed approaches
- Pharmacists are consistently identified as an underutilised professional group. Pharmacists are highly skilled clinicians, and the workforce is sustainable and generally well distributed through the Waikato

Activities:

- Realign service delivery models taking into account the desire to have care provided closer to home and work with locality networks on how those approaches can best be coordinated, resourced and delivered in their settings.
- Agree local mechanisms for care coordination to take place.
- Responsibility and accountability for Māori health access and outcome equity is built into primary care service agreements, with DHB support for the redesign of services
- Minimum standards for primary care are built into service agreements, incorporating key elements of expanded primary health care models
- Formalise the concept of individualised care plans for patients with complex clinical conditions that are developed in conjunction with the patients and whānau, and become a central function of the primary and community health care team. These plans are available to consumers via the patient portal
- In developing the service delivery models, identify where and how DHB-based specialist services provide timely general practice access to advice and diagnostics
- Develop expanded roles for community pharmacists as part of expanded service delivery approaches and identify opportunities where co-location may be beneficial particularly for pharmaceutical advice on the treatment of health conditions, self-management and early intervention.
- Enhance community health pathways to incorporate wellbeing, link to Whānau Ora and other whanau focussed approaches and encourage their use through promotion, improving systems to make them easy to use and upskilling clinicians

5.3. Develop, strengthen and embed whānau-centred approaches

Rationale:

- Māori models of health are based on a wellness or holistic health model (e.g. Te Whare Tapa Whā, Te Wheke, Te Pae Mahutonga) and are suitable for the whole population
- There are successful Kaupapa Māori whānau focussed approaches that support whānau using a holistic approach e.g. Waikato DHB has developed Hapu Wānanga, Harti Hauora Tamariki, and Whare Ora
- There is demand for whānau focussed approaches that can be accessed directly or through health providers
- Primary healthcare providers seek support from social services to address immediate social issues that they are not able to access as part of a team based approach to whānau wellness and wellbeing
- Using the “every door is the right door” concept, access to addressing immediate social issues is available to any provider including hospitals

- Urgent social needs have the potential to overload Whānau Ora providers and limit the long term support for whānau aspirations
- In addressing immediate social needs, there is the real potential for unmet need to overwhelm services. Intersectoral collaboration is essential to facilitate strategic and operational planning, and budgeting

Activities:

- Develop more whānau focussed programmes with Māori, consumers and stakeholders to address health and social issues that are aligned with district and locality priorities
- Collaborate with stakeholders on developing a workforce to enable ongoing delivery of the programmes
- Expand the primary and community health care team with a workforce who can assess and support whanau in addressing their immediate social needs
- Develop community and hospital health pathways .and optimise their use across the district
- Collaborate with stakeholders on a district wide approach to improving the knowledge and awareness service providers have of the determinants of health and how whānau can be linked into programmes and services

Goal 6: Strengthen intermediate care

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

This will mean:

- *People in hospital can be discharged early with care provided to them in their home or a community facility*
- *There are community options for care as an alternative to hospital for people who do not need to be in hospital*
- *Specialist services that can be decentralised are delivered in local facilities, either in person or virtually (e.g. nurse specialists, chemotherapy delivery)*
- *Rural hospitals and selected aged residential care facilities provide accessible local sites for bedded intermediate care*
- *Services provided to people in local bed facilities have services wrapped around them tailored to their needs that are provided by appropriately skilled providers*
- *Local community involvement with these facilities is strengthened through co-design*
- *GPs' and Nurse Practitioners' admitting rights for short stays in intermediate care facilities are expanded*
- *Local intermediate care facilities are utilised for safe, supported early discharge from secondary care, and respite care as part of enhanced carer support*
- *Intermediate care services are supported by specialist expertise as identified through co-design processes*

Goal 6 Actions

6.1. Develop specialist services closer to home

Rationale:

- Technology improvements are increasing the range of services that can be safely delivered outside of tertiary hospitals
- Numerous pre-existing health facilities (e.g. rural hospitals) could be more efficiently used for specialist service delivery
- Key candidates for delivery closer to home include chemotherapy, dialysis, endoscopy, and ongoing management of long term conditions
- Referrals to specialist services and presentations to emergency departments can often be managed by primary healthcare with the support and advice of specialist expertise. Specialist advice is not limited to medical practitioners and includes all professional groups working in specialist areas
- There are DHB specialist services that are ongoing and planned and provided to people with long term conditions from a Hamilton location. There are opportunities for these to be provided closer to home or in a different way to improve access and experience

Activities:

- The Waikato health system, in conjunction with providers and regional DHB partners, determines which specialist services could be appropriately delivered in the community, with explicit aims of addressing geographic and ethnic inequities in access to care
- Using the service delivery models development process, determine which additional specialist services linked to the service delivery models can be decentralised, where the demand for these services is distributed throughout the region, how they could be provided and how specialist support for primary care can be improved
- In the interests of accessibility and patient experience, some services may be better delivered to patients near DHB borders by other DHBs

6.2. Reorient services to reduce hospital admissions

Rationale:

- There are programmes that enable people to be discharged from hospital early and to be supported by specialist services in their homes or appropriate facilities close to home. These may be able to be configured to be used for people with deteriorating conditions as an alternative to being admitted to hospital

- General practice has access to programmes to provide services in community settings as an alternative to hospital. The suite of activities should fit with clinical care models and evidence based best practice, community based services in different localities and evolving service delivery models and be directed to those who would most benefit with acute conditions.

Activities:

- Reconfigure the programmatic approaches to focus on people with acute conditions particularly Māori to enable access to a broad suite of services that avoid hospital admission
- The DHB in collaboration with stakeholders look at whether step down services could also be used for step up services to avoid hospital use, identify changes needed and a plan for how this can be implemented and maintained

6.3. Develop and extend planned early discharge and step down care services

Rationale:

- Discharge from Waikato Hospital can be delayed if services a patient requires, such as speech therapy or rehab, are not available locally, disrupting hospital flow
- Provision of these services by the DHB, and stronger links with primary and community care, could facilitate earlier discharge to home, a rural hospital, or an aged care facility
- Some programmes already exist (e.g. START (Supported Transfer Accelerated Rehabilitation Team)) which could be scaled up and broadened

Activities:

- Support early discharge/hospital flow by providing services locally to patients in appropriate settings
- Build stronger links with primary and community care that allows collaborative discharge planning, including a system for early notification of discharge and so that local providers can prepare
- Build local expertise so that the DHB can work towards commissioning from community based providers
- Integrate early discharge services provided by specialists services with primary and community care, whānau ora and whanau focussed approaches

Enablers

Enabler 1: Leadership and partnerships

What this will mean:

- Clinical governance will reflect the principles of
  - consumer/whānau centred,
  - an open and transparent culture,
  - all staff actively participate and partner in clinical governance and
  - a continuous quality improvement focus
- A district-wide framework for planning, funding, service delivery and monitoring system performance will support the delivery of the health system plan.
- The framework will have clear roles and responsibilities for prioritising resources, service development, and a continuous quality improvement approach. Measures and indicators developed by stakeholders will be linked by an intervention logic model. At the delivery level, relationships need to be fostered to translate district direction into local action
- A Waikato leadership group will provide district-level leadership to ensure a unified, system-wide approach and oversee system performance and improvement. The group will be a partnership with Māori, consumers, providers and the DHB as commissioner of services, with shared responsibility for system performance
- Providers will have individual accountability to the commissioner and collective accountability to each other in the Waikato leadership group
- Partnerships will be developed with a broad range of stakeholders including NGOs not funded by health, volunteer groups and local government
- The Waikato leadership group will strengthen existing partnerships with the wider social sector and local government to support planning and action at district and local levels to address determinants of health
- Within the DHB, structures for leadership and governance have clear roles, responsibilities and accountabilities to support organisational decision making, performance and improvement

Activities:

- Establish a district wide leadership structure (involving Māori, clinical and consumer expertise) with responsibility to monitor and lead change for quality and performance improvement
- Empower DHB clinical teams to lead and improve quality by aligning clinical governance structures to facilitate whole of DHB performance and improvement. Processes should enable different perspectives (e.g. different professional groups, Māori and consumer) and structures should clarify roles and responsibilities

Enabler 2: Commissioning

What this will mean:

- Innovative solutions that address the determinants of health will be encouraged through adopting a system perspective in commissioning of services
- New contracting models will support collaboration and focus on outcomes
- Processes for ongoing service development and planning

Activities:

- Integrate the role of the district leadership into the commissioning process and cycle
- Clarify planning and decision-making processes within the DHB and the district, identifying where authority, accountability and responsibility lie
- Develop and promote a service planning framework that includes the development of long term system views for:
  - Maternity, children (tamariki) and youth (rangatahi)
  - Older people
  - Cancer
  - Mental health & addictions
  - People with multi-morbidity and long term conditions
  - Hospital based services

- Ringfence an HSP budget to resource a portfolio of prioritised initiatives that are developed for implementation.
- Take a portfolio approach to the planning and delivery of initiatives. Benefits are viewed across the portfolio rather than by individual project so initiatives can flex around risk profiles

Enabler 3: Workforce development

What this will mean:

- Health workers operate confidently and skilfully with Māori consumers and whānau
- Workforce distribution is matched to the population need
- Increasing participation by Māori and Pasifika in the health workforce
- Leadership, co-design, community development and quality improvement capability is developed across the system; this also includes capability to work within interdisciplinary teams
- There are increasing opportunities for training of the health workforce in system-wide settings
- An increasing proportion of the workforce will come from within Waikato communities

Activities:

- Ensure training and education activities provided by organisations are underpinned by tikanga, sharing of ideas and content
- Promote health as a career (particularly in schools) and support initiatives that enable Māori and Pasifika to attain academic achievements, succeed in roles where learning is through experience (e.g. placements, internships) and choose appropriate pathways to a health career
- Establish programmes where medical, nursing and allied health workforce training can be achieved in a mix of settings e.g. hospital/primary health care, urban/rural

Enabler 4: Technology and information

[Activities / rational covered elsewhere - statement / description incorporating need to prioritise technology and information initiatives to support the broader technology needed to support the activities and other support strategies e.g. People Strategy]

Enabler 5: Quality improvement

What this will mean:

- Equity will be embedded as a key goal of quality improvement, using frameworks for improvement and implementation
- Local communities will be supported in service co-design and improvement
- Opportunities for joint research and evaluation will be pursued with inter-sectoral partners

Actions:

- Develop and integrate a whole system quality improvement framework with decision making processes, leadership and clinical governance structures, system data analytics functions and reporting.
  Focus initially will be on services needing whole system approaches, and with opportunities for large scale impacts on inequities, such as cancer, diabetes, cardiovascular disease, maternity and mental health
- Develop an outcomes intervention logic (based on the equity framework) with networks, leadership and clinical governance groups that can be used to measure and improve system performance and is shared with the public
- Prioritise the resourcing of the Waikato Research Innovation and Improvement Hub to provide district wide expertise on the planning and delivery of change, inform improvements, conduct research and advise on benefits and outcomes achieved. Resourcing allows for rapid turnaround and long term research.

MEMORANDUM TO COMMUNITY & PUBLIC HEALTH AND DISABILITY ADVISORY COMMITTEE
10 APRIL 2019

AGENDA ITEM 5.2

WAIKATO DHB DRAFT ANNUAL PLAN

Purpose	For information

Background

The draft Waikato DHB Annual Plan 2019/20 (incorporating the 2019/20-2021/22 Statement of Intent) was submitted to the Ministry of Health on 5 April 2019. The version attached reflects the latest version available at time of agenda close for CPHAC and therefore may not be inclusive of all changes made prior to submission.

The Final Draft Annual Plan is due to be submitted on the 21 June 2019, and CPHAC will have an opportunity to feedback on that final version at the June committee meeting.

Overview of the Annual Plan

This draft Annual Plan has been developed in accordance with the guidelines and templates provided by the Ministry of Health on 20 December 2018 and the Minister's 2019 Letter of Expectations.

The 2019/20 Planning Priorities are:

- Achieving equity within the health system (overarching priority)
- Fiscal responsibility
- Strong and equitable public health system
- Mental health and addictions care (detailed guidance still to come)
- Child wellbeing (detailed guidance still to come)
- Primary health care
- Non-communicable disease prevention and management
- Public health and the environment

Service activities and performance measures have been developed to align with the Minister of Health's expectations. The Draft Plan includes links to the Waikato DHB Strategy and draft Health System Plan.

Formal feedback is expected from the Ministry on this draft Annual Plan by 10 May 2019.

As the draft Annual Plan is incomplete, the version attached is in MS Word format. Graphic design input will occur at a later date prior to the final draft plan being submitted to the Ministry in June.

Recommendation
THAT

The Committee notes and provides comment on the draft Annual Plan 2019/20 which incorporates the draft 2019/20 - 2021/22 Statement of Intent.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

Attachment
1. Draft 2019/20 Waikato DHB Annual Plan

Waikato District Health Board 2019/20 Draft Annual Plan

INCORPORATING THE 2019/20 STATEMENT OF PERFORMANCE EXPECTATIONS AND 2019/20-2021/22 STATEMENT OF INTENT

Important note: This is a draft plan written prior to funding confirmation and will require review following confirmation.

Annual Plan dated 26 March 2019

(Issued under Section 39 of the New Zealand Public Health and Disability Act 2000)

Published by Waikato District Health Board
Private Bag 3200, HAMILTON 3240

This document is available on the Waikato District health Board website
http://www.waikatodhb.health.nz/

Placeholder for contents page

Mihi

He honore, he kororia ki te Atua

He maungarongo ki te whenua

He whakaaro pai ki nga tāngata katoa

Ka tau te kei o te waka ki te Kiingi Tuheitia

me te whare o te Kahui ariki whānau whanui tonu

Paimarire.

Kahuri ki te korowai aitua

O ratou ko wehi ki te po

Takoto mai, moe mai koutou

Haere, haere, haere atu raa.

Noreira, ka puari te kuaha pounamu

Mahana kia taatou katoa.

“Mehemea ka moemoeā ahau

Ko au anake

Mehemeā ka moemoeā e tātou, ka taea e tātou”

All honour and glory to God

Peace on earth

And good will to all mankind

Including Kiingi Tuheitia his family

And the royal household

Paimarire.

We turn to acknowledge those

Who have passed beyond the veil

Rest in peaceful slumber.

Haere, haere, haere atu raa

Therefore the green stone door

Opens wide with a very warm greeting to us all

“*If I am to dream*

I dream alone

If we all dream together

Then we will achieve”

Minister's 2019/20 Letter of Expectations to Waikato DHB

Placeholder

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Dear Chair

Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20.

In early September, the Prime Minister announced a long-term plan to build a modern and fairer New Zealand; one that New Zealanders can be proud of. As part of the plan, our Government commits to improving the wellbeing of all New Zealanders and their families, and ensuring that the economy is growing and working for all.

Our health system has an important role in supporting the Government's goals. To do this we need to be sure that our public health system is: strong and equitable, performing well, and focused on the right things to make all New Zealanders' lives better.

Achieving equity within the New Zealand health system underpins all of my priorities. Māori as a population group experience the poorest health outcomes. As you consider equity within your district, there needs to be an explicit focus on achieving equity for Māori across their life course. Māori-Crown relations is a priority for this Government and I expect your DHB to meet your Treaty of Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I am expecting you to report on progress with how you are meeting these obligations as part of your Annual Plan reporting.

Unmet need also represents a significant barrier to achieving equity in health outcomes for all populations groups across New Zealand. I expect your Annual Plan to contain actions that will enable progress towards achieving equity and to address the key areas of unmet need especially for Pacific peoples and other population groups in your regions with poorer health outcomes.

Our approach

DHB Chairs are directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management to account for improved performance within their DHB, in relation to both equity of access to health services and equity of health outcomes. In addition, I will also be working towards ensuring that Māori membership of DHB Boards is proportional to the Māori population within your district.

Fiscal responsibility

Strong fiscal management is essential to enable delivery of better services and outcomes for New Zealanders. I expect DHBs to live within their means and maintain expenditure growth in line with or lower than funding increases.

My expectation is that DHBs have in place clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings. This is essential for ensuring financial and clinical sustainability of our health system.

A better collective understanding of the demand for services, drivers of deficits and financial risks remains a very significant priority and I expect you to work closely and proactively with the Ministry of Health on these matters. I will continue to meet and speak with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to deliver in the Government's priority areas, to keep within budget and to manage your cash position.

Strong and equitable public health and disability system

Building infrastructure
My expectation is for timely delivery of Ministers' prioritised business cases. I remind you that capital projects over $10 million are subject to joint Ministers (Minister of Health and Minister of Finance) approval. Business cases will be assessed to ensure that they are in line with the Health Capital Envelope priorities. I also expect you ensure that your agency is aware of the expectation that upcoming construction projects will be used to develop skills and training and that the construction guidelines will be applied for all procurement of new construction from this point onwards. I will be writing to you separately about this with further detail.

National Asset Management Plan
I expect you to support the National Asset Management Plan programme of work. I encourage you to actively interact with the project as, long term, the National Asset Management Plan will formulate the capital investment pipeline, and ensure DHBs' future infrastructure needs are met.

Devolution
I am considering devolution of certain services and expect to be making decisions in the New Year. DHBs will be consulted during the process to ensure the financial and service implications are well understood. Once any decisions have been made, I will expect you to work with the Ministry of Health to ensure a seamless transition of responsibilities.

Workforce
I expect DHBs to develop bargaining strategies that are consistent with the Government Expectations on Employment Relations in the State Sector, and to act collaboratively to ensure that any potential flow-on implications across workforces and/or across DHBs are understood and addressed in the bargaining strategies. A Government priority is raising the wages of the least well-paid workforces, which will require a different approach to the traditional one based on across-the-board percentage increases. I also expect DHBs to implement Care Capacity Demand Management in accordance with the process and timetable set out in the 2018-2020 MECA. I note that the State Services Commissioner has included wording that reflects the commitments in the New Zealand Nurses Organisation Accord in the performance expectations of the Director-General of Health and I ask you to consider including similar wording in the performance expectations of your Chief Executive.

DHBs have an essential role in training our future workforce and I expect you to support training opportunities for the range of workforce groups. As part of this, you should work closely with training bodies such as tertiary education institutes and professional colleges and bodies to ensure that we have a well trained workforce and to support research. I continue to expect DHBs will adhere to the Medical Council's requirement for community-based attachments for PGY1 and PGY2 doctors.

Bowel Screening
The National Bowel Screening programme remains a priority for this Government, and I expect you to develop a sustainable endoscopy workforce, be it medical or nursing, including the strategic support of training positions for both nursing and medical trainees in order to meet growing demand in this area. It is crucial that symptomatic patients are not negatively impacted by screening demand and the Ministry of Health will work closely with you on workforce issues to support this.

Planned Care
I am enabling DHBs to take a refreshed approach to the delivery of elective services under a broader "Planned Care" programme. Timely access to Planned Care remains a priority. The refreshed approach to Planned Care will provide you with greater flexibility in where and how you deliver services and will enable more care to be delivered within the funding envelope. I urge you to take advantage of the opportunity that will be made available, and support your teams to develop well considered delivery plans that align with your population's needs, support timely care, and make the best use of your workforce and resources.

Disability
Disabled people experience significant health inequalities and they should be able to access the same range of health services as the rest of the general population. My expectation is that DHBs are working towards or are implementing the Convention on the Rights of Persons with Disabilities. I expect DHBs to implement policies for collecting information, within their populations, about people with disabilities. In addition, please ensure your contracts with providers reflect their requirements to either ensure accessibility or put in place concrete plans to transition to a more accessible service.

System Level Measures
As part of your focus on improving quality, I expect you to continue to co-design and deliver initiatives to achieve progress on System Level Measures with primary health organisations (PHOs) and other key stakeholders.

Rural health
The Government expects DHBs with rural communities to consider their health needs and the factors affecting health outcomes for rural populations when making decisions regarding health services.

Mental health and addiction care

Mental health and addiction remains a priority area for this Government and I expect your DHB to prioritise strengthening and improving mental health and addiction service areas in your 2019/20 Annual Plan. The Mental Health and Addiction Inquiry report is under consideration by the Government and it is my expectation that DHBs are ready to move on implementing the Government's response to its recommendations.

Over the last year a number of deaths across the country have been attributed to use of synthetic cannabinoids. I expect DHBs to consider the role of both public health and specialist treatment services in providing coordinated local responses to emerging drug threats such as synthetic cannabinoids.

Child wellbeing

Child wellbeing is a priority for our Government. I expect your annual plans to reflect how you are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

In supporting the Government's vision of making New Zealand the best place in the world to be as a child I expect DHBs to have a specific focus on:

- supporting the development of the Child Wellbeing Strategy, particularly the First 1000 days of a child's life and child and youth mental wellbeing
- contributing to the review of the Well Child Tamariki Ora programme
- supporting the reduction of family violence and sexual violence through addressing abuse as a fundamental health care responsibility.

Maternity care and midwifery
High quality maternity care is recognised as a fundamental part of child wellbeing. I am listening to the issues the community is raising with me, and I take the concerns about the level of capacity in the midwifery workforce seriously. It is my expectation that DHBs implement a plan to support improved recruitment and retention of midwives, including midwives in the community and midwives employed in all maternity facilities.

Smokefree 2025
I also expect you to advance progress towards the Smokefree 2025 goal, particularly community-based wrap-around support for people who want to stop smoking, with a focus on Māori, Pacific, pregnant women and people on a low income. I also want to see DHBs collaborating across their region to support smoking cessation including, where appropriate, amongst programme providers, with a view to sharing and strengthening knowledge and delivery of effective interventions.

Primary health care

Improved access to primary health care brings significant benefits for all New Zealanders as well as our health system. Removing barriers to primary health care services and improving equity are key priorities for this Government. I also want to see closer integration of primary health care with secondary and community care. I intend to continue to invest in primary health care and expect all DHBs to support this important priority.

Non-communicable disease (NCD) prevention and management

As our major killers, NCDs, particular cancers, cardiovascular disease and type 2 diabetes need to be a major focus for prevention and treatment for your DHB. I want you to continue a particular focus on type 2 diabetes prevention and management, including an emphasis on ensuring access to effective self-management education and support. I want to see an increased focus on prevention, resilience, recovery and wellbeing for all ages, as part of a healthy ageing approach. You should also use PHO and practice-level data to inform quality improvement.

Public health and the environment

Environmental sustainability
I expect you to continue to contribute to the Government's priority outcome of environmental sustainability and undertake further work that leads to specific actions, including reducing carbon emissions, to address the impacts of climate change on health. This will need to incorporate both mitigation and adaption strategies, underpinned by cost-benefit analysis of co-benefits and financial savings and I expect you to work collectively with the Ministry of Health on this important area.

Healthy eating and healthy weight
As part of your sector leadership role, I strongly encourage you to support healthy eating and healthy weight through continuing to strengthen your DHB's Healthy Food and Drink Policy This includes increasing the number of food options categorised as 'green' in the National Policy and moving towards only selling water and milk as cold drink options. I actively encourage you to support other public and private organisations to do the same. There is a strong rationale for DHBs providing such leadership in their communities to both set an example and to 'normalise' healthy food and drink options. In particular I would like you to work directly with schools to support them to adopt water-only and healthy food policies.

Drinking water
You will be aware that our Government is undertaking system-wide reform of the regulatory arrangements for drinking water and I am confident that you will support any developments that may result. I expect you to work through your Public Health Unit across agency and legislative boundaries to carry out your key role in drinking water safety with a focus on the health of your population.

Integration
Improving equity and wellbeing and delivering on several other expectations I am setting in this letter will not be possible without strong cross-sectoral collaboration. I expect DHBs to demonstrate leadership in the collaboration between and integration of health and social services, especially housing.

Planning processes

Your DHB's 2019/20 Annual Plan is to reflect my expectations and I also ask you to demonstrate a renewed focus on your strategic direction, by refreshing your Statement of Intent in 2019/20.

I believe providing you with my expectations in December will support your planning processes, however I also acknowledge that some important decisions will be made in the coming weeks, including detail related to implementation of the Mental Health and Addictions Inquiry recommendations. To ensure my expectations are clear, it is my intention to provide an update to this letter in the New Year.

I would like to take this opportunity to thank you, the Board and your staff for your dedication and efforts to provide high quality and equitable outcomes for your population.

Yours sincerely

Hon Dr David Clark
Minister of Health

Minister's 2019/20 Letter to Waikato DHB

*(*Placeholder for Annual Plan approval letter*)*

SECTION ONE: Overview of Strategic Priorities

Introduction

This draft 2019/20 Waikato District Health Board Annual Plan (draft Plan) meets the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act and the expectations of the Minister of Health. In accordance with sections 100 and 141 of the Crown Entities Act 2004.

The draft Plan incorporates the organisation's Statement of Performace Expectations and the 2019/20-2021/22 Statement of Intent. More detailed planning and reporting, including Financial Performance, and our System Level Measure Plan are contained in the appendices.

The document sets out our goals and objectives and what we intend to achieve, in terms of improving the health of our population and ensuring the sustainability of the Waikato health system over the coming three years. The core components of the Statement of Intent can be extracted from the Waikato DHB's Annual Plan (sections x, y an z) and complied as a separate public accountability document.

Strategic intentions/priorities

**Insert additional information on our future direction/HSP **

This draft Plan articulates the Waikato District Health Board (DHB) commitment to meeting the Ministers expectations, and our continued commitment to our Board's vision – **Healthy People. Excellent Care**. It makes clear links to national, regional and district agreed strategic priorities including the Waikato DHB Strategy (2016) and draft Waikato DHB Health System Plan (2019).

It is a high-level document but still provides a strong focus on improved performance and access, financial viability, health equity and service performance to meet legislative requirements.

Waikato DHB is committed to working in partnership with local iwi and Māori providers, Pacific providers as well as the other Midland Region DHBs. This draft Plan is aligned with national, regional and local strategies.

Financial performance

Insert narrative on our current financial situation and how this plan will have a focus on ensuring financial stability moving forward

National

The Treaty of Waitangi

The Treaty of Waitangi (Te Tiriti o Waitangi) is New Zealand's founding constitutional document and is often referred to in overarching strategies and plans throughout all sectors. Waikato DHB values the importance of the Treaty. Central to the implementation of the Treaty principles is a shared understanding that health is a 'taonga' (treasure).

The principles within the Treaty of partnership, protection, participation implicitly recognise the important role the health sector plays in recognising the indigenous rights of Māori to achieve radical improvements in health and eliminate health inequities.

New Zealand Health Strategy

The New Zealand Health Strategy is the key source of direction for the health sector. The refreshed New Zealand Health Strategy provides the sector with clear strategic direction and a road map for the delivery of integrated health services for all New Zealanders. The strategy has a ten-year horizon so impacts on immediate planning and service provision as well as enabling and requiring DHBs and the sector to have a clear roadmap for future planning.

He Korowai Oranga

As New Zealand's Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. Pae Ora (Healthy Futures) is the Government's vision and aim for the refreshed strategy. It builds on the initial foundation of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments). DHBs in particular should consider He Korowai Oranga in their planning, and in meeting their statutory objectives and functions for Māori health.

The Healthy Aging Strategy

The Healthy Ageing Strategy presents the strategic direction for change and a set of actions to improve the health of older people, into and throughout their later years. It refreshes and replaces the Health of Older People Strategy 2002, and aligns with the new New Zealand Health Strategy 2016. The Healthy Ageing Strategy vision is that "older people live well, age well, and have a respectful end of life in age-friendly communities". It takes a life-course approach that seeks to maximise health and wellbeing for all older people.

The UN Convention on the Rights of Persons with Disabilities

The UN Convention on the Rights of Persons with Disabilities is the first United Nations human rights treaty of the 21st century. The Convention makes it explicit that member countries must ensure the full realisation of all human rights and fundamental freedoms for all disabled people, on an equal basis with others, and without discrimination of any kind on the basis of disability. It will also help to ensure that mainstream services are inclusive of disabled people and delivered in non-discriminatory ways.

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018

The purpose of Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018 is to facilitate the delivery of high-quality health services that meet the needs of Pacific peoples, 'Ala Mo'ui has been developed. This builds on the successes of the former plan, 'Ala Mo'ui 2010-2014. It sets out the strategic direction to address health needs of Pacific peoples and stipulates new actions, to be delivered from 2014 to 2018.

Regional

Legislation requires the DHBs to collaborate regionally and for each of the four regions of DHBs to develop a Regional Services Plan (RSP). The RSP is a companion plan to DHB Annual Plans. HealthShare Ltd, the Midland DHBs shared services agency, is tasked with developing the Midland RSP, on our behalf. This work is carried out in consultation with the Midland DHBs Annual Plan Writers Group and DHB Executive Groups to ensure collaboration and 'line of sight' (alignment) between the region and DHB planning. Specific activities that will be undertaken regionally can be found on page xx of this plan within the Delivey of Regional Service Plan priorities.

The Midland region has identified six regional strategic objectives that inform and support the direction of regional efforts:

- Health equity for Māori
- Integrate across continuums of care
- Improve quality across all regional services
- Build the workforce
- Improve clinical information systems
- Efficiently allocate public health system resources

Work programmes are developed by the regional clinical networks and action groups, the regional enablers, and also by services provided by HealthShare. Alignment with national and regional strategic direction is provided against each work programme's initiatives i.e. the New Zealand Health Strategy's five strategic themes; the national System Level Measures, and Midland's six regional strategic objectives. Resourcing for delivery of approved work programmes is regionally agreed, budgeted and approved.

Full details can be found in the Regional Services Plan 2018-2021.
Insert hyoperlink once RSP completed

Local

Waikato DHB is the Government's funder and provider of health services to an estimated 426,137 residents living in the Waikato district, covering almost nine percent of New Zealand's population, the fifth largest DHB in the country. The DHB has a larger proportion of people living in areas of high deprivation than in areas of low deprivation. The population is becoming proportionally older (the 65 plus age group is projected to increase by 40

percent between 2018 and 2028). This will increase the prevelance of chronic and complex health conditions and informs many of the strategies being put in place to meet future health need.

Twenty three percent of the population are Māori compared with the national average of 16 percent. The Māori population are significantly impacted by many chronic conditions such as diabetes and smoking related diseases and are disproportionally represented in adverse health statistics. These facts, combined with the acknowledgment of the status of iwi in the Waikato, provides a strong driver to include and engage Māori in health service decision making, and to deliver health information and health services in a culturally appropriate way.

The Pacific population also make up almost three percent of the DHB population and are a group that require targeted health initiatives.

Working with Waikato Public Health

Waikato Public Health provides activities to promote, improve and protect health and wellbeing with a focus on achieving equity for people living in the district. Good health and wellbeing is about more than healthcare. A good start in life, education, decent work and housing, and strong, supportive relationships and communities all play their part. For this reason, Waikato DHB is working closely with Waikato Public Health to ensure alignment between the Waikato DHB and Waikato Public Health annual plans, where approripate. This will strengthen work towards achieving better health outcomes for the district's population.

Some key focus areas we will work together on in 2019/20 are:[1]

- Māori health and equity.
- Disability and equity.
- First 1000 days.
- Climate change, environmental sustainability and transport.
- Healthy eating – healthy weight.
- Developing preventative capabilities in hard-to-reach communities.
- Cross-sectoral collaboration.

Waikato DHB Strategy

During 2016/17 Waikato DHB began implementing a new strategy which concentrated on ensuring the organisation was heading in the right direction, focusing its resources and making the most of future opportunities. It recognises that there are some fundamental challenges that must be faced along the way as the organisation continues to improve the health status of its population and works to achieve health equity. The strategy clearly articulated a future vision and set of strategic imperatives that provide a ten year overarching strategic framework that will ground all decisions within a priority hierarcy.

[1] See appendix xx PHU Annual Plan for activities that reinforce these focus area

Our Vision - **Healthy people. Excellent Care.**
Our Mission - Enable us all to manage our health and wellbeing. Provide excellent care through smarter, innovative deliver.

Our Strategic Imperatives	Our Priorities
Health equity for high needs populations - Oranga	• Radical improvement in Māori health outcomes by eliminating health inequities for Māori • Eliminate health inequities for people in rural communities • Remove barriers for people experiencing disabilities • Enable a workforce to deliver culturally appropriate services
Safe, quality health services for all - Haumaru	• Deliver high quality, timely safe care based on a culture of accountability, responsibility, continuous improvement, and innovation • Prioritise fit-for-purpose care environments • Early intervention for services in need • Ensure appropriate services are delivered to meet the needs of our populations at all stages of their lives
People centred services – Manaaki	• Utilise the expertise of communities, providers, agencies, and specialists in the design of health and care services • Provide care and services that are respectful and responsive to individual and whānau needs and values • Enable a culture of professional cooperation to deliver services • Promote health services and information to our diverse population to increase health literacy
Effective and efficient care and services - Ratonga a iwi	• Live within our means • Achieve and maintain a sustainable workforce • Redesign services to be effective and efficient without compromising the care delivered • Enable a culture of innovation to achieve excellence in health and care services
A centre of excellence in learning, training, research and innovation – Pae taumata	• Build close and enduring relationships with local, national, and international education providers • Attract doctors, nurses, and allied health staff to the Waikato through high quality training and research • Cultivate a culture of innovation, research, learning, and training across the organisation • Foster a research environment that is responsive to the needs of our population
Productive partnerships - Whanaketanga	• Incorporate te Tiriti o Waitangi in everything we do • Authentic collaboration with partner agencies and communities • Focus on effective community interventions using community development and prevention strategies • Work towards integration between health and social care services

Waikato DHB Health System Plan

In 2018/19 Waikato DHB developed a draft Health System Plan to improve our health system and futureproof it for the challenges we expect in the coming years. It translates the DHB strategy of **Healthy People. Excellent Care.** into a set of strategic goals and actions for the Waikato health system for the next ten years. The draft Health System Plan incorporates a roadmap of actions to guide implementation across the Waikato.

During a series of wānanga, focus groups, and workshop sessions, over 600 members of our community (including health workers from the DHB and the broader health system) took the opportunity to share their experience, knowledge and ideas. People said that they would like Waikato health services to be:

- Focussed on wellness and wellbeing
- Focussed on the needs of service users, not the services' needs
- Equitable and fair for everyone regardless of ethnicity, sex, age or where people live
- Integrated with smooth links between health and other social services
- Designed with the people who use them.

The community and whānau voices have been distilled into draft goals with underlying actions.

Healthy People goals.

- Goal 1: Partner with Māori in the planning and delivery of health services
- Goal 2: Empower whānau to achieve wellbeing
- Goal 3: Support community aspirations and address determinants of health

Excellent Care goals.

- Goal 4: Improve access to services
- Goal 5: Enhance the capacity and capability of primary and community health care
- Goal 6: Strengthen intermediate care

The following enablers will be critical in achieving the goals:

- Leadership and partnerships
- Commissioning
- Workforce Development
- Technology and Information
- Quality Improvement

Refer to the draft Health System Plan on the Waikato DHB website www.waikatodhb.health.nz/hsp for further details.

Draft Health System Plan Direction

Placeholder for HSP diagram

The future of health will see a greater focus on prevention, wellbeing and care in the community (hence the larger cog) to ensure our population remain healthy and reduce their need for health and treatment services and care (smaller cog).

Delivering on the strategic direction

Waikato DHB will focus on its strategic objectives (for the next three years), moving from contracting to commissioning and beginning implementation of the draft Health System Plan. The latter includes a focus on improving responsiveness to Māori, empowering local communities and enabling health and wellbeing, over treatment of illness.

Strategic objectives

The Waikato DHB's strategic objectives for the next three years are guided by the Waikato DHB Strategy and draft Health System Plan. They have links to the Minister's identified expectations of DHBs for 2019/20. Waikato DHB has identified five strategic objectives for the next three years to meet Statement of Intent expectations (see table x).

Table 1: Waikato DHB Startegic objections (2019/20-2021/220 and links to direction and expectations

Objective	Associated draft Health System Plan goal(s)	Associated Expectations of the Minister (2019/20)
1. Begin Implementation of the Health System Plan with a particular focus on health equity for Māori through partnerships with Māori, and enabling whānau wellbeing.	All goals	Achieving equity for Māori Devolution Workforce Unmet need for Māori and Pacific Disability Rural health Integration across sectors Refreshed strategic direction
2. Reorient primary and community service delivery across the district.	Goals 4-5	Primary health care – closer integration with secondary and community care
3. Implement the new model of service delivery for mental health and addictions services across the district in line with Te Ara Oranga and Te Pae Tawhiti.	All goals	Mental health and addiction care Integration across sectors
4. Strengthen action to improve productivity and fiscal management across the organisation.	All goals	Fiscal responsibility Building infrastructure
5. Develop and implement a Tamariki Oranga/Child Health Plan across the district.	All goals	Child wellbeing Maternity care and midwifery Integration across sectors

Commissioning

As noted above, five key enablers have been identified as critical in achieving the draft Health System Plan goals. One of these key enablers is the commissioning approach that was adopted by Waikato DHB in 2018. The commissioning approach is founded on its

commitment to working in partnership to improve population health and eliminate health inequities.

The principles that guide our approach to commissioning are:

- *Equity for vulnerable populations:* a 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.

- *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, Waikato DHB has developed the 'Commissioning Koru.'

What will this look like?

DHB Strategy Development

Developing the DHB Strategy provided an overarching strategic framework and is the first step in the commissioning process as it grounds all future decisions within a priority hierarchy.

Strategic Position Statements
Good planning requires clear definitions and descriptions of activities and areas of focus, position statements will provide a solid foundation upon which engagement with wider stakeholder groups can take place and guide service development.

Health Needs Assessment
Knowing where to invest in services to maximise health gain and reduce inequalities is entirely dependent on understanding the health needs of the population. Waikato DHB will run an active Health Needs Assessment Programme where aspects will be updated as new data becomes available.

Health System Design
A Health System Plan provides a schematic that outlines what a connected system of health services looks like at a future point in time. It will provide clear direction for on-going service planning and change management activity.

Investment Prioritisation
Ensures investment in services that maximise health gain and eliminate inequalities by identifying where investment is most likely to have the greatest impact, and to prioritise our investments based on clear evidence and rationale.

Service Development
Service development will be more collaborative and create better connections across the sector to ensure services are more people centred and are focussed on reducing inequalities, particularly for Māori. Services will be developed through co-design with stakeholders including our communities, Iwi Maori Council, the Consumer Council, Board and Committees.

Contracting for Outcomes
We will collaborate with our service providers to reorientate contracts to be clearly linked to desired outcomes. This will allow for services to be developed around people and their whanau and ensure we deliver the right service to achieve the desired outcomes.

Monitoring and managing performance
There will be a strong focus on monitoring performance and working together to remediate issues and take advantage of opportunities. The Strategy and Funding directorate of the DHB will have a stronger focus on evaluation to ensure that services continue to successfully impact on our strategic imperatives.

Outcomes/Value For Money measurement
Consideration will be given to all performance and evaluation information to determine the relative value and outcomes of the service and investment.

Re-commission or Decomission Services
In addition to considering the relative value and contribution to outcomes a service has made, re-commissioning or decommissioning decisions will also be driven by: changes in organisational priorities determined by the Government of the day or Board, the emergence of opportunities to deliver services in a more effective way, and the Government's Rules of Sourcing.

Implementing the Health System Plan

Health System Plan implementation will begin in 2019 subject to Waikato DHB Board approval of the final Plan. Implementation will be phased over a 10 year timeframe. To successfully achieve this new strategic direction over the short to medium term, the organisation and other health system partners will need to consider changes to how it funds services, to review the scope and nature of services provided and to transform the organisation's culture.

Action plans
Waikato DHB is developing a series of action plans over the next three years to support the implementation process. The development of these plans will guided by the Waikato DHB Strategy and Health System Plan.

Initial action plans prioritised for development and/or implementation in 2019/20 by Waikato DHB include:

- Te Pae Tawhiti/Mental Health and Wellbeing Plan,
- Tamariki Oranga/Child Health Plan, and
- A Disability Responsiveness Plan.

These plans will be delivered via a locality lens and have a three to five year implementation timeframe although some may adopt an extended timeframe.

Localities
The term 'locality' encompasses ideas of a community living within a geographic area, a physical place, or an administrative unit. Locality refers to places where people feel connected. It can be about links with history, family/whānau, communities of interest, relationships with people and involvement in different communities that make the place home. Localities are where people live, go to school, use services, and are involved in community activity. People feel comfortable in and are familiar with their local areas.

Waikato DHB recognises the particular role that localities play in shaping health outcomes. It therefore makes sense to focus services and community action by locality. Services can be more responsive and accessible in the future if they are both close to home and in familiar surroundings.

The organisation has identified seven localities across the district (see figure x). It recognises the potential of locality as a means of supporting Health System Plan implementation. Since 2017/18, Waikato DHB has used the concept of locality as a tool to support health planning and reporting.

Placeholder for HSP diagram

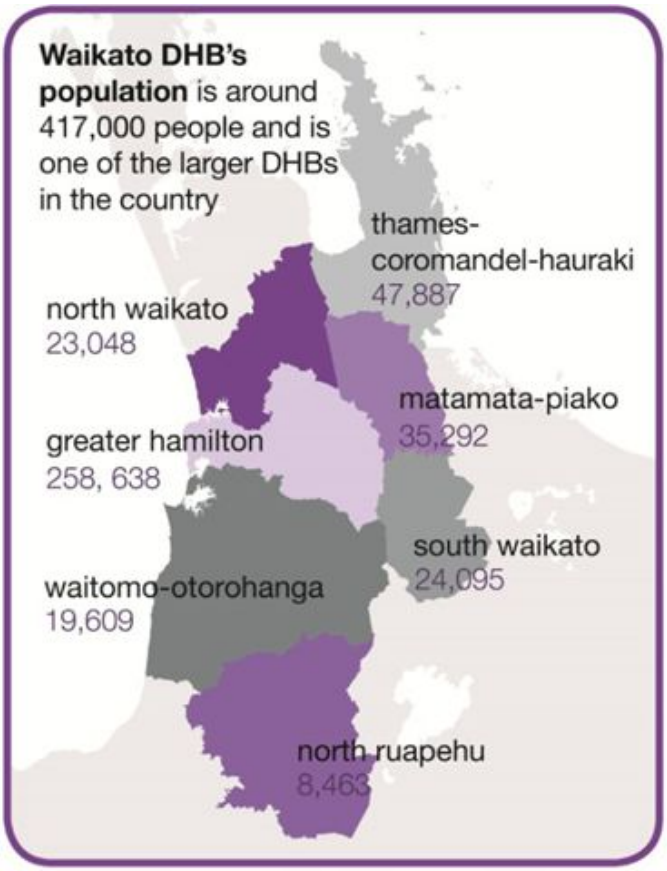


Figure x: Waikato DHB localities

Links to long term investment planning
Work is to occur over the next three years to determine what else is required over the longer term in order to support delivery of the organisation's new strategic direction i.e. Health System Plan goals and enablers.

The next Waikato DHB Long Term Investment Plan (LTIP) is due to be submitted to Treasury in July 2019. The LTIP will be based on the 10 year Health System Plan which will be completed in June 2019. Given the process required to develop investment scenarios that are rational and aligned to the Health System Plan, it is proposed that the organisation takes a staged approach and focuses on a few key components in this LTIP iteration. The LTIP will include narrative on the proposed phase(s) of its future development.

Foreword from the Waikato DHB Chair and Chief Executive

Insert Photo of Sally
Sally Webb, Chair

Over the coming year we need to start making some big changes to meet the challenges of the future and to have a health system that works for our people, particularly our large Māori community.

Our new ten year Health System Plan incoroprating the Care in the Community Plan will give us a pathway to help us do this. It will focus our work to address what is needed in communities to support people to stay well and live well with their health needs and to have better more affordable health services.

Most importantly, we want to design those changes with our communities and the people who use our services. We particularly want to partner with Māori in the planning and delivery of health services. Achieving a radical improvement to Māori health outcomes and their access to healthcare is our key priority so we can ensure equity for everyone.

Our mental health and addiction services have been working hard to engage with the community around new ways of delivering services and we are well placed to respond to the outcome of the mental health inquiry this year.

We are committed to our best endeavours to achieve the outcomes outlined in the Minister's Letter of Expectation, but like many DHBs we are struggling with a large deficit so this coming year we need to fully understand what is driving this and work hard to achieve a sustainable financial position.

In all of this we never forget that people are at the centre of all we do, both the amazing people who work for us and the people we serve in the community.

He aha te mea nui o te ao
What is it that's important in the world
He tangata, he tangata, he tangata
It is people, it is people, it is people

Insert photo of Derek
Derek Wright, Interim Chief Executive

This Annual Plan sets out the direction and priorities for the coming 2019/20 year for the Waikato DHB.

This DHB has had some financial challenges over the last year but we now have an opportunity to move forward in a number of areas. We have focused on strengthening our relationships across the Midland region and we will continue to look for new and innovative ways of working to deliver the best healthcare for the communities we serve that we can.

We will have a particular focus on reducing health inequalities – particularly for Māori - improving integration of services and making sure we deliver services in the most sustainable way – ensuring Waikato people have access to the highest quality health services no matter where they live.

Our Consumer Council has been in place for a little over 12 months and has assisted us in how we plan and deliver services at the DHB.

The Consumer Council is working in partnership with the DHB to provide a consumer perspective and help make sure our services meet the needs of Waikato communities. It also provides advice to the Board and senior management on the DHB's strategic priorities and improving aspects of DHB services.

This is an exciting but challenging time for the DHB as we move to implement the Health System Plan and look at innovative solutions to deal with the continued demands on our services.

None of our aspirations outlined in this plan would be possible without the 7,000 dedicated and hardworking staff who are delivering more healthcare both in our hospitals and in the community and living our vision of Healthy people. Excellent care.

Signatories

Agreement for the Waikato DHB 2019/20 Annual Plan

between

Hon Dr David Clark Minister of Health Date:	Sally Webb Chair Waikato DHB Date:	Derek Wright Chief Executive Waikato DHB Date:

SECTION 2: Delivering on Priorities

Waikato DHB is committed to delivering on the Minister's Letter of Expectations and to the agreed planning priorities. These planning priorities include a particular focus on improving Māori health and health equity.

Health Equity

Health inequities are systematic, avoidable and unfair differences in mental or physical health between groups of people. These differences affect how long people live in good health. They are often a result of differences in people's homes, education and childhood experiences, their environments, their jobs and employment prospects, their access to good public services and their habits.

Achieving equity within the New Zealand health system underpins all government priorities. In addition to the poor health outcomes that population group's impacted by inequities experience, unmet need is also a barrier. The draft Health System Plan supports this intent, and its implementation is underpinned by a commitment to health gain and equity for the Waikato DHB priority propulations across the district.

Waikato DHB's focus is on a radical improvement in equity for the following priority groups: Māori, people living in rural areas, people who experience disability, and Pacific people. These population goups are very likely to experience inequity in both access to health services and quality care. This requires an explicit focus on achieving equity for each group across their life course and in particular localities.

Health Equity Tools

Waikato DHB utilises the following health equity tools to assess and identify disparities and outline activities for improving equitable access and outcomes:

- The Health Equity Assessment Tool (HEAT). This tool will be updated after working with Te Puna Oranga and Iwi Māori Council (IMC) to ensure it is made more relevant for Waikato DHB.
- Equity of Health Care for Māori: A Framework.
- He Pikinga Waiora Implementation Framework.
- 'Ala Mo' ui: Pathways to Pacific Health and Wellbeing 2014-2018 as guidance for service design and development.
- Health improvement process (Waikato Public Health) – a whānau ora centred consistent framework for implementing the settings based approach and has an intentional emphasis on health equity, particularly for Māori and other vulnerable peoples and communities. Te Pae Mahutonga is embedded within this process as the framework for engaging effectively with communities within the key settings.

Waikato Public Health has significant expertise in understanding population needs. Work is currently underway to strenthgen service activity integration to enhance system development and service responsiveness, particularly for Māori and other priority populations.

Māori Health

Māori as a population group experience the poorest health outcomes, and the organisation requires an explicit focus on achieving equity for Māori across their life course.

Ki te Taumata o Pae Ora is Waikato DHB's Māori Health Plan. It identifies key elements required to improve Maori health across the Waikato DHB district. The operative plan - Ki te Taumata o Pae Ora 2016-17 - is in the process of being updated. This plan will support the organisation's broader planning for Māori health gain and achieving health equity for Māori. Ki te Taumata o Pae Ora means to reach the pinnacle of a healthy future and as He Korowai Oranga[2] outlines this encapsulates, healthy individuals, healthy whānau and healthy environments.

Māori whānau, hapū, and iwi want to have control over their own destinies, to live longer and enjoy a better quality of life, to confidently participate in te ao Māori and to feel valued as a member of their communities and environments. Good health/oranga, will be achieved on three levels. This aligns to the organisation value Te Iwi Ngakaunui (People at heart) (see figure x)

Waikato DHB wil continue to uphold our obligations as a Treaty of Waitangi partner as specified in the New Zealand Public Health and Disability Act 2000. To ensure we are staying on track with these obligations we will complete a progress report on how we are meeting these these obligations in our Annual Report.

Equitable Outcomes Actions (EOA)

There is a Ministry requirement that all equity actions specifically designed to reduce health outcome equity gaps be identified with 'EOA.' Waikato DHB is in the process of implementing a tool that will help prioritise investment based on whether it will drive radical improvements to Māori health.

The Radial Improvements to Māori Health Tool is based on the principles of Partnership (governance and decision-making), Participation (workforce and whānau), Protection (targeted approachs and services), and Pono (tikanga). It will support Waikato DHB planning and funding decisions that will enable the achievement of our key strategic objective; Radical improvement in Māori health outcomes by eliminating health inequities for Māori.

This tool will be used across the activities in this plan to assess if an activity is an EOA for Māori. The organisation will work with others in the coming year to determine an appropriate methodology to help assess activities in the future for equity for our remaining priority population groups i.e. Pacific peoples, those who experience disability, and people living in rural areas.

Responding to the Guidance

The draft Plan is a further refinement of the 2018/19 Annual Plan, however the priorities have been updated to reflect the Ministers direction and chosen priorities. Engagement with

[2] New Zealand Māori Health Strategy (2014)

relevant stakeholders including our primary care partners has been undertaken in developing this document.

Regional Service Planning

TBC - Guidance will be released in April 2019

Government Planning Priorities

The 2019/20 Planning Priorities are:

- Strong fiscal management
- Strong and equitable public health and disability system
- Mental health and addiction care
- Child wellbeing
- Primary health care
- Public health and the environment

Connection between the whole of government priorities and the health system priorities:

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
Support healthier, safer and more connected communities	We have health equity for Māori and other groups	Strong and equitable public health and disability system	Health equity for high need populations	**Engagement and obligations as a treaty partner** ***TBC*** Implementation of the Kaupapa Puna Waiora which is a kaupapa Māori support system offered by Waikato District Health Board (DHB), empowering and supporting Rangatahi Māori to pursue a career in health. Support services from year 9 through to employment; operationalising the continued partenership between Iwi Māori and Waikato DHB. The principles of Partnership, Participation, Protection and Pono will continue to underpin the special relationship between Waikato DHB and iwi, and are woven throughout our strategic direction. We will weave Tikanga principles into the key 'moments that matter' through the employee lifecycle, starting with recruitment. Have a workforce that is 23 percent Māori in all role types and at all levels within the DHB to ensure our workforce reflects our population and that Māori experiences and expertise can be found everywhere. Supports developed to allow our Māori and Pasifika DHB employed midwives to culturally engage with Māori and Pasifika students. Prioritise the development of the Māori workforce through partnerships with education providers and training institutions. The Public Health Unit (PHU) will focus on engagement and productive partnerships in Māori and Pacific communities to improve Māori and Pacific wellbeing (whānau ora) and health equity.[3] Enable community leaders to facilitate inquiry process within the setting to understand needs and opportunities for health improvement.[4] Enable community leaders to develop and implement action and evaluation plans to evaluate their health improvement strategies and monitor change over time.[5]				Oversight: Loraine Elliott

[3] Reporting for this activity will be completed by the Public Health Unit.
[4] Reporting for this activity will be completed by the Public Health Unit.
[5] Reporting for this activity will be completed by the Public Health Unit.

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
	We have improved quality of life	Strong and equitable public health and disability system	Productive partnerships	**Cross-sectoral collaboration** **Waikato DHB continues to work with all key partners to significantly improve the Districts performance, 2019/20 will see a particular focus on:** <u>Waikato Plan</u> The Waikato Plan is a collaborative strategic plan developed by central and local government and iwi, to address the challenges facing the region. The key areas of focus being housing affordability and mental illness. Waikato DHB will take a lead role in working with partners to scope and once agreed, implement action on mental health which will also be aligned with Te Pae Tawhiti. <u>Cross-sector</u> Collaborating with other government agencies to provide digital health solutions to underserved populations and to those in difficult circumstances. For example, Waikato DHB partners with local law-enforcement agencies to provide mental health triaging facilities using FaceTime at police stations. <u>The Waikato Projections Working Group</u> The group consists of representatives from all the district councils, Hamilton City and Waikato Regional Council, the New Zealand Transport Authority and Waikato DHB. The purpose of the working group is to plan and deliver a regionally consistent set of future population and economic projections for the Waikato region, at the district and local level, providing a shared and common evidence-base for consistency in planning and decision-making. <u>Smokefree Environments</u> The Waikato DHB will work with local councils and other health system partners to strengthen their local smoke free environments policy. <u>Gateway</u> Waikato DHB will maintain its membership of the Gateway Governance Group (Ministry of Education, Oranga Tamariki, Disability Support Link, Waikato DHB mental health Services, DHB Child Health Pediatricians). The Group is chaired by Oranga Tamariki. <u>Family Start (0-5years)</u> Waikato DHB will lead further development of joint network activities linked to comprehensive community health workers support i.e. Family Start, Well Child Tamariki Ora and Primary Health Care Organisations.	Q1 and Ongoing Q1 and Ongoing Q1 and Ongoing Q4 Q4 Q4		EOA EOA	Oversight: Tanya Maloney Reporting: Regan Webb and Greg Morton

Waikato DHB Key Response Actions to Deliver Improved Performance								
Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
	We live longer in good health	Stong and		**Strategic health measures** ***TBC awaiting govt. decision***				Oversight: Tanya Maloney Reporting: Regan Webb, Rachel Poaneki, Nina Scott
	We have improved quality of life	Stong and equitable public health and disability system	People centered services	**Disability** Staff training on how to interact with a person with a disability will be included in our "Supportive Employment" stream of work for 2019/20. Once the new HRIS system has been implemented we will monitor training completions. At face-to-face patient interactions any disability the patient discloses is collected and updated in iPM as a Patient Alert. This information is also populated into Clinical Work Station (CWS). All clinicians have access to CWS and administrators have access to iPM.	Q1 and ongoing Q4 Ongoing			Oversight: Tanya Maloney Reporting: Gil Sewell and Gil Sewell
	We live longer in good health	Stong and equitable public	Effective and efficient care and services	**Planned care** ***Awaiting guidance from the Ministry***				Oversight: Ron Dunham Reporting: David Nicholson and Gareth Fannin

Waikato DHB Key Response Actions to Deliver Improved Performance								
Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Stong and equitable public health and disability system	Safe, quality health services for all	**Acute demand** Waikato DHB carefully considered the implementation of SNOMED coding In ED. Due to the expected impact on the department plus concerns around local prioritisation and resourcing processes we will look at implementing SNOMED ED in the 20/21 year. System Level Measure Improvement plan contains activities to improve management of patients to ED with LTC. Review of POAC and urgent and emergency care will lead to new arrangements with GPs and urgent care facilities to avoid acute admissions from 1 July 2019. Whole of system group to be set up to address high and complex users of ED to put collaborative management plans in place with primary care partners. **As part of a review of ED the following initiatives are underway:** Access to Kaitiaki will be a 24/7 service- this will provide the whanau support which will effectively get patients home quicker. Increase cultural training for all ED staff and identify innovative ways to provide this. The mental health initiative for 24/7 coverage in ED will help address the current demand from high need populations and provide a better service. Work with primary healthcare around education to provide alternative options to presenting to ED. This will help alleviate the workload pressures on the ED system and the patients can be fast tracked to the most suitable pathway. As a result of the acute Geriatric team in ED trial, evaluation will be completed and a model of care developed.				Oversight: Ron Dunham Reporting: Barb Garbutt and Damian Tomic

Waikato DHB Key Response Actions to Deliver Improved Performance								
Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Strong and equitable public health and disability system	Health equity for high need populations	**Rural health** **Waikato DHB is commited to improving access and reducing inequities for our rural population by:** Completing the Southern Rural Maternity Project: • Complete refurbishment of Tokoroa hospital primary birthing unit and implement new roster that is supported by midwives and LMCs working in the South Waikato. • Complete refurbishment of Taumarunui hospital primary birthing unit. • Establish Maternity Resource Centres at Taumarunui and Tokoroa. Implementing the Rural Lactation Consultant Service. Establish mother to mother support groups via the maternity resource centres. Improve equity of access for rural women to specialist support by increasing community capability that supports breast feeding. Complete the single point of entry model of care in Taumarunui and move to business as usual. This project has been in partnership with Taumarunui Community Kokiriri Trust. Whānau Ora principles and approach are central to this model of care. As a result we expect: • A reduction in low acuity presentations to Taumarunui ED • Re-engagement of people with their general practice or other primary care provider • Emergency Department being used for Emergency Care Future service design will include utilisation of a locality planning approach to enable solutions to be delivered that meet the needs of local communities. *Include intentions for more locality designed primary and community care*	Q4 Q1 Q3 Q4 Q1 Q1 Q4 Q4 Q1 Q3		EOA EOA EOA EOA	Oversight: Ron Dunham/Hayley McConnell/Tanya Maloney Reporting: Jill Dibble

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Stong and equitable public health and disability system	Productive partnerships	**Healthy ageing** working with ACC, HQSC and the Ministry of Health to promote and increase enrolment in S&B programs and improvement of osteoporosis management especially in alliance with Primary Care as reflected in the associated "Live Stronger for Longer" Outcome Framework (This expectation aligns most closely to the Government's 'Prevention and Early Detection' priority outcome; and the Ageing Well and Acute and Restorative Care goals of the Healthy Ageing Strategy) Developing local protocols for working through the in-home strength and balance programme for cognitively impaired older people at risk of falls and fractures. Regular communication with GP/Practice nurses through BPAC to improve the programme's visibility. The cross sector Waikato DHB Falls Working Group to understand the reasons for low referral volumes from ACC case managers. Work with primary care providers to aged residential care to increase the prescribing of Vitamin D / cholecalciferol to ARRC residents - increase % of residents on Vitamin D from 65% to 75%. Review the updated evidence (April 2019) on the HQSC website and map against current activity in Waikato DHB to identify opportunities. aligning local DHB service specifications for home and community support services (HCSS) to the vision, principles, core components, measures and outcomes of the national framework for HCSS (This expectation aligns most closely to the Government's 'Health Maintenance and Independence' priority outcome; and the Living Well with Long-Term Conditions goal of the Healthy Ageing Strategy). Once the national framework and service specification are made available to DHBs, implement a service development programme to identify actions needed across the H&CSS sector.				**Oversight:** Tanya Maloney and Barb Garbutt **Reporting:** FRM S&F

Waikato DHB Key Response Actions to Deliver Improved Performance								
Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
Support healthier, safer and more connected communities	We have health equity for Māori and other groups	Stong and equitable public health and disability system	People centered services	**Improving Quality** **Waikato DHB is committed to improving quality by:** ***Atlas of Healthcare Variation activity – TBC – focus on Asthma*** Patient experience data shows work is required with regard to medication knowledge. As part of the SLM improvement plan, a quality improvement project is planned in one locality that has a rural hospital, GP, pharmacy. This includes establishing a multidisciplinary working group (primary care, pharmacy, secondary care, consumers, Māori providers) to: • Develop terms of reference and scope of an improvement project. • Review data – ethnicity/age etc. • Review international innovation best practice. • Define roles for medication safety i.e. who does what from prescribing through to taking. The DHB Antimicrobial Steering Group formed in November 2018 and has developed a work plan for 2019, which aligns activity with the New Zealand Antimicrobial Resistance Action Plan. It includes : • Centralising antimicrobial guidelines – available to all staff, reviewed and up to date. • A 'restricted' antimicrobial list agreed by the steering group. • Working with the Sepsis Working Group to optimise antimicrobial use in patients with sepsis. • Raising awareness – grand round presentation and participation in World Antimicrobial Awareness Week in November.			EOA	Oversight: Mo Neville and S&F (Atlas activity)
	We live longer in good health	Stong and equitable public	Safe, quality health services for all	**Cancer services** ***TBC***		Health Target: FCT		Oversight: Ron Dunham Reporting: Alex Gordon and Gareth Fannin
		Stong and	Safe, quality health services for all	**Bowel screening** ***Awaiting guidance from the Ministry***				Oversight: Ron Dunham Reporting: Lu-ana Ngatai and Gareth Fannin

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
	We have improved quality of life	Stong and equitable public health and disability system	People centered services	**Healthy food and drink** Supported by the Public Health Unit, Waikato DHB will develop and implement a Healthy Food and Drink Policy. Contracts held with provider organisations will include a clause stipulating the expectation they develop a Healthy Food and Drink Policy. The nutrition and physical activity strategy group will engage and support key community settings (e.g. workplaces, schools, sport, local government, Māori and Pacific settings) to inquire, plan and transform food environments and physical activity levels.[6] Public Health Unit will support marae in developing and implementing healthy food and drink policies including water only policies.[7]	Q4 Q4 Q1 and ongoing Q1 and ongoing			Oversight: Tanya Maloney Reporting: Phil Grady and Deryl Penjueli

[6] Reporting for this activity will be completed by the Public Health Unit.
[7] Reporting for this activity will be completed by the Public Health Unit.

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
	We live longer in good health	Strong and equitable public health and disability system	Effective and efficient care and services	**Workforce** **Waikato DHB will support our workforce by:** Identify current workforce planning, supply issues and opportunities internally and externally. Work towards having a workforce that is 23 percent Māori across all areas to be reflective of our population. Complete workforce modelling and agree a workforce plan that shows anticipated composition (employee, alternative workforce types and automation), size and cost of the Waikato DHB workforce across 2019-2024. Build Employee Value Proposition (EVP). Integrate Tikanga into all Human Resource processes. Redesign the recruitment model for target/critical workforce groups with the aim to eliminate, automate or streamline our work, increasing speed to value while maintaining sufficient checks and balances. Create governance of learning that will set the direction and make key decisions regarding learning and development across the organisation. Organisational capability needs analysis to identify the critical shared requirements of our workforce. Implement "Speaking Up for Safety" programme, requiring leaders to visibly role model the focus on wellbeing and inclusive behaviours. Begin the "Supportive Employment" initiative to provide the most supportive culture we can. Complete a organisation wide learning inventory stocktake and review to inform our current HR service review. Incorporate Tikanga principles into the key moments that matter through the employee lifecyle. Prioritise the development of the māori workforce through partnerships with education providers and training institutions. **Identify new workforce roles required to implement the HSP strategic direction ** ***Full details see section four: Stewardship***	Q4 Q1 and ongoing Q4 Q4 Q4 Q4 Q4 Q4 Q4 Q4 Q1 Q4		EOA EOA EOA EOA EOA EOA	Oversight: Gil Sewell

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
	We have equity for Māori and other groups	Stong and equitable public health and disability system	Health equity for high need populations	**Data and digital** **Waikato DHB will continue to support services through advancements in data and digital services, including:** Continuing to provide multiple ways of contacting the DHB, including increased usage of telehealth and virtual health. These two services have proven popular with Māori patients, particularly renal services, which use Telehealth. Accelerating the achievement of equity for Māori by focusing on responsiveness in information systems that are used by the DHB to manage Māori and other patients' health, including systems in diabetes, women's health (breast and cervical screening, smoking cessation), oral health and breastfeeding services. Improving the quality of ethnicity data collected at the DHB and by primary care. Collaborating with GPs in evaluating booking systems to move towards same-day-access and next-available-appointment for patients. Building prompts in IT systems to ensure that patient prompts, decision support and audit tools exist and are used to support Māori health. The Mobility Programme has enabled clinicians with mobile devices. A number of clinical projects will be expanding the functionality and applications that are available on mobile devices. FaceTime will continue to be used by Police to facilitate triage for Mental Health concerns. ***Full details see section four: Stewardship***	Ongoing Q4 Q1 and ongoing Q1 and ongoing Q4 Q4 Q1		EOA EOA EOA EOA	**Oversight:** Geoff King
	We have improve	Stong and	Productive partners	**Delivery of regional service plan prioities** ***Awaiting guidance from the Ministry***		SI2		Bay of Plenty DHB
Support healthier, safer and	We live longer and in good	Mental Health and	Safe, quality health	**Inquiry into mental health and addiction** ***Awaiting guidance from the Ministry – expected by late April***				Oversight: Vicki Aitken

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Mental Health and Addictions Care	Health equity for high need populations	**Population mental health** **Waikato DHB is committed to improving our populations mental health and addictions, especially for priority populations including vulnerable children, youth, Māori and Pasifika by:** Engagement by Kaitakawaenga with all tāngata whaiora who are Māori to inform the provision of culturally based/appropriate services. Development of a detailed business case for new acute mental health facilities. Partner with the Department of Corrections for the development of a proposed fit for purpose acute forensics and mental health services at Waikeria Prison. Engagement with community and key stakeholders in co-design of future workforce requirements. Align Mental Health and Addictions service transformation with the goals enablers and actions of the Waikato DHB Health System Plan. Greater partnership and greater collaboration with NGO partners to co-design service delivery that is person centred and closer to home. Scope and develop a range of housing alternatives for mental health and addictions tāngata whaiora. Review the range of respite options across the district moulding new contracting arrangements. Improve capability of Public Health staff in the mental health and wellbeing area through increased literacy.[8] PHU will support key community settings to destigmatise mental illness/issues; and raise awareness regarding mental wellbeing.[9]	Q4 Q4 2019-2022 2019-2022 Q4 2019-2021 Q4 Q3 Ongoing Ongoing	PP26	EOA EOA EOA EOA	Oversight: Tanya Maloney Reporting: Phil Grady, Wayne Skipage, Vicki Aitken
		Mental Health and	Safe, quality health services for	**Mental health and addictions improvement activities** **TBC**		PP7		Oversight: Vicki Aitken Reporting: Areann Libline/Brendon Dolman
		Mental	Safe, quality	**Addiction** **TBC**		PP8		Oversight: Vicki Aitken

[8] Reporting for this activity will be completed by the Public Health Unit.
[9] Reporting for this activity will be completed by the Public Health Unit.

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Mental Health	Safe, quality health services for all	**Maternal mental health services** ***Awaiting results of stocktake to identify activities***				Oversight: Tanya Maloney Reporting: Kathryn Fromont and Adam Wardle
Make New Zealand the best place in the world to be a child	We have health equity for Māori and other groups	Child Wellbeing	Productive partnerships	**Immunisation** **Waikato DHB continues to proactively work with all key partners to significantly improve the Districts performance and ensure at least 95 percent of our children are immunised on time:** Implement the agreed immunisation action plan. Work with Māori providers of Well Child Tamariki Ora services to identify the reasons for lower immunisation rates within their cohort of children, and the potential solutions, support and resources required to lift on time immunisation rates for Māori. Trial an expansion of outreach immunisation for high need/Māori whānau in partnership with Plunket and DHB funded Hapu Wananga pregnancy and parenting courses. The PHU will provide immunisation teaching for medical students, practice nurses, Public Health Nurses and GP registrars.[10] The PHU will support the DHB work on enabling a Māori community led approach to immunisation.[11] The PHU will support the DHB work on a pilot of pharmacy provided scheduled childhood vaccinations.[12]	Q1 and Ongoing Q1 Q1 Q1 and ongoing Q1 and ongoing Q1 and ongoing	Health Target: Increased Immuisation	EOA EOA EOA	Oversight: Tanya Maloney Reporting: Ruth Rhodes, Kathryn Hugill, Adam Wardle, Deryl Penjueli, Greg Morton
	We have improved quality of life	Child Wellbeing	Safe, quality health services for all	**Supporting health in schools** ***Indication from Ministry that this focus area will be removed once the stocktake has been completed.***				Oversight: Tanya Maloney Reporting: Kathryn Hugill, Adam Wardle, Deryl Penjueli

[10] Reporting for this activity will be completed by the Public Health Unit.
[11] Reporting for this activity will be completed by the Public Health Unit.
[12] Reporting for this activity will be completed by the Public Health Unit.

Waikato DHB Key Response Actions to Deliver Improved Performance								
Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Child Wellbeing	Safe, quality health services for all	**School-based health services** ***Awaiting guidance from the Ministry – indication from Ministry that this will be rolled out further***				Oversight: Tanya Maloney and Ron Dunham/Hayley McConnell Reporting: Kathryn Hugill and Adam Wardle
		Child Wellbeing	Effective and efficient care and services	**Midwifery workforce – hospital and LMC** **Waikato DHB is committed to supporting our current and furture workforce by:** Ensuring all applicants identifying as Māori will be offered an interview. Engagement with the WINTEC Employer Partnership Group to support students in order to reduce attrition rates. Supports developed to allow our Māori and Pasifika DHB employed midwives to culturally engage with Māori and Pasifika students. Identifying what supports are required to allow registered midwives to work to the full breath and depth of their scope. Reduce barriers to enable midwives to access and participate in ongoing relevant education.	Q2 Q2 Q4 Q3 Q4		EOA EOA	**Oversight:** Sue Hayward **Reporting:** Joanne Clarke, Clinical Midwife Director

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
	We live longer in good health	Child Wellbeing	People centered services	**First 1000 Days** **Waikato DHB is committed to supporting whānau and their pēpi through the First 1000 Days (conception to around two years of age) and will:** Enhancement of the first 1000 days service. This is a wrap-around integrated Māori maternity and child First 1000 Days service consisting of Lead Maternity Carers, Kiawhina, GPs, Well Child Tamariki Ora provider, Family Start, a Family Violence Co-ordinator, Smoking Cessation Co-ordinator and Lactation Consultants working together to provide intensive support for the woman, her pēpi and whānau. During 2019/20 a pilot of the service will take place and if it is successful, will be rolled out further across the Waikato District focusing on Māori, rural and vulnerable women. Develop and roll-out of the Harti Mama assessment and decision support tool focused on the First 1000 Days. This tool is for use in the Tīmatanga Hauora (Healthy Start) Service, Hapu Wanaga classes and rural maternal/baby hubs. Launch the Waikato Community Breastfeeding Service into Hamilton and rural locations. This will be monitored and quality improvement methodology applied. Breastfeeding clinic and support groups run in rural maternal/child hubs as the hubs launch. Investigate healthy nutrition resources for the First 1000 Days. Identify public health ways to respond to "First 1000 Days" mental wellbeing for hapu wahine (women), nga whaea (new mothers), and pepe (babies).[13]	Q4 Q2 Q1 Q1-Q4 Q2 Q1	Health Target: Raising Healthy Kids and SI18	EOA EOA	Oversight: Ron Dunham Reporting: Michelle Sutherland and Adam Wardle/Kathryn Fromont

[13] Reporting for this activity will be completed by the Public Health Unit.

Waikato DHB Key Response Actions to Deliver Improved Performance								
Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Child Wellbeing	Productive partnerships	**Family violence and sexual violence** **Waikato DHB is committed to reducing family violence and sexual violence by:** Establishing a Violence Intervention Programme (VIP) advisory Group that includes senior clinicians, quality improvement, HR, Māori and Pacific staff, Oranga Tamariki, Police, Women's Refuge, and PHOs. This group will support the implementation of the VIP strategic service plan (2018/21). VIP will provide staff training on how to deal with child protection and intimate partner violence. The DHB will promote a DHB Employee Assistance Programme (EAP) or equivalent as a means for offering support to DHB employees who are victims or perpetrators of violence and abuse. Improve health pathways for women and children known to Women's Refuge. Embed the national child protection alert system enabling child protection alerts and birth plans to be generated in a timely way in collaboration with LMC's and Oranga Tamariki. Employ a Midwife Specialist for the vulnerable unborn. In cases of child sexual abuse provide faster access for children to specialist services in collaboration with Police and Oranga Tamariki.	Q1-Q4 Q1 and ongoing Q1 and ongoing Q4 Q1-Q4 Q1 Q1 and ongoing		EOA	Oversight: Tanya Maloney Reporting: Claire Tahu, Damian Tomic, Ruth Rhodes, Adam Wardle and Greg Morton

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
		Child Wellbeing	People centered services	**Sudden Unexplained Death in Infancy (SUDI)** **Waikato DHB is committed to reducing the rate of SUDI by:** Expansion of Hapu Wananga to cover a wider rural area and reach the targeted population with key risk factor messages. Increase referrals from Hapu Wananga to the 'Once and For All' smoking cessation service. Introduction of a smoke free coordinator in Waikato Hospital Maternity Services. Whare Ora refresher training on hospital wards and presentations to Midwives, Kohanga, daycare and attending community events to increase knowledge and referrals. Improved access to lactation support services in rural locations to increased breastfeeding rates. Workshop wananga for Tamariki Ora Well Child providers to train, refresh and emphasise the SUDI risks and risk reduction techniques. Development and distribution of Māori Breastfeeding resources packages. Promotion of our Māori Mama who are hearty breastfeeders at five Māori events - Iwi Poukai.	 Ongoing Ongoing Ongoing Ongoing Ongoing Q3 Q3 Q4		 EOA EOA EOA EOA EOA EOA	Oversight: Tanya Maloney Reporting: Adam Wardle, Kathryn Hugill
Support healthier, safer and more connected communities	We have improved quality of life	Primary Health Care	People centered services	**Primary health care integration** **Waikato DHB is committed to supporting Primary health care integration by:** Implementing the Waikato DHB Health System Plan through a sector wide health system leadership group (alliance). Developing a model of enhanced primary care inclusive of GPs, Pharmacy and St. John. This model will deliver better acute demand management, models of intermediate care and will re-develop our current urgent and emergency model of care. Addressing equity thorugh the enhancement of the Whānau Ora approach to community care and general practice. This will help to strengthen networks and connections with other services and ensure services link effectively across the system. Reconfiguration of community health services towards locality designed services that will meet the need and support the aspirations of those localities	 Q4 Q3 Q4		 EOA	**Oversight:** Tanya Maloney **Reporting:** Ruth Rhodes, Damian Tomic, Wayne Skipage

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
	We have health equity for Māori nd other groups	Primary Health Care	Productive partnerships	**Pharmacy** **Waikato DHB is committed to enhanced pharmacist service by:** Piloting the pharmacy provided scheduled childhood immunisation in three pharmacies. Via the Midland Community Pharmacy Group implement a free minor ailment programme for tamariki Māori aged 0-4 to reduce ambulatory sensitive hospitalisations for skin conditions. Establishing a time limited workgroup with representation from general practitioners, pharmacists and New Zealand ePrescription Service (NZEPS) to progress NZEPS uptake in Waikato DHB general practice within primary care to support the national implementation process. Offering support and advise to the national processes to separate medicine supply and clinical advice. Working with the sector to develop a Pharmacy Action Plan aligned to the Health System Plan.	Q2 Q3 Q4 Q4 Q3		EOA	Oversight: Tanya Maloney Reporting: Ruth Rhodes
		Primary Health Care	Health equity for high need populations	**Smokefree 2025** **Waikato DHB is committed to smokefree 2025 and will:** Expand our Tupeka Kore programme, a stepwise, co-designed policy change management programme that has been successfully implemented in Waikato Hospital Maternity Service to support women and whānau to be smoke free. Introduce new requirements that funded services actively contribute to eliminating smoking for Māori. New reporting and monitoring systems will also be introduced to support the move to Smokefree 2025. Actively support the expansion of Tupeka Kore to include LMCs, Primary Birthing Facilities, general practices, and community organisations, particularly those with significant engagement with Māori. Linked to the above, Waikato DHB will work with all government agencies and services operating in the Waikato district to demonstrate the same active commitment to supporting Māori to be smoke free and provide support where appropriate and possible. Build on the Waikato DHB smoking cessation service directly funded by Ministry of Health by: • actively promoting the service to potential referrers. • investigate top-up funding (above that provided by the Ministry to the PHO provider) for any person who refers a Māori smoker who completes the funded smoking cessation service – particularly with the aim of promoting referrals from LMCs and whānau.	Q4 Q4 Q1 and ongoing Q1 and ongoing	Health Target	EOA EOA EOA EOA EOA	Oversight: Tanya Maloney Reporting: Rachel Poaneki, Rose Black and Nina Scott

Government Priority Outcomes	Health Sysytem Outcome	Government Planning	Link to Waikato DHB Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance Activity	Milestone	Ministry reporting measure	Equity Outcome Action (EOA)	Reporting lead & oversight
Support healthier, safer and more connected communities	We live longer in good health	Primary Health Care	People centered services	**Diabetes and other long-term conditions** **Waikato DHB is commintted to addressing Diabetes and other long-term conditions by:** Establishing a diabetes collaborative group that brings primary and secondary care together to plan for service delivery. Following the completion of the Waikato Health System Plan a road map of actions including the development of a "Long Term Conditions Plan" for the Waikato DHB district will be developed. These plans have Māori health as a focus and will address the continuum of care from prevention to specialist services. The PHOs will implement the new consensus statement on Cardiovascular Disease risk assessment and management. Extend investment for the diabetes retinal screening services in Tokoroa, a high need rural area. Delivering targeted care, close to home will increase the uptake of our most at risk population groups: Māori and Pasifika. If this is successful then the service may be rolled out in other high need rural areas.	Q4 Q3 Q1 Q1	PP20(1) and PP20(2)	EOA EOA EOA	**Oversight:** Tanya Maloney **Reporting:** Damian Tomic, Gareth Fannin, Karina Elkington, Nina Scott
		Environment sustainability and	Effective and efficient care and services	**Climate change** **Waikato DHB is committed to addressing climate change by:** Reducing hospital food wastage through the implementation of new integrated software that will help accurately forecast the amount of food to purchase and prepare based on trend information of actual patient meal orders.	Q2	PP40		**Oversight:** Chris Cardwell **Reporting:** Michael Fitzpatrick / Melinda Ch'ng
		Environment	Effective and efficient care and services	**Waste disposal** **Waikato DHB is committed to reducing waste disposal and will:** Reduce the amount of landfill waste produced each year. Reduce the number of single use items such as polystyrene cups which in non-clinical areas will be replaced with bio-degradable/compostable cups. Investigate the viability of recyclable paper towels and air dryers for non-clinical bathroom facilities.	Q4 Q1 and ongoing Q4	PP41		**Oversight:** Chris Cardwell **Reporting:** Melinda Ch'ng
		Envir onm	Effectiv e and efficient	**Drinking water** ***Awaiting guidance from the Ministry***				**Oversight:** Tanya Maloney

FINANCIAL PERFORMANCE SUMMARY

**Placeholder for the consolidated statement of comprehensive income (previous year's actual, current year's forecast and three years plan)* - Full details will be in Appendix 'A' when available*

Forecast Comprehensive Income	**2019/20 $M PLANNED**
Budgeted Surplus/(Deficit) for the 2019/20 year	(68.6)
The 2019/20 budget is in the process of development based on analysis of the cost of appropriate service delivery for planned volumes for the year, and draft funding estimates provided by the Ministry of Health. The result of this first budget estimate is a deficit of $68.6 million. Work on challenging this initial budget is ongoing. The first financial budget template is due to the Ministry of Health on 5 April 2019.	

SECTION 3: Service Configuration

Service Coverage

Waikato DHB is required to deliver a minimum of services, as defined in *The Service Coverage Schedule*, which is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability Act 2000, and is updated annually.

Responsibility for Waikato District service coverage is shared between Waikato DHB and the Ministry of Health. The DHB is responsible for taking appropriate action to ensure that service coverage is delivered for the population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups.

Waikato DHB may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services.

Waikato DHB is not seeking any changes to the formal exemptions to the Service Coverage Schedule in 2019/20.

Service Change

The table below describes all known at thime of publication service reviews and service changes that have been approved or proposed for implementation in 2019/20.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Cancer **Adolescent and Young Adult Patients with Acute Lymphoblastic Leukaemia (AYA ALL)**	Working with Auckland DHB for the future referral of AYA ALL patients through to Auckland DHB for inclusion in the COG trial programs. This is considered to be best practice and to have better outcomes for patients that existed in the Midland Region prior to the proposed changes.	Midland AYA ALL patients have better outcomes, treatment path moves to current best practice	This change impacts all Midland DHB AYA ALL patients
Possible change in Hospice nursing model of care	Working with Hospice around possible changes to the mix of nursing service provided to palliative patients by both Hospice and District Nursing Services.	Hospice have requested a change as they currently provide an intensive service (Hospice at Home) to palliative patients in Hamilton, Cambridge and Ngaruawahia and a shared care service with the District Nurses in the rest of the Waikato. Hospice would like to move resource out of the Hospice at Home service and into the rural services to provide the same level of service across the Waikato. This would have major impacts on District Nursing resources in Hamilton, Cambridge and Ngaruawahia.	Local

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Primary care lesion service	Funded removal of suspected skin cancers in the community, PHO run and operated, funded lesions triaged by Waikato DHB Teledermatology service.	Services closer to home and faster access to services for patients. Some potential cost savings.	
Community based postmenopausal bleeding clinic	Exploration to set up community based postmenopausal bleeding clinic run by GPs in conjunction with DHB women's health service.	Allowing examination and scan to be done on the same day following agreed clinical pathway.	
Community COPD	Changes to community COPD initiative to ensure GPs have access to an admission avoidance scheme.	Patients are better supported to remain safe and well in the community and St John and Urgent Care work together to avoid ED presentations.	
Primary Options	Review of Primary Options for acute Care will lead to changes for general practice and PHOs.	This will ensure that all funded services available to general practice are clearly linked to hospital admission avoidance.	
Urgent and emergency care	Review of urgent and emergency care arrangements should lead to enhanced subacute service run by Urgent Care.	Help to avoid inappropriate hospital admissions.	
Primary Care delivery model	Explore options for primary care delivery in line with outputs from the Health System Plan	System configured to meet the needs of consumers and their whanau as captured in the HSP consultation	
Alliance structure	Implement broad primary & community care local Alliance	Consolidates existing alliancing structures into one broader alliance	

SECTION 4: Stewardship

(refer to Waikato DHBs 2019/20 Statement of Intent for more information)

Waikato DHB has a statutory responsibility to improve, promote and protect the health of our people and communities. This section will outline Waikato DHBs stewardship of its assets, workforce, IT/IS and other infrastructure needed to deliver planned services. In addition it will show our commitment to working in partnership with our Public Health Unit in their work on health promotion/improvement services, delivering services that enhance the effectiveness of prevention activities in other parts of the health system, and in undertaking regulatory functions.

Greater detail is included in Waikato DHBs three-yearly Statement of Intent, recently produced in June 2019 and is available on our website at *www.waikatodhb.health.nz*

Managing our Business

Organisational performance management

Waikato DHBs performance is assessed on both financial and non-financial measures, which are measured and reported at various levels of the organisation. These are reported daily, weekly, fortnightly or monthly as appropriate.

Table: External Reporting Framework

Reporting	Frequency
Information requests	Ad hoc
Financial reporting	Monthly
National data collecting	Monthly
Risk reporting	Quarterly
Health target reporting	Quarterly
Crown funding agreement non-financial reporting	Quarterly
DHB Non-financial monitoring framework	Quarterly
Annual report and audited accounts	Annual

Funding and financial management

Waikato DHBs key financial indicators are Revenue, Net Surplus/Deficit, Fixed Assets, Net Assets and Liabilities. These are assessed against and reported through Waikato DHBs performance management process to stakeholders on a monthly basis. Further information about Waikato DHBs planned financial position for 2019/20 and out years is contained in the Financial Performance Summary section of this document on page xx, and in Appendix A: Statement of Performance Expectations on page xx.

Investment and asset management

Waikato DHB has recently completed a Health System Plan and a stand-alone Long Term Investment Plan (LTIP) both covering the next 10 years. LTIPs are part of the new Treasury

system for monitoring investments across government, the Investment Management and Asset Management Performance (IMAP) system.

Shared service arrangements and ownership interests

Waikato DHB has a part ownership interest in HealthShare. In line with all DHBs nationally, Waikato DHB has a shared service arrangement with TAS around support for specified service areas. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management

Waikato DHB has a formal risk management and reporting system, which entails incident and complaint management as well as the risk register (Datix management system) and routine reporting. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality assurance and improvement

Waikato DHBs approach to quality assurance and improvement is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits. The DHB Board approved and published a quality governance strategy 'listen, learn, improve' in December 2016 with the ongoing direction reflected in the DHB strategic imperatives. Progress is monitored by the Executive Leadership Team. The consumer council ensures a person / whanau centred approach to our planning.

Building Capability

Waikato DHB is currently developing a Health System Plan across the whole of the DHB. It is anticipated that capabilities will be identified from this process for the next two to five years.

Capital and infrastructure development

Placeholder Capital planning and budget process is currently underway (meeting 27 March) – update to be provided early April 2019

Information Technology (IT) and Communications Systems

Improving equity through IT

Progress in health equity towards pae ora includes developing good-quality ethnicity data, developing knowledge and reconfiguring services to deliver high quality health care meeting the needs of Māori and other groups where inequity has been proven.

Waikato DHB Information Services (IS) have met with the newly formed Waikato Consumer Council, including Māori representatives and formed a relationship with the Council to enable ongoing co-development of the IS strategy. Current activities to address inequity supported by IS can be found on *placeholder* page xx data and digital section.

IS have supported the development of the iHub which provides visitors and staff at Waikato Hospital with health screening and opportunistic vaccination, smoking cessation support and cervical screening. Over the next 12 months IS will also support the development of iHubs in the four rural hospitals.

Development of new database tools is ongoing and will enable us to capture ethnicity, allowing for transparency and easy recognition of inequities. Overlying databases with business intelligence tools such as Qliksense in the future will provide ready reporting and data access to clinicians allowing them to improve practice, disclose and address proven inequity.

Provision of health services via digital technology

Currently the Waikato DHB supports telehealth hubs in Thames, Taumaranui, Te Kuiti and Tokoroa to provide; acute stroke support (diagnosis and thrombolysis), ad hoc emergency support, virtual ward rounds to Assessment, Treatment and Rehabilitation (AT&R) patients in Thames, infectious disease support, outpatient clinics in renal medicine, respiratory medicine and oncology, and wound care clinic (currently under development).

In addition, the DHB provides support for speech language therapy delivered to the patient location on a smart device with developing service for renal transplant patients and community health (in particular delivery of Video Direct Observation of Therapy).

Other Telehealth services include: supply of a variety of clinics to the Midland DHBs and mental health services within the Waikato DHB (including support to patients relating with police officers acutely).

The DHB is in the process of formulating its Health Systems Plan and whilst the plan is yet to be finalised improving access to services is seen as a goal with actions focused on supporting district wide service delivery models with technology & information (including virtual care, virtual consults, tele monitoring, and integration across the continuum of care).

Access to regional patient notes is a pivotal part of healthcare provision, this is provided for by collaboration with eSPACE through HealthShare and a shared clinical portal. Currently, local primary care and community providers such as Lead Maternity Carers (LMC) have access to the Waikato DHBs Clinical Workstation (CWS) improving the accessibility of health information to health care providers and through them to patients. Current work with Health Alliance to access Starship patient notes is underway with a view to extend beyond paediatrics.

Given the Waikato DHBs large territory, being able to work remotely is vital, particularly to our community teams. Many of our clinical teams have been issued with mobile devices to enable remote access to Clinical Workstation and tools such as Lippincott to enable guideline based care.

The DHB is progressing access for a wide group of primary and community care partners to the patient data within CWS. Partners with access to CWS include; GP's, Nurses, St John, Hospice, LMC's, Community Pharmacies, Mental Health Providers, Radiology Providers, DHBs/Private Hospitals, Corrections/Prison Services, and private clinics. During the 2019/20 year this solution is being enhanced by adding two factor authentication and expanding the solution to include regional radiology records. This is an interim tactical solution which will be replaced by the eSpace Orion based regional solution once it is available.

Health Pathways are currently being developed for many services and these are directly available through Clinical Workstation when accessing a patient's record (for remote staff, inpatient teams and our community and primary care partners) as well as via the DHB intranet.

Aligning with national and regional initiatives

Waikato DHB is committed to leveraging, where it is appropriate to do so, national and regional investments. Accordingly the DHB is midway through implementing the AoG IaaS solution, has previously confirmed its commitment to implement the national maternity solution, and has previously implemented Titanium, National Oracle Solution, ProVation and Dendrite. The DHB is also strongly committed to, and the major funder of, regional solutions.

Monthly regional Information Services Leadership Team (ISLT) oversight and sharing of initiatives are progressed regionally and within each of the DHBs. Waikato's project portfolio reporting is provided monthly to the Midland Chief Information Officer group. In addition, we have established the Regional Capital Committee to ensure oversight at the Midland Chief Executive level of all significant DHB IS investments to ensure alignment.

At a practical level we are focused on leveraging maximum value from regional investments and advoiding investment duplication through; ensuring all local initiatives are reviewed with reference to the Regional ISSP to ensure effort is not duplicated or in competition, initiatives related to or delivering functionality similar to eSpace are progressed through the regional eSpace Programme Board for endorsement, and all significant investments are progressed through the Regional Capital Committee.

Regional solutions utilised by the DHB include; MCPFP, Datix, ePharmacy and PACS/RIS. The objective of the regional eSpace Programme is to deliver a regional clinical information system. Waikato has limited development of its local system, CWS, to critical tactical changes only. The DHB has a significant investment commitment over the next three years to enhance the functionality within Midland Clinical Platform (MCP), including the delivery of eOrders, eReferrals, Results Management and Medication Management.

Local road mapping references national and regional plans, with national initiatives included in regional and local plans as appropriate.

Application Portfolio Management

The DHB plans to continue the work both locally and with the Ministry of Health on establishing a robust Application Portfolio Management Framework covering all classes of

Information Communications Technology (ICT) asset, with a focus on appropriate lifecycle management of existing ICT assets. Historical funding for ICT has been constrained to annual depreciation, which has funded asset replacement, enhancements, and innovation. As per previous reporting to the Ministry of Health the DHB has, as a result of the historical funding mechanism and financial constraints, a ~$28m deferred maintenance (technical debt) which it has proposed to address through increased ICT capital funding over each of the next five years.

IT security maturity improvement

IS security maturity is overseen by the Audit and Risk Subcommittee of the DHB Board, with quarterly reporting in place. A rolling audit and assurance programme is in place, overseen by Internal Audit, and reported to the Audit and Risk Subcommittee of the DHB Board.

The DHB has an Information Security and Privacy Governance Group (ISPG) in place which is a subcommittee of the Executive Leadership Team (ELT) and is chaired by the Chief Data Officer. Membership includes the; CIO, Chief Data Officer, Privacy Officer, Risk Officer, and ELT. The primary role of the ISPG is to ensure that information security and privacy are an integrated and integral part of the mission of the DHB. The ISPG specifically includes a commitment to ensure the DHB meets its; HISO 10029 (Health Information Security Framework), HISO 10064 (Health Information Privacy Guideline), HIPC (Health Information Privacy Code), Privacy Act, and NZISM (New Zealand Information Security Manual) obligations.

The DHB has a Security Manager in place and an active, positive, and constructive engagement with Nick Baty (Ministry of Health, Chief Security Advisor). All of which will continue.

The DHB has an IS Operations Security Team in place consists of operational security personnel, vulnerability, threat management and application security personnel.

Key IT Initiatives for 2019/20

Initiative	Key milestones 2019/20
HRIS	
Detailed Design	Q1
Payroll – Build	Q2
HealthShare payroll go-live	Q3
Waikato DHB payroll go-live	Q4
Learning Management System / Health and Safety functionality	Q4
Decommission PeopleSoft	Q1 2020/21
Development and Performance Management functionality	Q2 2020/21
Succession Planning functionality	Q2 2020/21
DR	
Detailed Design and Planning	Q1 2020/21
Infrastructure Implementation	Q4
Network Implementation	Q4
Application	Q2 2020/21
DR Plan Update and Test	Q3 2020/21
Project Closure	Q3 2020/21
iCNET (Infection Control Net Platform) The DHB is in the process of developing the Single Stage Better Business Case (BBC) for implementation of an Infection Control Net Platform. The investment proposal supports the national objective by recommending investment in an integrated electronic surveillance system which will enable increased data availability and automation (where possible) of analysis.	
Business Case Approval	Q1
Go Live	Q4
Nutrition and Food Management This project aims to implement the CBORD integrated Nutrition and Food management system, so as to transform the DHBs ability to effectively manage, produce and deliver 1.386 million safe, suitable, nutritious and cost effective meals per annum. This includes meals for patients, Meals on Wheels, visitors and the Waikato Hospital workforce.	
Business Case Approval	Complete
Implement FSS	Q3
Implement NSS	Q3 2020/21
Trend AV SMX project The DHB is enhancing its Trend AV solution to deliver better levels of information security management for the Waikato DHB.	Complete
Business Case Approval	Q4 2018/19
Design and Planning	Q1

Go Live	
Observation Platform The DHB is in the process of developing the Single Stage Better Business Case (BBC) for implementation of an electronic Observation and Early Warning System (EWS). The contract for this is not yet approved; however the proposed vendor has already delivered to other existing DHBs. By digitising the EWS system we are removing any bias (perceived or otherwise) that may affect the equity of care for all patients. Rules of deteriorating patients can be centrally managed irrespective of race or gender and will ensure consistent timely escalations are handled as efficiently as possible, thereby creating a more efficient workforce. This meets both Regional Service Plan strategic outcomes of improving the health of the midland population, eliminate health inequalities and addresses one of the three NZ Triple Aims by improved quality, safety and experience of care. As the BBC is currently under development the risk mitigations are under development. EObservations is being proposed as a regional solution with Waikato as the lead provider post. Risk mitigation is being included in the Better Business Case (BBC). The implementation of this solution will further the DHBs Electronic Medical Record Adoption Model (EMRAM) aspirations as it will enable vital signs and nursing documentation to be included through a subsequent phase. Once implemented this system will be added to the IS PMO Architectural Roadmap for inclusion in furture years lifecycle maintenance.	Q2 Q4 Q1 2020/21 Q2 (decision on Nursing Assessment and therefore EMRAM alignment) Q4 2020/21
Anaesthesia Information System The DHB is in the process of developing the Single Stage BBC for implementation of an electronic Anaesthesia Information System enabling workflow through pre-operative assessment and planning, operating room processes, and post-operative care. The solution is seeking to improve patient outcomes, clinical efficiencies, and administrative efficiencies. Point of Entry Document Business Case Approval	 Q1

Workforce

Future workforce development - Our People Strategy – will see evolving alignment and integration with the Ministry of Health's New Zealand Health Strategy: Future Direction, and the Waikato DHB Strategy. Futher detail can be found in the section on local and regional enablers within this document, on page 18.
In summary the key areas are:

Organisational culture
Waikato DHB aspires to be an inclusive, supportive and safe place to work with a culture of innovation. Understanding our current Employee Value Proposition (EVP) will inform the strengths in our organisational culture. Embedding our culture will require our leaders to champion it. A new learning operating model should be used to build capability to reinforce our target culture.

Leadership
Waikato DHB supports leadership developmen a number of programmes which provides learning opportunities for new or experienced managers, or those with leadership potential in the Midland DHBs.
Waikato DHB also aspires to drive future performance through focusing on leader development, building valuable team management skills. Values-based leadership is increasingly important with leaders and teams hiring, retaining, developing teams an individuals based on organisation values, for Waikato DHB this would be: Whakamana (give and earn respect), Whakarongo (listen to me, talk to me), Mauri Pai (fair play), Whakapakari (growing the good) and Kotahitanga (stronger together).

Workforce development
To achieve for our communities and patients, we must focus internally on all our employees. Our strategic direction for "Our People" is about putting our people at the heart of everything we do. This means putting our people at the centre of how we shape what it's like to work here, how we develop our people's capability, and build a workplace to best serve our patients and communities. To make this a reality HR will be developing and implementing a workforce plan which will be used to inform which workforce capabilities are required and what development/ learning opportunities we need to provide for our workforce.
Over the 2019/20 year we will be implementing a cultural component to Mental Health and Addictions service orientation for new staff. In the future all Waikato DHB staff will attend cultural training with a view to ongoing cultural compentency training through essential cultural skills based on 'the seven real skills' in "Let's Get Real Training."

Māori workforce development
Waikato DHB is commintted to attracting and retaining Māori staff and to building partnership capabilities in both Māori and non-Māori staff. Our workforce must reflect our population, this means 23 percent of our workforce should be Māori in all role types and at all levels accross our organisation, to ensure Māori experiences and expertise can be found everywhere. HR will be integrating Tikanga into all HR processes and traditional Māori culture and language will be upheld and valued. This means that karakia, waiata, whakawhānaungatanga, powhiri and Te Reo Māori will be embedded into our organisation practices to better support Māori staff. In addition, all services will need to develop a Māori health plan, which is included in

the induction of all new staff. Training rates will also be reported by Māori and non-Māori so potential inequalities in the furture workforce can be eliminated.

Co-operative developments

Waikato DHB works and collaborates with a number of external organisation and entities, including:

- Ministry of Education,
- Corrections,
- Ministry of Justice,
- Police,
- Ministry of Social Deveopment,
- Oranga Tamariki,
- Local Government,
- Other DHBs,
- NGO health care providers.

SECTION FIVE: Performance Measures

The DHB non-financial monitoring framework aims to provide a rounded view of performance in key areas using a range of performance markers. The measures are intended to cover a specific set of markers of DHB performance in key areas, rather than all health services or DHB activity. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- Achieving Government's priority goals/objectives and targets or 'Policy priorities.'
- Meeting service coverage requirements and supporting sector inter-connectedness or 'System Integration.'
- Providing quality services efficiently or 'Ownership.'
- Purchasing the right mix and level of services within acceptable financial performance or 'Outputs.'

Each performance measure has a nomenclature to assist with classification as follows:

Code Dimension
HS Health Strategy
PP Policy Priorities
SI System Integration
OP Outputs
OS Ownership
DV Developmental – Establishment of baseline (no target/performance expectation is set)
Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2019/20.

Performance measure	Performance Expectation 2019/20 *Placeholder 19/20 SPE currently out for consultation, changes indicated in this column. TBC April/May.*
HS: Supporting delivery of the New Zealand Health Strategy	Signalled for removal in 19/20
SS: Strong and equitable public health and disability system	Progress updates for actions included in Annual Plans
MH: Mental health and addiction care	Progress updates for actions included in Annual Plans
CW: Child Wellbeing	Progress updates for actions included in Annual Plans
PH: Primary Health Care	Progress updates for actions included in Annual Plans
PE: Public Health and the Environment	Progress updates for actions included in Annual Plans
PP6: Improving the health status of people with severe mental illness through improved access	(to be reviewed following decisions that are made in regard to the MH&A Inquiry)
PP7: Improving mental health services using wellness and transition (discharge) planning	
PP8: Shorter waits for non-urgent mental health and addiction services	To be reviewed as a result of the MHandA Inquiry

PP10: Oral health: Mean DMFT score at school year 8	
PP11: Children caries free at 5 years of age	
PP12: Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	
PP13: Improving the number of children enrolled and accessing the Community Oral health service	
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	
PP21: Immunisation coverage at 2 years of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	
PP22: Delivery of actions to improve system integration and SLMs	
PP23: Delivery of actions to improve Wrap Around Services for Older People	
PP25: Youth mental health initiatives	
PP26: Rising to the Challenge: The Mental Health and Addiction Service Development Plan	to be reviewed as a result of the MHandA Inquiry
PP27: Supporting child well-being	Updates to deliverables expected
PP28: Reducing rheumatic fever	
PP29: Improving waiting times for diagnostic services	Measure currently under review for CT, MRI and Angiography (excludes Colonoscopy) through the Planned Care refreshed Strategic approach work underway. Further information to be advised early in 2019. (Colonoscopy likely to be included as a separate measure)
PP30: Faster cancer treatment – 31 day indicator	
PP31: Better help for smokers to quit in public hospitals	
PP32: Improving the quality of ethnicity data collection in PHO and NHI registers	
PP33: Access to Care (PHO Enrolments)	
PP36: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	
PP37: Child Health (Breastfeeding)	
PP38: Delivery of response actions agreed in annual plan	
PP39: Supporting Health in Schools	Removed - to be replaced by annual plan update reports
PP40: Responding to climate change	Removed - to be replaced by annual plan update reports
PP41: Waste disposal	Removed - to be replaced by annual plan update reports
PP43: Population mental health	Removed - to be replaced by annual plan update reports
PP44: Maternal mental health	Removed - to be replaced by annual plan update reports
PP45: Elective Surgical Discharges	Measure under review through Planned Care refreshed Strategic approach. Further information to be advised in February 2019.

SI1: Ambulatory sensitive hospitalisations (ASH)	
SI2: Ensuring delivery of Regional Service Plans	
SI3: Ensuring delivery of Service Coverage	
SI4: Elective Services Standardised Intervention Rates	Measure currently under review through the Planned Care refreshed Strategic approach work underway. Further information to be advised in early 2019.
SI5: Delivery of Whānau ora	Measure currently under review awaiting Government decision
SI7: SLM total acute hospital bed days per capita	
SI8: SLM patient experience of care	
SI9: SLM amenable mortality	
SI10: Improving cervical Screening coverage	Expectations updated
SI11: Improving breast screening coverage and rescreening	
SI12: SLM youth access to and utilisation of youth appropriate health services	
SI13: SLM number of babies who live in a smoke-free household at six weeks post natal	
SI14: Disability support services	Removed - to be replaced by annual plan update reports
SI15: Addressing local population challenges by life course and demonstrating overall progress in improving equity	Measure removed for 2019/20
SI16: Strengthening Public Delivery of Health Services	Measure removed for 2019/20
SI17: Improving Quality	Removed - to be replaced by annual plan update reports
SI18: Newborn enrolment with General Practice	
OS3: Inpatient length of stay	Elective LOS Measure currently under review through the Planned Care refreshed Strategic approach work underway. Further information to be advised in early 2019.
OS8: Acute readmissions to hospital	Measure currently under review through the Planned Care refreshed Strategic approach work underway. Further information to be advised in early 2019.
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Further updates to come
OP1: Output delivery against plan	
OP2: Engagement and obligations as a Treaty partner	New Measure 2019/20

APPENDIX A: 2019/20 Statement of Performance Expectations including Financial Performance

Statement of Performance Expectations

Placeholder for titlepage

PRESENTED TO THE HOUSE OF REPRESENTATIVES PURSUANT TO SECTION 149(L) OF THE CROWN ENTITIES ACT 2004

We have worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop the Statement of Performance Expectations (SPE) in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2019/20. The performance measures chosen are not an exhaustive list of all of our activity, but they do reflect a good representation of the range of outputs that we fund and / or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes. Where possible, included with each measure is the past performance as baseline data.

Activity not mentioned in this section will continue to be planned, funded and/or provided to a high standard. The DHB reports quarterly to the Ministry of Health and/or internally to governance on performance related to this activity.

National Performance Story

Health System Future Direction	All New Zealanders live well, stay well, get well, we will be people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system				
Strategic Themes	People-powered	Closer to home	Value and high performance	One team	Smart system

Regional Performance Story

Midland Vision	All New Zealanders live well, stay well, get well					
Regional Strategic Outcomes	To improve the health of the Midland populations			To eliminate health inequalities		
Regional Strategic Objectives	Health Equity for Māori	Integrate across continuums of care	Improve quality across all regional services	Improve clinical information systems	Build the workforce	Efficiently allocate public health system resources

Waikato DHB Performance Story

Our Vision	Healthy people. Excellent Care					
Our Strategic Imperatives	Achieving health equity for high needs populations	Ensuring quality health services for all	Providing people centred services	Delivering effective and efficient care and services	Becoming a centre of excellence in teaching, training and research	Developing productive partnerships

Service performance

Long-term Impacts	People take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate specialist care
Intermediate Impacts	Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours	An improvement in childhood oral health Long term conditions are detected early and managed well Fewer people are admitted to hospital for avoidable conditions More people maintain their functional independence	People receive prompt acute and arranged care People have appropriate access to ambulatory, elective and arranged services Improved health status for those with severe mental illness and/or addictions More people with end stage conditions are supported appropriately
Outputs*	Percentage of eight months olds will have their primary course of immunisation on time	Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years	Percentage of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours

Stewardship

Stewardship	Workforce	Organisational Performance Management	Clinical Integration / Collaboration / Partnerships	Information

Impacts

Over the long-term, the aim is to make positive changes in the health status of the population. As the major funder and provider of health and disability services in the Waikato, the decisions made about which services will be delivered have a significant impact on the population and, if coordinated and planned well, will improve the efficiency and effectiveness of the whole Waikato health system. Understanding the dynamics of the population and the drivers of demand is fundamental when determining which services to fund and at which level. Just as fundamental is the ability to assess whether the services purchased and provided are making a measureable difference in the health and wellbeing of the Waikato population.

One of the functions of this document is to demonstrate how the DHB will evaluate the effectiveness of the decisions made on behalf of the population. Over the long–term, this by measuring our performance against the desired impacts outlined below. That way we demonstrate our commitment to an outcome-based approach to measuring performance.

Impact Measures – Measure of Performance

We seek to make a positive impact on the health and wellbeing of the Waikato population and contribute to achieving the longer-term impacts we seek. Impact measures are defined as “the contribution made to an outcome by a specified set of goods and services (outputs),

or actions or both". While we expect our outputs will contribute to achieving the impact measures, it must be recognised that there are outputs from other organisations and groups that will also contribute to the results obtained for the impact measures. The following impact measures will be used to evaluate the effectiveness and quality of the services the DHB funds and provides:

Long-term Impact One: People are supported to take greater responsibility for their Health

New Zealand is experiencing unprecedented levels of demand for health services and a growing prevalence of long-term conditions such as respiratory and cardiovascular disease, cancer and diabetes. These conditions are the leading drivers of poor health and premature death and place significant pressure on the health system in terms of demand for health services.

The likelihood of developing long-term conditions increases with age and these conditions are more prevalent amongst Māori and Pacific Island populations. With our higher than average Māori population (23 percent) and a predicted 40 percent increase in 65+ year olds in the Waikato DHB over the next 10 years, it is crucial that people are supported to take control of their health and help prevent illness to ensure the sustainability of our health services in the future.

Many health issues stem from health and lifestyle choices. With this in mind we must empower our people to make the right lifestyle choices. By shifting our focus from treatment to prevention, proactively promoting wellness and increasing health literacy we will enable our population to live well and stay well.

To support this Waikato DHB have chosen three key areas we believe will deliver the best long term impact for our population: smoking cessation; avoiding vaccine preventable diseases; and improving health behaviours.

Long-term Impact Two: People Stay Well in their Homes and Communities

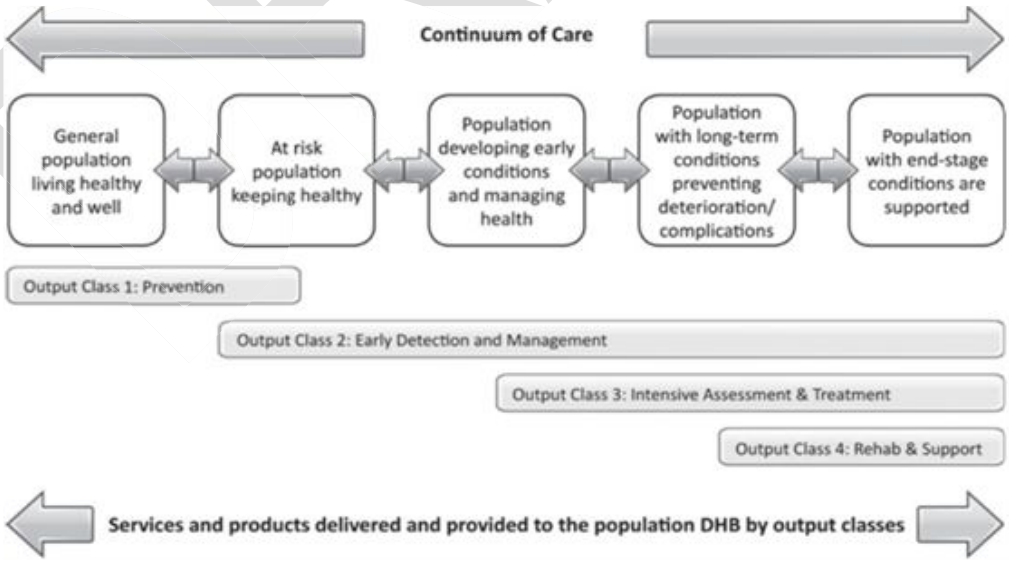
Having an accessible primary and community health service lowers rates of premature mortality from long-term conditions and achieves better health outcomes and equity, at a lower cost than relying on specialist level care. Providing services that support people to stay well in their home and community has many positive outcomes including good oral health, reduced hospital admissions for avoidable conditions, and long-term conditions being detected early and managed well. Meeting people's needs before they become acute reduces pressure on hospitals and frees up specialist capacity and financial resources. It also means people are able to maintain independence, remain in their community and return to work or normal activities sooner.

Good health begins at home and in communities so it makes sense to support people's health through services located as close to home as possible. This poses some challenges for Waikato DHB where we have communities that range from affluent urban areas to isolated rural areas, some of which experience high deprivation. We are dedicated to delivering faster, more convenient health care closer to home. To achieve this we are using new technologies, mobile health screening services and developing workforce skills to provide a wider range of preventative and treatment services in the community.

Long-term Impact Three: People Receive Timely and Appropriate Specialist Care
Providing timely care can slow the progression of health conditions and improve health outcomes. Ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays, readmissions, and complications that have a negative impact on the health of our population, people's experience of care, and their confidence in the health system. Ineffective or poor quality treatment and long waits also waste resources and add unnecessary cost into the system. Health care needs to be organised to meet the needs of patients in a timely manner. When people receive prompt and appropriate care it is indicative of a system that is working in a unified, coordinated, whole of system approach that improves hospital productivity and ensures health resources are used effectively and efficiently. Such a system would have timely access to acute care and elective services and effective services for those suffering from severe mental illness.
Where people have end-stage conditions it is important that they and their families are supported, so that the person can live comfortably, have their needs met and die without undue pain and suffering.

Achievement of this long term impact will improve the quality of life for our population through early diagnosis and intervention to avoid further deterioration, timely corrective actions to relieve pain or illness, and appropriate supports to manage end stage conditions.

Output Measures
In order to present a representative picture of performance, outputs have been grouped into four 'output classes' that are a logical fit with the stages of the continuum care and are applicable to all DHBs. Identifying a set of appropriate measures for each output class can be difficult. We do not simply measure 'volumes'. The number of services delivered or the number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'.



In order to best demonstrate this, we have chosen to present our Statement of Performance Expectations using a mix of measures of timeliness, quantity and quality - all of which help us to evaluate different aspects of our performance and against which we have set targets to demonstrate the standard expected. The output measures chosen cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term, and to the health impacts we are seeking over the intermediate and longer term. They also cover areas where we are developing new services and expect to see a change in activity levels or settings in the coming year - and therefore reflect a reasonable picture of activity across the whole of the Waikato health system.

Output Class

Prevention
Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.

Preventative services include health promotion to ensure that illness is prevented and equity of outcomes is achieved; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation.

On a continuum of care these services are public wide preventative services.

Early detection and management
Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. These include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Intensive assessment and treatment services
Intensive assessment and treatment services are delivered by a range of secondary and tertiary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services;
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services;
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.

On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

Rehabilitation and support
Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Service Co-ordination (NASC) Services for a range of services including palliative care services, home-based support services and residential care services.

On a continuum of care these services provide support for individuals**.**

Setting Targets
Wherever possible, we have included baseline data to support evaluation of our performance at the end of the year. All baseline data is taken from 2014/15 unless stipulated. In setting performance targets, we have considered the changing demographics of our population, increasing demand for health services and the assumption that funding growth will be limited. Our targets reflect our commitment to reducing inequalities between population groups, and hence most measures are reported by ethnicity. Targets tend to reflect the objective of maintaining performance levels against increasing demand growth but reducing waiting times and delays in treatment to demonstrate increased productivity and capacity. Targets that demonstrate growth in service activity or the establishment of new services tend to be based in primary and community settings (closer to people's own homes) and are set against programmes that will support people to stay well and reduce demand for hospital and residential care. Measures that relate to new services have no baseline data.

Where Does The Money Go?

(placeholder for table one: "Revenue and expenditure by Output class")

People are supported to take greater responsibility for their health

Long term impact	Intermediate impact	Impact and outputs
People are supported to take greater responsibility for their health	Fewer people smoke	Percentage of Year 10 students who have never smoked (Replacement TBC) NEW*Percentage of babies living in smokfree homes at six weeks Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking
	Reduction in vaccine preventable diseases	Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time Percentage of two year olds are fully immunised and coverage is maintained Percentage of eligible children fully immunised at 5 years of age Percentage of eligible 12 year old girls have received HPV dose three Seasonal influenza immunisation rates in the eligible population (65 years and over)
	Improving health behaviours	95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2017) The number of people participating in Green Prescription programmes

		Percentage of Kura Kaupapa Māori primary schools participating in Project Energize Percentage of total primary schools participating in Project Energize

Fewer People Smoke

Impact Measure	Output class	Measure Type	Baseline 2014/2015	Target 2018/19	Target 2019/20
Percentage of Year 10 students who have never smoked	1	Qn	74%	≥ 80%	≥ 82%
NEW Percentage of babies living in smokefree homes at six weeks	1	Qn	Baseline (2018) Māori 26% Pacific 42% Other 51% Total 43%	New Measure in 2019/20	Māori 60% Pacific 60% Other 60% Total 60%

Output Measure	Output class	Measure Type	Baseline 2014/2015	Target 2018/19	Target 2019/20
Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	1	Qn	Māori 94% Pacific 100% Other 91% Total 94%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of primary health organisation enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	1	Qn	Māori 92% Pacific 91% Other 89% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of pregnant women	1	Qn	Māori 95% Pacific N/A	Māori 90% Pacific 90%	Māori 90% Pacific 90%

who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking			Other 66% Total 95%	Other 90% Total 90%	Other 90% Total 90%

Reduction in Vaccine Preventable Diseases

Impact Measure	Output class	Measure Type	Baseline 2014/2015	Target 2018/19	Target 2019/20
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds			8.8	<8.8	

Output Measure	Output class	Measure Type	Baseline 2014/2015	Target 2018/19	Target 2019/20
Percentage of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	1	Qn	Māori 90% Pacific 95% Other 83% Total 91%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of two year olds are fully immunised and coverage is maintained	1	Qn	Māori 91% Pacific 95% Other 91% Total 90%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of eligible children fully immunised at 5 years of age	1	Qn	Māori 73% Pacific 78% Other 76% Total 73%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of eligible 12 year old girls have received HPV dose three	1	Qn	Māori 70% Pacific 106% Other 62% Total 66%	Māori 75% Pacific 75% Other 75% Total 75%	Māori 75% Pacific 75% Other 75% Total 75%
Seasonal	1	Qn/T	Māori 46%	Māori 75%	Māori 75%

influenza immunisation rates in the eligible population (65 years and over)			Pacific 49% Other 53% Total 52%	Pacific 75% Other 75% Total 75%	Pacific 75% Other 75% Total 75%

Improving Health Behaviours

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2017)			Māori 7% Pacific 19% Other 8% Total 9%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
The number of people participating in Green Prescription programmes	1	Qn	5802	6700	xxxx
Percentage of Kura Kaupapa Māori primary schools participating in Project Energize	1	Qn	100%	100%	100%
Percentage of total primary schools participating in Project Energize			100%	100%	100%

Long term impact	Intermediate impact	Impact and outputs
People stay well in their homes and communities	An improvement in childhood oral health	Mean decayed missing and filled teeth score of Year 8 children Percentage of children (0-4) enrolled in DHB funded dental services Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination Percentage of adolescent utilisation of DHB funded dental services
	Long-term conditions are detected early and managed well	*To be confirmed* Percent of the eligible population who have had their cardiovascular risk assessed in the last five years Percentage of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years Percentage of women aged 25 – 69 years who have had a cervical screening event in the past 36 months Percentage of eligible women aged 50 to 69 who have a Breast Screen Aotearoa mammogram every two years
	Fewer people are admitted to hospital for avoidable conditions	Ambulatory sensitive hospitalisation rate per 100,000 for the following age group: 45 – 64 year olds Percentage of eligible population who have had their B4 school checks completed Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)
	More people maintain their functional independence	Average age of entry to aged related residential care Percentage of needs assessment and service co-ordination waiting times for

		new assessment within 20 working days Percentage of people enrolled with a Primary Health Organisation Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan

An Improvement in Childhood Oral Health [i]

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Mean decayed missing and filled teeth score of Year 8 children			Māori 1.65 Pacific 1.40 Other 0.87 Total 1.08	Māori 0.69 Pacific 0.69 Other 0.69 Total 0.69	*To decrease – confirm after Q4 1819 result known* Māori 0.69 Pacific 0.69 Other 0.69 Total 0.69

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of children (0-4) enrolled in DHB funded dental services	2	Qn	Māori 72% Pacific 72% Other 72% Total 72%	Māori ≥ 95% Pacific ≥ 95% Other ≥ 95% Total ≥ 95%	Māori ≥ 95% Pacific ≥ 95% Other ≥ 95% Total ≥ 95%
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	2	Qn/T	Māori 18% Pacific 20% Other 25% Total 18%	Māori ≤10% Pacific ≤10% Other ≤10% Total ≤10%	Māori ≤10% Pacific ≤10% Other ≤10% Total ≤10%
Percentage of adolescent utilisation of DHB funded dental services	2	Qn	Māori 45% Pacific 53% Other 80% Total 70%	Māori 85% Pacific 85% Other 85% Total 85%	*Increase?* *Māori 90%* *Pacific 90%* *Other 90%* *Total 90%*

Long-Term Conditions are Detected Early and Managed Well

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
To be developed				NA	

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percent of the eligible population who have had their cardiovascular risk assessed in the last five years	2	Qn	Māori 87% Pacific 88% Other 91% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	*Increase?* *Māori 95%* *Pacific 95%* *Other 95%* *Total 95%*
Percentage of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years	2	Qn	74%	90%	*Increase to 95%?*
Percentage of women aged 25 – 69 years who have had a cervical screening event in the past 36 months	2	Qn/T	Māori 60% Pacific 65% Other 80% Total 74%	Māori 80% Pacific 80% Other 80% Total 80%	Māori 80% Pacific 80% Other 80% Total 80%
Percentage of eligible women aged 50 to 69 who have a Breast Screen Aotearoa mammogram every two years			Māori 58% Pacific 60% Other 70% Total 68%	Māori 70% Pacific 70% Other 70% Total 70%	Māori 70% Pacific 70% Other 70% Total 70%

Fewer People are admitted to Hospital for Avoidable Conditions

Impact Measure	Output class	Measure Type	Baseline (2017)	Target 2018/19	Target 2019/20
Ambulatory sensitive hospitalisation rate per 100,000 for the following age group: 45 – 64 year olds			Māori 9314 Pacific 6636 Other 3426	Māori 8942 Pacific 6371 Other 3357	*Māori* *Pacific* *Other*

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of eligible population who have had their B4 school checks completed	1	Qn/T	Māori 77% Pacific 83% Other 98% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%	*Increase?* *Māori 95%* *Pacific 95%* *Other 95%* *Total 95%*
Acute rheumatic fever initial hospitalisation target rate (per 100,000 total population)			3.9/100,000	1.2/100,000	*Decrease?*

More People Maintain their Functional Independence

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Average age of entry to aged related residential care: • Rest home • Dementia • Hospital			Resthome 85 years Dementia 83 years Hospital 86 years	Resthome >84 years Dementia >80 years Hospital >85 years	Resthome >84 years Dementia >80 years Hospital >85 years

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of older people receiving long-term home based support have a comprehensive clinical assessment and an individual care plan	4	Qn/T	100%	100%	100%
Percentage of people enrolled with a Primary Health	2	Qn/T	Māori 91% Pacific 88% Other 96% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%

Organisation					
Percentage of needs assessment and service co-ordination waiting times for new assessment within 20 working days			62%	100%	100%

Long term impact	Intermediate impact	Impact and output
People Receive Timely and Appropriate Specialist Care	People receive prompt and appropriate acute and arranged care	Percentage of patients admitted, discharged, or transferred from emergency departments within six hours 90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks Arranged caesarean delivery without catastrophic or severe complications as a percentage of total secondary and primary deliveries
	People have appropriate access to elective services	Standardised intervention rates (per 10,000) Percentage of patients waiting longer than four months for their first specialist assessment Improved access to elective surgery, health target, agreed discharge volumes Did-not-attend percentage for outpatient services Acute inpatient average length of stay Elective surgical inpatient average length of stay
	Improve health status of those with severe mental health illness and/or addiction	28 day acute readmission rates Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks Percentage of child and youth with a transition (discharge) plan Average length of acute inpatient stay Rates of post-discharge community care Improving the health status of people with severe mental illness through improved access
	More people with end stage conditions are supported appropriately	*Measure to be developed* Percentage of aged residential care facilities utilising advance directives

		Number of new patients seen by the Waikato hospital palliative care service
	Support services	Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days) Percentage of accepted referrals for CT scans will receive their scan within 6 weeks (42 days) Percentage of accepted referral for MRI scans will receive their scan within 6 weeks (42 days) Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive) Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days Percentage of people waiting for a surveillance colonoscopy will wait no longer than 84 days beyond the planned date Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt

People Have Prompt and Appropriate Acute and Arranged Care

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of patients admitted, discharged, or transferred from emergency departments within six hours			Māori 92% Pacific 91% Other 91% Total 94%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	3	Qn/T	56%	90%	90%

People Have Appropriate Access to Elective Services

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Standardised intervention rates (per 10,000): ○ Major joint replacement procedures ○ Cataract procedures ○ Cardiac surgery ○ Percutaneous Revascularisation ○ Coronary Angiography Services			 27 25 7.3 11.4 33.9	 21 27 6.5 12.5 34.7	*To be allocated*

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of patients waiting longer than four months for their first specialist assessment	3	Qn/T	2.7%	0%	0%
Improved access to elective surgery, health	3	Qn/T	15,693	18,037	*To be allocated*

target, agreed discharge volumes					
Did-not-attend percentage for outpatient services	3	Qn/T	Māori 21% Pacific 18% Other 7% Total 10%	Māori 10% Pacific 10% Other 10% Total 10%	Māori 10% Pacific 10% Other 10% Total 10%
Elective surgical inpatient average length of stay	3	Qn/T	1.71 days	1.5 days	1.5 days
Acute inpatient average length of stay	3	Qn/T	3.89 days	2.3 days	2.3 days

Improved Health Status for those with Severe Mental Illness and/or Addiction

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
28 day acute readmission rates			Māori 14% Pacific 8% Other 12% Total 12%	Māori <13% Pacific <13% Other <13% Total <13%	Māori <13% Pacific <13% Other <13% Total <13%

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of young people aged 0-19 referred for non-urgent mental health or addiction services are seen within three weeks or eight weeks			**3 weeks** Māori 82% Pacific 86% Other 72% Total 75% **8 weeks** Māori 93% Pacific 95% Other 90% Total 91%	**3 weeks** Māori 80% Pacific 80% Other 80% Total 80% **8 weeks** Māori 95% Pacific 95% Other 95% Total 95%	***3 weeks*** *Increase?* *Māori* *Pacific* *Other* *Total* **8 Weeks** Māori 95% Pacific 95% Other 95% Total 95%
Mental health clients discharged have a transitional (discharge) plan	3	Qn/T	New Measure – no baseline available	37%	95%
Average length of acute inpatient stay	3	Qn/T/QI	Māori 14.51 days Pacific 10.79 days Other 13.16 days Total 14.41 days	Māori 14 to 21 days Pacific 14 to 21 days Other 14 to 21 days Total 14 to 21 days	Māori 14 to 21 days Pacific 14 to 21 days Other 14 to 21 days Total 14 to 21 days
Rates of post-discharge	3	Qn/T/QI	Māori 69% Pacific 73%	Māori 90% to 100%	Māori 90% to 100%

community care			Other 72% Total 87%	Pacific 90% to 100% Other 90% to 100% Total 90% to 100%	Pacific 90% to 100% Other 90% to 100% Total 90% to 100%
Improving the health status of people with severe mental illness through improved access: 0-19 years 20-64 years 65 plus years	**3**	**Qn**	**0-19 years** Māori 2.89% Pacific 1.96% Other 3.07% Total 2.97% **20-64 years** Māori 7.12% Pacific 4.34% Other 4.34% Total 4.33% **65+ years** Māori 2.12% Pacific 2.13% Other 2.28% Total 2.27%	**0-19 years** Māori 4.73% Pacific 3.13% Other 4.23% Total 4.36% **20-64 years** Māori 8.77% Pacific 4.07% Other 3.78% Total 4.81% **65+ years** Māori 2.39% Pacific 1.69% Other 2.09% Total 2.11%	*To be allocated*

More People with End Stage Conditions are Supported Appropriately

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Measure to be developed					

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of aged residential care facilities utilising advance directives	3	Qn	100%	100%	100%
Number of new patients seen by the Waikato hospital palliative care service	3	Qn	652 original *1085 revised*	1,000	*To be allocated*

Support services

Impact Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Measure to be developed					

Output Measure	Output class	Measure Type	Baseline	Target 2018/19	Target 2019/20
Percentage of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	3	Qn/T	94%	95%	95%
Percentage of accepted referrals for CT scans will receive their scan within 6 weeks (42 days)	2	T	Māori 92% Pacific 100% Other 90% Total 90%	Māori 95% Pacific 95% Other 95% Total 95%	Māori 95% Pacific 95% Other 95% Total 95%
Percentage of accepted referral for MRI scans will receive their scan within 6 weeks (42 days)	2	T	Māori 55% Pacific 53% Other 52% Total 48%	Māori 90% Pacific 90% Other 90% Total 90%	Māori 90% Pacific 90% Other 90% Total 90%
Percentage of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive)	2	T	78%	90%	90%
Percentage of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure (Baseline 15/16) within 42 days	2	T	49%	70%	*Increase?*
Percentage of people waiting for a **surveillance** colonoscopy will wait no longer	2	T	70%	70%	*Increase?*

than 84 days beyond the planned date					
Percentage of all laboratory tests are completed and communicated to referring practitioners within 48 hours of receipt	2	T	100%	100%	100%

Financial Performance

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Placeholder for financial performance

Forecast Comprehensive Income	2019/20 $M PLANNED
Budgeted Surplus/(Deficit) for the 2019/20 year	(68.6)
The 2019/20 budget is in the process of development based on analysis of the cost of appropriate service delivery for planned volumes for the year, and draft funding estimates provided by the Ministry of Health. The result of this first budget estimate is a deficit of $68.6 million. Work on challenging this initial budget is ongoing. The first financial budget template is due to the Ministry of Health on 5 April 2019.	

Statement of accounting policies

Reporting entity

Waikato District Health Board ("Waikato DHB") is a District Health Board established by the New Zealand Public Health and Disability Act 2000 and is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled and operates in New Zealand.

The group consists of Waikato DHB and its controlled entity, Waikato Health Trust. Its 20 percent share of its jointly controlled entity, HealthShare Limited, is equity accounted. These entities are incorporated and domiciled in New Zealand.

Waikato DHB's activities are the purchasing and the delivering of health services, disability services, and mental health services to the community within its district. Waikato DHB does not operate to make a financial return. Waikato DHB has designated itself and its group as a Public Benefit Entity (PBE) for financial reporting purposes.

Basis of preparation
Financial statements are prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

Statement of Going Concern
The going concern principle has been adopted in the preparation of these financial statements. The Board has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances *which* it consider is likely to affect the DHB, and to circumstances which it knows will occur in the next 12 months which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Operating and Cash flow forecasts
The Board has considered forecast information relating to operational viability and cash flow requirements. The Board is satisfied that there will be sufficient cash flows generated from operating activities and either access to equity, lease financing or private debt to meet the investing and financing cash flow requirements of the DHB as set out in its current Statement of Intent and based on current trading terms and legislative requirements.

Borrowing covenants and forecast borrowing requirements
The forecast for the next year prepared by the DHB shows that the peak borrowing requirement will not exceed the available borrowing facilities if access to equity, lease financing or private debt is achieved. The Board has confidence that this can be achieved. The forecast borrowing requirements can be met without breaching covenants or other borrowing restrictions.

Statement of compliance
Financial statements are prepared in accordance with the New Zealand Public Health and Disability Act 2000 and Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practices in New Zealand (NZ GAAP).

Financial Statements are prepared in accordance with, and comply with, Tier 1 PBE accounting standards.

Presentation currency and rounding
Financial statements are presented in NZ dollars and all values are rounded to the nearest thousand dollars ($000).

Standards issued and not yet effective and not early adopted
Standards and amendments, issued but not yet effective as at 30 June 2018 that have not been early adopted, and which are relevant to the Waikato DHB and group are:

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34 – 38). These new standards replace the existing standards for interests in other entities

(PBE IPSAS 6-8). The new standards are effective for annual periods beginning on or after 1 January 2019 with early application permitted.

These changes have no implication on the Waikato DHB and group.

Financial Instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces IPSAS 29 *Financial Instruments: Recognition and Measurement*. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The main changes under PBE IFRS 9 are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses.

The Treasury has decided that the Financial Statements of the government will early adopt PBE IFRS 9 for the 30 June 2019 financial year. Waikato DHB will also early adopt PBE IFRS 9 for the 30 June 2019 financial year to be consistent with Crown's accounting policy for financial instruments. The Waikato DHB and group has not yet assessed the effects of the new standard. Based on initial assessment, Waikato DHB anticipates that the standard will not have a material effect on the Waikato DHB's financial statements.

Impairment of revalued assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes revalued property, plant and equipment into the impairment accounting standards. Previously, only property, plant and equipment measured at cost were scoped into the impairment accounting standards.

Under the amendment, a revalued asset can be impaired without having to revalue the entire class-of-asset to which the asset belongs. This amendment is effective for the 30 June 2020 financial statements with early adoption permitted. The timing of the Waikato DHB adopting this amendment will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt the amendment.

Service Performance Reporting

In November 2017, the XRB issued PBE FRS48, a new standard for Service Performance Reporting. PBE FRS48 is effective for periods beginning on or after 1 January 2021 with early adoption permitted.

The main components under PBE FRS48 are information to be reported, presentation, comparative information and consistency of reporting, and disclosure of judgements.

The Waikato DHB plans to apply this standard in preparing its 30 June 2022 financial statements. The Waikato DHB and group has not yet assessed the effects of the new standard.

Summary of significant accounting policies

Subsidiaries
Waikato DHB is required under the Crown Entities Act 2004 to prepare consolidated financial statements in relation to the economic entity for the financial year. Consolidated financial statements are prepared to include Waikato Health Trust due to the control that Waikato DHB has over the appointment and removal of the Trustees of Waikato Health Trust. Transactions between Waikato DHB and the Waikato Health Trust have been eliminated for consolidation purposes.

Associates
The group's associate investment is accounted for using the equity method. Associates are those entities in which Waikato DHB has significant influence, but not control, over the financial and operating policies.

Financial statements include Waikato DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence begins until the date that significant influence ceases.

Joint ventures
Joint ventures are those entities over whose activities Waikato DHB has joint control, established by contractual agreement.

Financial statements include Waikato DHB's interest in joint ventures, using the equity method, from the date that joint control begins until the date that joint control ceases. When Waikato DHB's share of losses exceeds its interest in a joint venture, Waikato DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Waikato DHB has incurred legal or constructive obligations, or made payments on behalf of a joint venture.

Budget figures
The Waikato DHB's budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by Waikato DHB in preparing financial statements.

Revenue
Revenue from exchange transactions is measured at the fair value of consideration received or receivable, taking into account the amount of any trade discounts and volume rebates allowed by the Waikato DHB.

Revenue from non-exchange transactions is revenue other than revenue from exchange transactions, such as donations, grants and transfers.

The specific accounting policies for significant revenue items are explained below:

Ministry of Health (MoH) population-based revenue

Waikato DHB is primarily funded through revenue received from MoH, which is restricted in its use for the purpose of Waikato DHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder. Revenue from MoH is recognised as revenue when earned. The fair value of revenue from MoH has been determined to be equivalent to the amounts due in the funding arrangements.

Ministry of Health (MoH) contract revenue

The revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contracts. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of the revenue recognition for contracts that span a balance date and multi-year funding arrangements.

ACC contract revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Revenue from other district health boards

Inter-district patient inflow revenue occurs when a patient treated by Waikato DHB is domiciled outside of Waikato DHB's district. MoH pays Waikato DHB with monthly amount based on estimated patient treatment costs for non-Waikato DHB residents. An annual revenue washup occurs at year end to reflect the actual number of non-Waikato DHB patients treated at Waikato DHB.

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

Lease receipts under an operating sublease are recognised as revenue on a straight-line basis over the lease term.

Provision of services

Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at balance date.

Grants received

Grants are recognised as revenue when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as grants received in advance and recognised as revenue when conditions of the grant are satisfied.

Donations and bequests

Donations and bequests to Waikato DHB are recognised as non-exchange revenue when control over the asset is obtained. When expenditure is subsequently incurred in respect of these funds, it is recognised in the statement of comprehensive revenue and expense. Volunteer services received are not recognised as revenue or expenses.

Vested or donated assets

For assets received for no or nominal consideration, the asset is recognised at its fair value when the group obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.
The fair value of donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Finance costs

All borrowing costs are recognised as an expense in the financial year in which they are incurred.

Leases

Waikato DHB as lessee

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased term or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether Waikato DHB will obtain ownership at the

end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight line basis over the lease term.

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Waikato DHB as lessor

A lease where Waikato DHB, as lessor, has in fact all the benefits and risks of ownership is designated as an operating lease; otherwise, such agreements are recognised as finance leases. Property, plant and equipment made available to third parties by means of an operating lease is recognised in accordance with the accounting standards for property, plant and equipment.

Lease revenue from operating leases shall be recognised as revenue on a straight-line basis over the lease term, unless another systematic basis is more representative of the time pattern in which benefits derived from the leased asset is diminished.

Initial direct costs incurred by Waikato DHB in negotiating and arranging an operating lease shall be added to the carrying amount of the leased asset, and recognised as an expense over the lease term on the same basis as the lease revenue.

Foreign currency transactions

Transactions in foreign currencies (including those for which forward foreign exchange contracts are held) are translated into New Zealand dollars (the functional currency) using the spot exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transaction and from the translation at year end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held at call with banks, other short term highly liquid investments and bank overdrafts. Bank overdrafts are presented in current liabilities in the statement of financial position.

Financial assets recognised subject to restrictions

Included in cash and cash equivalents and investments are unspent funds with restrictions that relate to the delivery of health services by the DHB. Other than for trust funds, it is not practicable for the DHB to provide further detailed information about the restrictions.

Receivables

Short-term debtors and other receivables are recognised at their face value, less any provision for impairment. Bad debts are written off during the period in which they are identified.

A receivable is considered impaired when there is evidence that the group will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Derivative financial instruments

Derivative financial instruments are used to manage exposure to foreign exchange risk arising from the group's operational activities. The group does not hold or issue financial instruments for trading purposes. The group has not adopted hedge accounting.

Derivatives are initially recognised at fair value on the date a derivative contract is entered into and are subsequently remeasured at their fair value at each balance date with the resulting gain or loss recognised in the surplus or deficit.

Forward foreign exchange derivatives are classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, the fair value of foreign exchange derivatives is classified as non-current.

Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost and adjusted where applicable for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition. Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost and net realisable value. The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised as an expense in the period of the write-down.

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and its fair value less costs to sell.

Impairment losses for write-downs of non-current assets held for sale are recognised in expenses. Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have previously been recognised.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

Property, plant and equipment

Classes of property, plant and equipment

The asset classes of property, plant and equipment are:

- freehold land
- freehold buildings
- plant, equipment and vehicles.

Land and buildings

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairments losses.

Revaluations

Land and buildings are revalued to fair value with sufficient regularity to ensure that the carrying amount does not differ materially to fair value, and at least every five years. The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

Land and buildings revaluation movements are classified on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised as a movement in the revaluation reserve in the statement of comprehensive revenue and expense, but is recognised in the expense section of the statement of comprehensive revenue and expense. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, with the remainder then recognised as a movement in the revaluation reserve in the statement of comprehensive revenue and expense.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to Waikato DHB and the cost of the item can be measured reliably. Work in progress is recognised at cost less impairment and is not depreciated. In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction it is recognised at its fair value as at the date of acquisition.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefit or service potential associated with the item will flow to Waikato DHB and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Disposal

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

Depreciation

Depreciation is charged to the statement of comprehensive revenue and expense on a straight-line basis. Land and work in progress is not depreciated. Depreciation is set at rates that will write off the cost or valuation of the assets to their estimated residual values over their useful lives.

Class of asset	**Estimated life**	**Depreciation rate**
Buildings	3- 85 years	1.2 – 33.3%
Plant, equipment and vehicles	2 - 35 years	2.5 – 50.0%

The useful lives and associated depreciation rates of the major classes of property, plant and equipment have been estimated as:

The residual value and useful life of assets is reviewed and adjusted if applicable, at balance sheet date.

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

Impairment of property, plant, equipment and intangible assets

Waikato DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate commercial return.

Non-cash generating assets

Property, plant, equipment and intangible assets held at cost that have a finite useful life are reviewed for indicators of impairment at balance date and whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. If any such indication exists, Waikato DHB shall estimate the recoverable amount of the asset. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate

approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised in the movement of revaluation reserve in the statement of comprehensive revenue and expense to the extent that the impairment loss does not exceed the amount in the revaluation reserve in equity for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised as an expense in the statement of comprehensive revenue and expense. For assets not carried at a revalued amount, the total impairment loss is recognised as an expense in the surplus or deficit.

The reversal of an impairment loss on a revalued asset is credited to movement in the revaluation reserve in the statement of comprehensive revenue and expense and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised as an expense in the surplus or deficit, a reversal of the impairment loss is recognised as revenue in the surplus or deficit. For assets not carried at a revalued amount, the reversal of an impairment loss is recognised as an expense in the statement of comprehensive revenue and expense.

Intangible assets

Software acquisition and development

Acquired software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised as an expense when incurred. Costs associated with maintaining computer software are recognised as an expense when incurred. Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset. Costs associated with developing and maintaining the Waikato DHB's website are recognised as an expense when incurred.

Information technology shared services rights

The Waikato DHB has provided funding for the development of information technology (IT) shared services across the DHB sector and the rights to the shared services is recognised as an intangible asset at the cost of the Waikato DHB's capital investment.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The estimated useful lives and associated amortisation rates of the major classes of intangible assets are:

Type of asset	Estimated life	Amortisation rate
Computer software	2 - 10 years	10 - 50%

Impairment of intangible assets

The same approach applies to the impairment of intangible assets as to property, plant and equipment, except for intangible assets that are still under development. Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is any indication of impairment.

Trade and other payables

Short term payables are recorded at their face value.

Borrowings

Borrowings are initially recognised at their fair value. After initial recognition all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless Waikato DHB has an unconditional right to defer settlement of the liability for at least twelve months after balance date.

Finance Leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest over the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the group will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within twelve months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up

to balance date, annual leave earned but not yet taken, continuing medical education leave and sick leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

A liability and expense are recognised for bonuses where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements

Employee benefits that are due to be settled beyond twelve months after the end of the period in which the employee renders the related service, such as sick leave, long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of employee entitlements

Sick leave, annual leave, and vested long service leave are classified as a current liability. Non-vested long service leave and retirement gratuities expected to be settled within twelve months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

Defined contribution schemes

Obligations for contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

The group makes employer contributions to the DBP Contributors Scheme (the scheme), which is managed by the board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.
Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus or deficit of the scheme will affect future contributions by individual employers as there is no prescribed basis for the allocation. The scheme is therefore accounted for as a defined contribution scheme.

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of future economic benefits that settlement payment will be required and a reliable estimate can be made of the amount of the obligation.

ACC Partnership Programme

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date. Consideration is given to anticipated future employee remuneration levels and history of employee claims and injuries. Expected future payments are discounted using market yields on New Zealand government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash out flows.

Repairs to motor vehicles provision

A provision is provided for the costs of repairing motor vehicles at the end of their operating lease period before return to the lessor.

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or for which implementation has already commenced.

Demolition

A provision for demolition is recognised when an approved detailed formal plan for the demolition has either been announced publicly or for which demolition has already commenced.

Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

- Crown equity;
- accumulated surpluses/(deficits);
- property revaluation reserves; and
- trust funds.

Revaluation reserves

These reserves relate to the revaluation of land and buildings to fair value.

Trust funds

Trust funds represent the unspent amount of unrestricted donations and bequests received.

Income tax

Waikato DHB is defined as a public authority in the Income Tax Act 2007 and consequently is exempt from the payment of income tax. Accordingly no provision has been made for income tax.

Goods and services tax (GST)

All items in the financial statements are presented exclusive of GST except for receivables and payables which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax then it is recognised as part of the related asset or expense. Commitments and contingencies are disclosed exclusive of GST.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department is included as part of receivables or payables in the statement of financial position. The net GST received from, or paid to, the Inland Revenue Department, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows. Commitments and contingencies are disclosed exclusive of GST.

Cost Allocation

Waikato DHB has determined the cost of outputs using the cost allocation system outlined below.

Direct costs are those costs directly attributable to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output.

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Other indirect costs are assigned to outputs based on responsibility centre.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

In preparing financial statements, the Board makes estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Land and buildings revaluations

The significant assumptions applied in determining the fair value of land and buildings are as follows:

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. Adjustments have been made to the unencumbered land value for land where there is a designation against the land or the use of the land is restricted. These adjustments are intended to reflect the negative effect on the value of the land where an owner is unable to use the land more intensively.

Restrictions on Waikato DHB's ability to sell land would normally not impair the value of land because it has operational use of the land for the foreseeable future and will receive substantially the full benefits of outright ownership.

Buildings:

Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings. Depreciated replacement cost is determined using a number of significant assumptions including:

- The replacement asset is based on the replacement with modern equivalent assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- For Waikato DHB's earthquake prone buildings that are expected to be strengthened, the estimated earthquake strengthening costs have been deducted off the depreciated replacement cost in estimating fair value.
- The remaining useful life of assets is estimated.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialist buildings are valued at fair value using market-based evidence. Market rents and capitalisation rates are applied to reflect market value. These valuations include adjustments for estimated building strengthening costs for earthquake prone buildings and the associated lost rental during the time to undertake the strengthening work.

Restrictions:

Waikato DHB does not have full title to the Crown land it occupies but transfer is arranged if and when land is sold. Some of the land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provision of section 40 of the Public Works Act 1981.

Estimating useful lives and residual values of property, plant, and equipment

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates requires Waikato DHB to consider a number of factors such as the physical condition of the

asset, advances in medical technology, expected period of use of the asset by Waikato DHB, and expected disposal proceeds (if any) from the future sale of the asset.

Waikato DHB has not made significant changes to past assumptions concerning useful lives and residual values.

Retirement gratuities and long service leave

The present value of sick leave, long service leave, and retirement gratuity obligations depends on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability.

Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash flows. The salary inflation factor is determined after considering historical salary inflation patterns and after obtaining advice from an independent actuary. Two discount rates for retirement and long service leave are used together with a salary inflation factor.

Critical judgements in applying accounting policies

Management has exercised a critical judgement in applying accounting policies for determining whether an agency relationship exists requires judgement as to which party bears the significant risks and rewards associated with the sale of goods or the rendering of services. This judgement is based on the facts and circumstances that are evident for each contract and considering the substance of the relationship.

APPENDIX B: System Level Measures Improvement Plan

Placeholder for 2019/20 SLM Improvement Plan

APPENDIX C: 2019/20 Public Health Unit Annual Plan (Summary)

Placeholder for 2019/20 Public Health Unit Annual Plan

MEMORANDUM TO COMMUNITY & PUBLIC HEALTH AND DISABILITY ADVISORY COMMITTEE
10 APRIL 2019

AGENDA ITEM 5.3

DRAFT PUBLIC HEALTH UNIT ANNUAL PLAN 2019/20

Purpose	For information

The draft Public Health Annual Plan was submitted to the Ministry of Health on 29 March 2019, in line with planning requirements. The final plan is due for submission on 31 May 2019; thus, there is an opportunity to amend the plan following feedback from CPHAC/DSAC and any feedback received from the Ministry of Health.

The annual plan sets out the work to be undertaken by the Public Health Unit (PHU) in the coming year, 2019/20. The Waikato DHB PHU provides public health services under the public health service specifications (tiers one, two and three) as agreed by the Ministry of Health. The annual plan outlines what we intend do to fulfil this contract and is aligned with the Ministry of Health's guidance for 2019/20 planning. The annual plan is presented in relation to our core functions, which are public health capacity and development, health assessment and surveillance, health improvement and health protection.

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

The PHU is committed to achieving health equity for Māori and high need populations. There are activities under each core function that specifically relate to reducing health inequities for Māori.

Recommendation
THAT

The Committee receives the report/proposal.

TANYA MALONEY
EXECUTIVE DIRECTOR STRATEGY, FUNDING AND PUBLIC HEALTH

Public Health

1 July 2019 – 30 June 2020

Public Health
Waikato District Health Board

Author: Dyfed Thomas
Last updated: 19 March 2019
Version: v2.0 Final

Date	Author	Summary of changes	Version
04/03/2019	Dyfed Thomas	Document creation	1.0 Final
19/03/2019	Dyfed Thomas	Incorporate feedback from across PHU	1.1 Final
29/03/2019	Dyfed Thomas	Incorporate Strategy and Funding feedback	2.0 Final

mihi

Ka tū whera te tatau pounamu o te Ao
E takoto te whā riki o te Atua ki mua i a tātou
He hō nore, he korōria ki te Atua
He maungārongo ki te whenua
He whakaaro pai ki ngā tāngata katoa
Ka huri te kei o te waka ki te Kīngi a Tūheitia
Me te whare Kāhui Ariki whānau whānui tonu
Māte Atua e tiaki, e manaaki i a rātou
Me ngā whakaaro tonu ki ngā mate o te wā
Takoto mai, moe mai koutou, haere, haere, haere
Kāti rātou ki a rātou, tātou ki a tātou
Nō reira, he korowai rau whero o te whare Waiora o Waikato
Haere mai, Haere mai
Nau mai

The green stone door to the world opens
The whariki of God is laid before us
All honour and glory be to God
May there be peace on Earth
And good will to all people
The keel of our waka turns to King Tuheitia
And the household of the Kahui Ariki
May God care and bless them
Our thoughts turn to those who have passed on recently
Rest in peace sleep in peace depart journey on
Let the dead be separated from us the living
Therefore to our distinguished guests gathered here
Welcome, welcome,
Welcome.

Contents

1. Introduction

The annual plan is presented in relation to our core functions, which are outlined in Figure 2. Recently the Public Health Unit (PHU) was merged with the Strategy and Funding arm of the Waikato District Health Board (DHB) to form Public Health, Strategy and Funding. With this formal joining of the two groups, the PHU will be able to increase its collaboration and integration of public health action and effort across the DHB. The annual plan will highlight areas of alignment and support of wider DHB work and strategies.

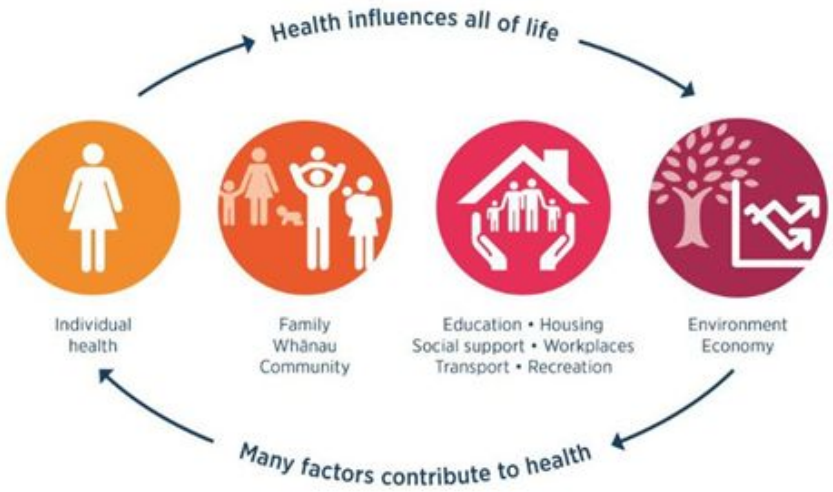
1.1 Why do we have an Annual plan?

The annual plan sets out the work to be covered by the PHU in the coming year, 2019/20. The Waikato DHB PHU provides public health services under the public health service specifications (tiers one, two and three) as agreed by the Ministry of Health. The annual plan outlines what we intend do to fulfil this contract as well as being mindful of the Ministry of Health's guidance for 2019/20 planning. The plan is also aligned with the Waikato DHB strategic imperatives (Waikato DHB, 2016) and the New Zealand Health Strategy themes (Ministry of Health, 2016).

1.2 Waikato Public Health Unit

In Public Health we strive to improve health across the life course of populations, from early life to older life. Waikato DHB prides itself on having an integrated public health service that prioritises its activities on promoting, improving and protecting health with a focus on achieving equity for people living in the Waikato DHB area. We work with communities such as Māori, those living in poverty, people in rural communities and those with disabilities to remove barriers that keep them from being well. Good health and wellbeing are about more than healthcare. A good start in life, education, decent work and housing, and strong, supportive relationships all play their part, which is why we take a broad look at health in our work covering many aspects as shown in Figure 1.

Figure 1: Health links with the wider environment.



(Ministry of Health, 2016)

The PHU's core functions, as outlined in Figure 2, underpin all we do. We fulfil regulatory and statutory functions relating to the public's health largely covered by the Health Protection Team and Medical Officers of Health. The Public Health Advisory and Development Team provide leadership through evidence based information, analysis, advice and practice. Reflecting the wider influences on health the Unit operates in a variety of settings which in turn shapes the way our Health Improvement Team works.

The Health Improvement Team (formerly Health Promotion) has adopted a settings based approach (see Figure 2). This allows us to work with key decision makers/leaders of community settings and to support them to provide an environment that is conducive to improving the health and wellbeing of our population. The team works in three settings; Healthy Education, Healthy Whānau with a focus on Māori and Pacific families and Healthy Workplaces. By working in this way, with the support of the Health Improvement Team, communities to lead and identify public health issues that require attention in their setting.

We deliver public health services across our communities and within settings using our public health process (bottom of Figure 2) as a guide. This process is a consistent framework for implementing the settings based approach and supports integration of public health core functions and change in practice. At the centre of our public health process is whānau ora. The settings based approach has an intentional emphasis on health equity, particularly for Māori and other vulnerable peoples and communities. Te Pae Mahutonga is embedded within this process as our framework for engaging effectively with communities within our key settings.

Figure 2:

With a systems view in mind and consideration of a life course approach, targeted services are being negotiated with communities and organisations through the settings across the

Waikato DHB Rohe and ensures a strong equity focus as it allows assessment of current or future impacts on achieving health equity.

Healthy education

The education settings encompass early childhood education services (ECEs); years 1-8 in primary and intermediate schools[1] (previously covered by health promoting schools); and years 9-13 in secondary schools. To create a health promoting setting, health improvement advisors work with Ngā Manukura (leadership) within education settings, where they consider three levels of influence, which are organisational structures, environmental structures and whānau wellbeing.

Using the health improvement process to review these three levels of influence, the Health Improvement Advisors (HIA) 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.

Healthy whānau

Healthy whānau concentrates on social and cultural settings that whānau connect with. We acknowledge the need to address health equity for Māori and Pacific communities and understand that culture is a key determinant of health. We work in partnership with Māori and Pacific communities to influence healthy settings that support wellbeing, utilising tools and processes influenced by Māori and Pacific realities, practices and understandings.

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 their holistic health and wellbeing needs and work together to determine ways to support and improve their health. The PATH tool is being used to advance the engagement and inquiry processes with great success to date.

Healthy workplaces

Healthy workplaces acknowledges 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.

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.

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

1.3 An overview of the Waikato DHB area

The Waikato Public Health Unit covers a vast geographical area that stretches from northern Coromandel to close to Mount Ruapehu in the south, and from Raglan on the west coast to Waihi on the east and covers more than 21,000km^2.

The principal iwi (Māori tribal groups) in the Waikato DHB district are Hauraki, Ngāti Maniapoto, Ngāti Raukawa, and Waikato. Ngāti Tuuwharetoa and Whanganui iwi groups also reside within the district, and a significant number of Māori living here affiliate to iwi outside the district.

Waikato had an estimated resident population of 377,940 based on the 2013 Census. Of this total population, Māori made up 22.5% (or 85,000) which is a higher proportion than the national average of 14.4%. Pacific peoples made up 4.1% (or 15,610) which is a lower proportion than the national average of 7.8% (Statistics New Zealand, 2015). Projections for 2019/20 (based on the 2013 Census) show Waikato DHB serving a population of 426,400, with 22.9% (or 97,500) of the population identifying their primary ethnicity as Māori (Ministry of Health, 2018).

The Waikato region has a similar percentage of people aged 65 years compared to the national average (14.5% compared to 14.1% nationally), and slightly higher percentage of people aged under 15 years (21.7% compared to 20.5% nationally). While the non-Māori and non-Pacific population is projected to increase to 315,500 by 2034, an increase of 6%, the Māori and Pacific population is growing much faster. The projected increase for the Māori population is 28%, to 124,900, and the Pacific population is expected to grow by 38%, to 18,800. By 2033 Māori are projected to make up 26% and Pacific Peoples 4% of the total population (Ministry of Health, 2018).

There are 10 territorial local authorities within Waikato DHB boundaries – Hamilton City, Hauraki, Matamata-Piako, Otorohanga, (part of) Ruapehu, South Waikato, Thames-Coromandel, (part of) Waikato, Waipa, and Waitomo.

2. How our plan links to DHB, regional and national priorities

The PHU is also committed to working in partnership through our settings approach, Public health advice and development support and health protection arms with the DHB, the DHB's Consumer Council, local iwi and Māori providers, Pacific providers as well as the Midland Public Health Network. The Annual Plan is aligned with national, regional and local strategies.

All of the Waikato DHB strategic imperatives have relevance to the Waikato Public Health Unit as shown below.

Figure 3: Waikato District Health Board strategic imperatives along with how the PHU's work relates to them.

Waikato DHB Health System Plan

In 2018/19 Waikato DHB developed a Health System Plan to improve our health system and futureproof it for the challenges we expect in the coming years. It translates the DHB Strategy vision - 'Healthy people, excellent care' - into a set of strategic goals and actions for the Waikato health system for the next ten years.

During a series of wānanga, focus groups, and workshop sessions, over 600 members of our community (including health workers from the DHB and the broader health system) took

the opportunity to share their experience, knowledge and ideas. People said that they would like Waikato health services to be:

- Focussed on wellness and wellbeing
- Focussed on the needs of service users, not the services' needs
- Equitable and fair for everyone regardless of ethnicity, sex, age or where people live
- Joined up health services with smooth links between health and other social services
- Designed with the people who use them.

The community and whānau voices align strongly to key public health have been distilled into goals with underlying actions. At least two of these goals have clear links to recognised public health approaches.

Healthy People.

- Partner with Māori in the planning and delivery of health services
- Empower whānau to achieve wellbeing
- Support community aspirations and address determinants of health

Excellent Care.

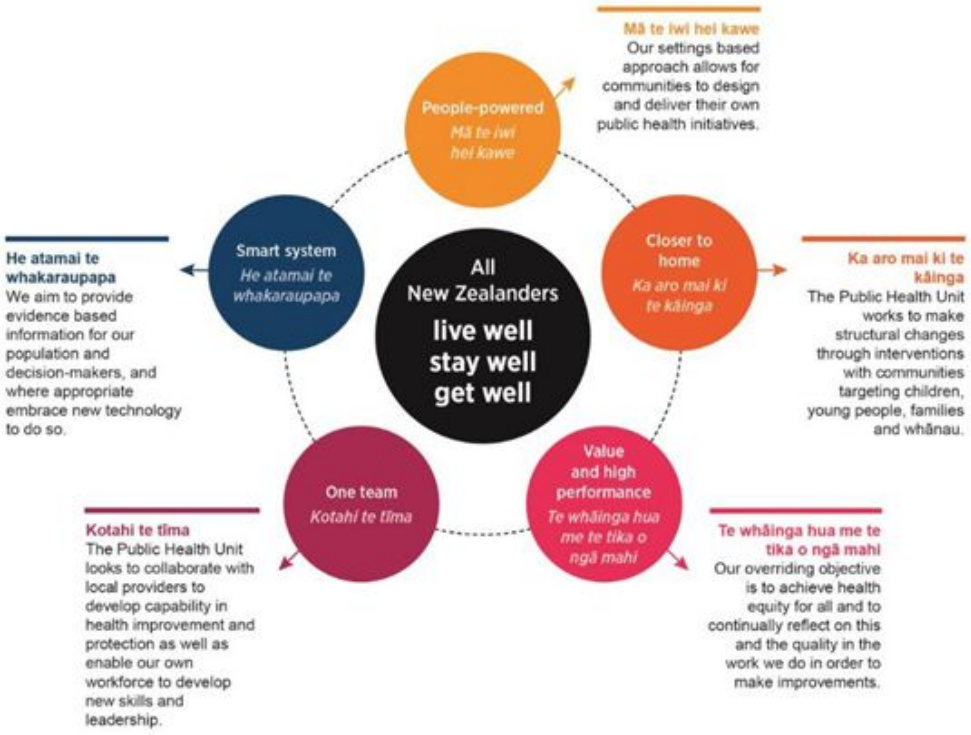
- Improve access to services
- Enhance the capacity and capability of primary and community health care
- Strengthen intermediate care

Key areas Public Health are working to support the DHB for 2019/20 includes:

- Māori health and equity.
- Disability and equity.
- First 1000 days.
- Climate change and environmental sustainability.
- Healthy eating – healthy weight.
- Developing preventative capabilities in hard-to-reach communities.
- Cross-sectoral collaboration.

The NZ Health Strategy: Future Direction (Ministry of Health, 2016) outlines the high-level direction for New Zealand's health system over the 10 years from 2016 to 2026. It has a vision and it lays out some of the challenges and opportunities the system faces; describes the future we want, including the culture and values that will underpin this future; and identifies five strategic themes for the changes that will take us toward this future (Figure 4).

Figure 4: New Zealand Health Strategy five strategic themes (2016).



The annual plan tables that follow will highlight (two left-hand columns) which strategic imperative (DHB) or strategic theme (NZHS) each action relates to. This is not done for the health protection section as the actions relate to specific legislation, which is noted.

3. Midland Public Health Regional Network

The Waikato PHU is part of the Midland Public Health Network, which also includes, Bay of Plenty and Lakes, Taranaki and Tairawhiti PHUs. The Network provides an opportunity for PHUs to work together on issues affecting the Midland region and this annual plan aligns with its goals, which are:

- Enhance the consistency, coordination and quality of public health service delivery across the region.
- Share innovative public health practice.
- Explore opportunities for increased efficiency through collaborative actions.
- Support and provide public health advice to other Midland clinical networks where they have a focus on upstream prevention.

Reflecting the Ministry of Health's expectations of continuing to share best-practice innovations with other PHUs, the region will support a commitment in the following areas for 2019/20:

a) Health equity

The Midland PHUs are committed to achieving health equity for high need populations and will share knowledge and practice that contributes for reducing differences which are unnecessary and avoidable, and are unfair and unjust.

b) HealthScape – Public Health Information Management system

The five regional PHUs are committed to adopting technology where a need is identified and its adoption will improve their service. HealthScape is currently being used by Toi Te Ora and Waikato PHU is currently implementing the system. Drinking Water operations will be the first area of implementation for Waikato. Taranaki and Tairawhiti PHUs are currently considering options for adoption. The Network recognises the value in adopting this system and will continue to share resources and knowledge on HealthScape.

c) Healthy Public Policy Network

In the last year this network has been established nationally, initiated by members of the Midland Region. The Midland Region will continue to promote and improve healthy public policy action through sharing knowledge, effective communications, improved consistency, improved capacity and reduced duplication of effort.

d) Health literacy

In order for people to stay healthy, improve their health and benefit from services we need health services to operate in a way that is appropriate, relevant and effective for them; this is a key area for all PHUs. This includes cultural competency so we can better communicate with Māori, Pacific peoples, disabled peoples and our migrant populations. The Network will continue to share knowledge and resources on health literacy for this purpose.

e) Sexual health

As noted in the Ministry of Health annual plan guidance the incidence of syphilis is increasing rapidly. The Network will collaborate and share resources and solutions in the effort to reduce incidence.

4. Health assessment and surveillance 2019/20

Health assessment and surveillance support will provide the evidence to inform and drive service design, delivery and practice. We aim to:

- Develop and foster relationships with key partners that enable access and sharing of data to collaboratively discuss public health issues.
- Review and refine surveillance data management systems to ensure best quality data is collected, collated, analysed and reported.
- Explore opportunities to disseminate public health data with a focus on health determinants, in particular health inequities and the health of Māori and Pacific people.
- Engage with regional and national projects to develop and utilise consistent indicators that measure public health outcomes.

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Public Health surveillance					
He atamai te whakara-upapa Ka aro mai ki te kāinga Te whāinga hua me te tika o ngā mahi	Pae taumata	Access and assess all available health related data. Explore additional data sources and the integration of health and social care data Continue indicator development and refinement for service in relation to the health status of the Waikato Population and the PHU strategy areas. Monitor and/or undertake regional or local analysis reports of alcohol intake, alcohol-related harm/disease, trends and highlight disparities.	No. of regional and/or local reports prepared and shared internally and externally as appropriate. No of: • Reports developed. • Reports analysed. Describe the scope, content and audience of regional or local analysis reports.	Any documents produced are robust with high quality data and in line with peer review processes. Methodologies utilised are robust and culturally responsive. Describe how reports have considered: • Impact on specific population and health inequities. • Complied with relevant data collection, collation, analysis, and output protocols. • Any barriers to analysis of data by ethnicity.	Service direction and delivery is informed by quality epidemiological data and complemented with community-up information. Long-term project, therefore narrative of progress. Indicators clearly link through various strategies. No. and proportion of external service users report that they used the information disseminated to inform their planning, programme design and delivery of prevention and control services (BC, S). Describe how useful the report was for internal planning e.g. to develop submission on LAP. Provide a summary of outcomes of
He atamai te whakara-upapa	Haumaru	Conduct surveillance for the purpose of preventing, identifying and responding to emerging communicable disease issues. Report on communicable disease (CD) data. Produce and/or contribute to disease-specific reports for communicable diseases (CD) of concern.	No. of (CD): • Surveillance reports. • Reports disseminated to the sector and/or community groups that you have contributed to or		

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	**How well (quality of effort)**	**Is anyone better off (quantity and quality of effect)**
			produced. Description (CD) type of report and the stakeholders the reports were disseminated to.	Describe how well CD surveillance system is performing and any challenging or emerging issues. Describe emerging CD issues and how PHU is addressing these.	CD surveillance activities.
Population Health assessment					
Ka aro mai ki te kāinga	Whaneke-tanga	Submissions made, and advice provided to organisations (within and outside the health sector) on issues of interest to PH.	No. of: • Submissions made and captured in database. • Position statements developed. • Current position statements reviewed and updated. • Sections updated and developed. • Discussion documents promoted. • Strategic documents are developed or updated. • Impact assessments undertaken with stakeholders.	100% of submissions will be guided by evidence best practice and follow internal process and be collaborative. Percentage of submissions contributed to by DHB's Strategy and Funding Division PHU peer review and appropriate service procedures will be followed. Database updated regularly of all submissions made and their outcomes. Percentage of position statements submitted to DHB's Community and Public Health Advisory Committee	Service direction and delivery is informed by quality epidemiological data and complemented with community-up information. Number/percentage of recommendations made by PHU adopted by receiving authority. Narrative on barriers to adoption provided. Public health issues are raised with a view to positively influence decision-making. Stronger collaboration within the sector enables services to be streamlined and actively promoted. Extent to which PHU input is reflected in steering group decisions. Narrative of advocacy actions and results. HIA recommendations utilised
	Haumaru	Waikato DHB position statements on public health issues are developed and updated.			
	Ratonga a iwi	Work with Waikato DHB to develop position statements on sustainability and equity for the Waikato DHB region			
	Whaneke-tanga	Develop plan for the healthy policy function of the Unit.			
Kotahi te tīma	Haumaru	Support the Waikato DHB in further development of the DHB Healthy Food and Drink Policy.			
Mā te iwi hei kawe	Oranga	Continue to support marae in developing and implementing healthy food and drink policies including water only policies			
He atamai te whakara-upapa	Haumaru	Continue to embed an internal strategic planning process for key identified priority areas			
Kotahi te tīma	Whaneke-tanga	Advocacy at national, regional, and local levels to support policies and practices that address PH issues.			
	Ratonga a iwi	Support the Waikato DHB in the development of the DHB Transport Policy			
Ka aro mai ki te	Haumaru	Identify opportunities and apply HIA as appropriate in response to organisation			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
kāinga		determined priority.		for approval.	where appropriately internally and externally.
Kotahi te tīma	Whaneke-tanga	Advocate for and offer to partner stakeholders to undertake impact assessments.		100% of planning resources guided by evidence and best practice. Collaborative alliances are formed with stakeholders to enable the review and development of policies, processes and resources. Describe the extent to which the advice given by PHU promoted best practice.	

5. Public health capacity development 2019/20

Within this core function we aim to:

- Develop and implement professional development pathway to provide access to appropriate training and professional development to all Population Health staff.
- Develop and implement an information and knowledge framework to strengthen programme planning and transferring knowledge to inform policy and service design and delivery.
- Use consistent approaches to research and evaluation.
- To foster and develop leadership across the service from management to service delivery.
- Strengthen key internal partnerships and develop opportunities for inter-sectoral collaboration to achieve equity in health.

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Capacity and capability (Human Resource)					
Kotahi te tīma Te whāinga hua me te tika o	Pae taumata	Provide guidance and best practice advice for research and evaluation to PHU staff (TUK: 1.4, 1.6, 7.1). Access to learning and development opportunities provided and or identified by DHB or PH. (TUK: 1.6). Public health medicine registrar post provided and successful candidate supported. (TUK: 1.6, 4.2, 9.3) Facilitate and support access to training and development opportunities. (TUK: 1.4, 1.6, 4.2).	Number of: • Staff receiving training and / or research and evaluation support. • Staff attending training. • Setting specific health promotion training by type (for HIT). One review completed to determine practicality of trainee position. Career and development plans in place for 100% of PH staff. Number of staff	Guidance and advice provided is aligned with PH best practice frameworks and processes. Appropriate guidelines and tools are developed to ensure staff can transfer knowledge into practice. Support training that has appropriate cultural frameworks embedded in the sessions. Responsive to needs and requests for training. PH continues to be an	Quality documentation produced by staff. Increase in staff confidence and skills to carry out PH activities, project and evaluation planning. Increase in staff professional development/improvement, confidence and skills to carry out PH activities. Increased number, and skills of, regulated and designated workforce. Designation and skills of existing regulated workforce maintained in line with best practice and requirements of regulatory
	Ratonga a iwi	Build Public Health leadership through supporting PHU staff to apply for and attend public health leadership training or equivalent (TUK: 1.6, 2.1). PHU staff participates in orientation and annual performance reviews including cultural competencies (TUK: 1.1, 8.2, 8.5).			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
ngā mahi			participation reported. One induction and orientation process provided to each new staff member. Annual performance reviews held with 100% of staff. Number of mentoring/ coaching sessions provided by specialists in PH Unit. Service Improvement plan (SIP) (Māori / Pacific) in place Annual report on SIPs implementation completed. Advice provided on request. Access to study resources including but not limited to: Public Health Unit library, DHB libraries. No. of staff attending NPHAWG and other training workshops. No. of training activities (alcohol) or professional development activities delivered. Also, nature of	approved workplace for registrars. Registrars complete all activities required for competencies assessment. For training: • Evaluation following training sessions. • Staff engaged to develop training plan with manger. • Record of training and development for each PH staff member. Annual reviews: • Training and support needs identified and planned for. • Career development plans produced. • Leadership objectives reviewed. • Provided within a safe environment that encourages openness. • Advisors to evaluate roles after six months' time.	authorities. Increased awareness and uptake among staff of accessible professional development opportunities Public Health Unit staff engaged in professional planning processes. PHU support enhances the learning of the Public Health Unit workforce. Supportive workplace culture for building capability and capacity amongst the workforce. Local Māori and/or Pacific provider has increased capability and capacity for research, project and evaluation planning. Advance workforce planning and capacity building to grow public health workforce. Content of planning and evaluation advice/workshop enhanced. No. and proportion (alcohol) of: • Participants report an increase in the level of knowledge of the topic of the training activities (SK, S). • Participants report they can
Kotahi te tīma	Pae taumata	All staff will prepare learning and development plans (reviewed annually).			
		Support provided to staff undertaking relevant public health tertiary training. (TUK: 1.1, 1.6, 9.3)			
Te whāinga hua me te tika o ngā mahi	Oranga	Support the implementation of a service wide approach to improving the health of Māori and Pacific communities in the Waikato DHB area. (TUK: 1.3, 1.6, 2.2, 3.3, 5.1).			
Mā te iwi hei kawe	Manaaki	Provide planning, research, evaluation advice and support for Māori and Pacific public health providers. (TUK: 1.6, 2.1, 3.1, 7.1)			
Te whāinga hua me te tika o ngā mahi	Oranga	Support DHB initiatives to develop preventative capabilities in hard-to-reach communities			
Mā te iwi hei kawe	Whaneke-tanga	Undertake collaborative projects with key stakeholders (e.g. South Island Public Health Partnership Alcohol Working Group).			
Kotahi te tīma	Pae taumata	Support alcohol team staff to attend National Public Health Alcohol Working Group (NPHAWG) workshops and other training.			
		Provide training and professional development for relevant PHU staff on alcohol policy analysis, information systems and health promotion to reduce harm from alcohol.			
		Maintain a communicable diseases (CD) response capacity and support CD staff to attend ESR epidemiological skills courses			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
		and other relevant courses.	training delivered and to whom. No. of: • CD staff attended at least 1 in 3 of ESR's epidemiological skills development programme core courses. • CD staff attended other relevant courses. • Education sessions delivered to health professionals external to the PHU. Description of non-core courses delivered to CD staff. No. of : • Trainings attended / completed by staff in effective health literacy communication. • Information resources produced/ provided for the target audience (partners and communities) including	Proportion (alcohol) of : • Participants report they are satisfied or very satisfied with training. • Training activities include a focus on improving health of Maori and Pacific, and fostering equity. • Training documents provided demonstrate high quality content and are responsive to the needs of staff. • Training reports/learnings shared at the service level by staff that attend • Documents or information resources produced include quality data and use plain language. • Type and extent of support/contributions made by MWSG members.	confidently apply the knowledge acquired to their alcohol and other drug work[2] (BC, S). Narrative of timely notifications occurring and if not, what will be done to address the issue. Narrative around: • Competency in communicating health information. • Stakeholders are accessing relevant mental wellbeing resources that are useful in their roles. • Whanau/communities/patients are enabled, through knowledge gain, to make informed and timely decisions around accessing mental health and related services. • Stakeholders engagement with the MWSG members and how that engagement has contributed to the de-stigmatisation of mental illness/issues and improved awareness of positive mental wellbeing.
		Maintain a planned programme annually to upskill investigating officers (CD)			
		Deliver education to health professionals (external to the PHU) and promote the importance of timely notification of CDs.			
Te whāinga hua me te tika o ngā mahi	Haumaru	Improve capability of Public Health staff in the mental health and wellbeing area through increased literacy.			
		Support key community settings to destigmatise mental illness / issues; and raise awareness regarding mental wellbeing.			
		Explore PH ways to respond to "First 1000 Days" mental wellbeing for hapu wahine (women), nga whaea (new mothers), and pepe (babies).			
Kotahi te tīma	Pae taumata	Immunisation teaching provided for medical students, practice nurses, PHNs, GP registrars			
		Support DHB work on enabling a Māori community led approach to immunisation			
		Support DHB work on a pilot of pharmacy provided scheduled childhood vaccinations			
		The nutrition and physical activity strategy group will engage and support key community settings (e.g. workplaces, schools, sport, local government, Māori and Pacific settings) to inquire, plan and transform food environments and physical activity levels.			

3 Based on relevant assessment tool available within the organisation or from competency training provider.

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	**How well (quality of effort)**	**Is anyone better off (quantity and quality of effect)**
			through a variety of media and technological approaches. • Networks supported / engaged with by MHW Strategy Group members. • Type of scoping activity (research, needs assessment, engagements) by PH that informs a "First 1000 days" mental wellbeing focus.	• The MWSG advocates that the explorative methods utilised are robust, culturally appropriate with a public health perspective evident. • Key priorities from "First 1000 Days" mental wellbeing literature are communicated across the service.	• The service direction and response are supported by the MWSG on identified/ prioritised first 1000 days initiatives and related activities. • Prepare a summary of actions (for initiation, delivery and evaluation) with a focus on MW during First 1000 days across PH teams and other service/regional groups to inform the PH leadership group. Narrative on immunisation activities. Narrative on how healthy nutrition and physical activity is supported by strategy group across settings
Information and knowledge services					
He atamai te whakara-upapa	Pae taumata	Provide research, analysis, interpretation and/or present evidence-based information on specific health and wellbeing issues.	No: of: • Analysis. • Advice. • Research. • Evaluations. Digital platform policy developed.	Evidence-based information provided to inform strategic PH action across a wide range of sectors. Documents produced have been through internal peer review	Evidence based information utilised internally and externally to inform service design and delivery. Narrative on the process of development and application of digital platform policy. No. and proportion of parents
Mā te iwi hei kawe	Manaaki	Continue PHU wide process/policy on the use and communication through digital platforms. Raise awareness in communities of legislation relating to social supply to minors and alcohol-related harm.			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Manaaki	Alcohol harm strategy group to work with settings (e.g. workplaces, education whaanau) to develop evidence-based PH action (e.g. strategies and policies) which support the reduction of alcohol-related harm where there is an agreed priority for that setting. As appropriate we will prompt setting to consider alcohol as a priority.	No. of (alcohol): • Awareness raising activities. • Communities provided with information on legislation relating to supply to minors. Description of communities assisted. No. of (alcohol): • Settings supported. • Support resources developed. • Key activities delivered. Description of organisations engaged with and advice and support (alcohol) given.	process. PHAD request form utilised to capture all requests. Proportion of communities supported (alcohol) that are in low SES/high number of Māori areas. Proportion of (alcohol): • Settings supported that are in low SES areas. • Settings supported that are kaupapa Maori settings.	report increased knowledge of the legislation around social supply of alcohol to minors (SK, S). No. and proportion of: • Organisations that have adopted evidence-based PH action to support the reduction of alcohol-related harm as a result of the PHU support activity (BC, S). • Organisations report increased knowledge about alcohol related harm and/or evidence to reduce alcohol related harm (SK, S). Impact of any PH action in settings as a result of PHU support/contribution. Narrative on reports and progress, networking and partnerships, submissions, hearings and other opportunities for advocating for nutrition and physical activity Narrative on engagement with LG and outcomes in relation to smokefree environments
		Nutrition and physical activity strategy group will advocate at local, regional and national levels through group representation to influence environmental opportunities for nutrition and physical activity			
		Tobacco control strategy group will support key community settings (workplaces, schools, sport, Māori and Pacific settings) to develop solutions to tobacco harm, with a focus on smokefree policies and environments, and access to cessation support.			
Ka aro mai ki te kāinga	Whaneke-tanga	Tobacco control strategy group will encourage Local Government to develop and expand smokefree environments through policies and/or bylaws			
Organisation and Infrastructure services					
Te whāinga hua me te tika o	Haumaru	Support the development and monitoring of service plans and indicators to ensure service improvement.	Plans are developed and reviewed / updated on a regular basis.	Scheduled updates and/or reporting. Internal monitoring	Infrastructure support systems maintained and developed with a focus on quality improvement; risk identification and minimisation;
		Quality linked plans / programmes			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
ngā mahi		developed and monitored include: • Risk register (via Datix) • Coordinating hazards review (via Datix) • Audit programme • Service annual plan • Standard operating procedures (SOPs)	A minimum of two "clinical" audits completed. Reports delivered to management monthly against annual plan deliverables through governance and strategy group. Resources will be provided in response to requests. Number and type of requests for graphic design support (internal and external).	process is developed and implemented. Actions identified through audits are monitored for implementation and reflected in process updates. SOPs database monitored and updated regularly. Requests are fulfilled in a timely manner and database maintained. Documents produced have been through internal peer review process.	consistency of service. Effective and efficient health education resources distribution is maintained. Resources provided to meet regional demand. Narrative on effectiveness of public health information presented digitally and/or graphically, to key stakeholders and communities. Narrative on office move.
Kotahi te tīma	Ratonga a iwi	Manage office relocation to Hamilton CBD.			
He atamai te whakara-upapa	Haumaru	Provide health education resources in accordance with authorised provider duties. Provide high quality PH literacy focused information utilising digital and graphic formats to present key information for PH projects, programmes and strategies.			
Networks and partnerships services					
Kotahi te tīma	Whaneke-tanga	Active participation in forums / and workshops with relevant partners and stakeholders. Actively participate as members of the Midland Regional Public Health Network governance group and sub-groups. Participate in other relevant forums/networks to support the sharing of best practice. Undertake collaborative projects with key alcohol working groups. Contribute to steering group advising on screening for harmful use of alcohol and brief interventions.	Number of relevant forums / networks participated in and actions delivered by the PHU. Number of forums/networks attended. Minimum of one leadership team member is represented on each Midland working group. No. of alcohol related	Documented process in place to evidence PHU's contribution and the value provided. Encourage appropriate protocols are followed during the forums. Proportion of collaborative projects that are focused on health of: • Māori and Pacific communities.	PH issues are considered by decision makers. Public heath leadership, performance and sustainability are strengthened at a national and Midland level. Narrative of outcomes of the projects or initiatives. Extent to which PHU input is reflected in alcohol steering group decisions.

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Mā te iwi hei kawe	Manaaki	Assess the feasibility of promoting alcohol screening and brief intervention strategies in Primary Care and Emergency Departments.	collaborative projects. Partner organisations (alcohol): • Description of partners. • Nature of collaboration. • Value added by PHU staff. Description of PHU contribution for alcohol screening and brief interventions. No. of (alcohol): • Feasibility studies carried out (Target =1). • Stakeholders approached to discuss screening and brief intervention strategies in Primary care and Emergency Departments. Details of stakeholders approached. No. of event organisers supported (alcohol). No. of national social marketing supported (alcohol) by PHU. No. of (alcohol):	• Low socio-economic areas. • Youth. Describe the extent to which the advice (alcohol) given by PHU promoted best practice. Summary of successes and barriers encountered in engaging with the event organisers (alcohol). Description of PHU role and the partners supporting alcohol marketing campaigns Proportion of (alcohol): • Communities and others supported that are in low SES/high number of Māori areas.	No. and proportion of external stakeholders report greater understanding of potential alcohol screening and brief intervention approaches (SK, S). No. and proportion of event organisers that have implemented alcohol-free events as a result of provider support (BC, O). Extent to which LAPs reflect a PH perspective. Describe the successes, any barriers to success, PH impact and outcome of upstream/proactive work with stakeholders. No. and proportion of: • Communities and other stakeholders that have adopted evidence-based PH action to support the reduction of alcohol-related harm as a result of the PHU support activity (BC, S). • Communities and other stakeholders report increased knowledge about alcohol related harm and/or evidence to reduce alcohol related harm (SK, S).
Kotahi te tīma	Whaneke-tanga	Work with event organisers and support them to adopt alcohol-free policies at events.			
Ka aro mai ki te kāinga		Support national social marketing campaigns related to reduction of alcohol related harm.			
Kotahi te tīma		Support TLAs to develop, implement and monitor their local alcohol policy (LAP).			
Mā te iwi hei kawe		Liaise with and where appropriate undertake joint projects to proactively influence other local authority alcohol-related policies and bylaws prior to the formal consultation process.			
		Work with communities and other stakeholders to develop evidence-based PH action which support the reduction of alcohol-related harm.			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
			• Communities and other stakeholders supported. • Key activities facilitated or delivered. Provide description of research or information summaries provided and community activities actively supported (alcohol). All TLAs visited.		

6. Health improvement 2019/20

The Health Improvement Team works through a setting based approach and the health improvement team will:

- Provide evidence of service delivery to support Waikato DHB priority of achieving radical improvement to Māori Health.
- Establish key communication messages to address the social determinants of health across settings and in communities.
- Showcase examples of the Health Improvement process.

The current three health improvement settings are:

Healthy Māori and Pacific Communities

Healthy Māori and Pacific Communities programme focuses on influencing socio-cultural environments and conditions to protect and improve health and wellbeing of whānau and communities. We acknowledge that culture is a key determinant of health – cultural identity, customs and traditions, and the beliefs of the family and community all affect wellbeing. We will work in partnership with Māori and Pacific communities to create healthy settings in ways that support and enhance whānau wellbeing.

Healthy Education

Healthy Education programme focuses on influencing education/school environments and conditions to protect and improve health and wellbeing of tamariki and rangatahi, whānau and communities. We acknowledge that education is a determinant of health, and not merely a setting for targeting populations. We will work in partnership with education leaders and key stakeholders in the Waikato to ensure wellbeing for learning is a shared outcome.

Healthy Workplaces

Healthy Workplaces programme focuses on influencing employment/workplace environments and conditions to protect and improve health and wellbeing of employees, whānau and communities. We acknowledge that employment is a determinant of health, and not merely a setting for targeting populations. We will work in partnership with employers and key industry players in the Waikato to ensure equitable opportunities and conditions in employment (and pre-employment).

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Healthy Māori and Pacific Communities					
Ka aro mai ki te kāinga	Whaneke-tanga	Focus on engagement and productive partnerships in Māori/Pacific communities to improve Māori/Pacific wellbeing (whānau ora) and health equity. Examples include in Marae and with Kaumatua	No of: • Partnership agreements/ MOUs. • Māori/Pacific communities engaged in Healthy settings (by type and locality). • Partnership activities completed by type. • Community outcomes profiled and opportunities to share successes / learnings. • Health improvement learning and development opportunities by type.	Proportion of: • Māori/Pacific communities engaged in Health Improvement Process. • Community members' feedback report satisfaction with health Improvement collaboration for wellbeing initiatives.	Narrative on productive partnerships developed and value of collaboration. Narrative of evidence of Māori/Pacific communities moving through the HI process and achievement of their identified health outcomes Narrative on capacity & capability initiatives and community feedback. Combined narrative on transformational outcomes for targeted Māori/Pacific communities.
Kotahi te tīma		Engage priority Māori/Pacific communities in the health improvement process as per targeted engagement strategy.			
Mā te iwi hei kawe	Oranga	Enable community leaders to facilitate inquiry process within the setting to understand needs and opportunities for health improvement.			
Te whāinga hua me te tika o ngā mahi	Manaaki	Enable community leaders to develop and implement action and evaluation plans to evaluate their health improvement strategies and monitor change over time.			
He atamai te whakara-upapa		Provide up to date evidence based PH information and advice to develop community leadership capability and capacity for health improvement.			
	Pae taumata	Provide opportunities to profile and celebrate good community leadership and successful initiatives aligned to the settings based approach for the development of other Māori/Pacific communities.			
Healthy Education					
Kotahi te tīma	Whaneke-tanga	Engage priority education services, ECE, Primary and secondary, in the settings based approach, as per targeted engagement strategy.	No of: • Type and locality of education settings engaged. • Type and locality of education settings engaged in the HI	Proportion of: • Education settings engaged with and meet prioritisation criteria. • Education settings engaged in the HI process meet	Narrative of evidence of settings moving through the HI process and the achievement/plan of attaining their identified health outcomes.
Mā te iwi hei kawe	Manaaki	Enable education leaders to facilitate inquiry process within the setting to understand needs and opportunities for health improvement; including a self-review of key child health issues.			

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Te whāinga hua me te tika o ngā mahi		Enable Education leaders to develop and implement action and evaluation plans for health improvement, using evidence based tools. Enable education leaders to evaluate their health improvement strategies and monitor change over time, using evidence based tools.	process. • Type of Health and Wellbeing issues identified by settings. • Type of evidence provided to settings.	prioritization criteria. • Education settings using evidence based tools meeting prioritisation criteria.	
He atamai te whakara-upapa	Oranga	Provide up to date evidence based PH information and advice to develop education leadership capability/capacity for health improvement.	• Type of opportunities offered/ provided to settings.		Narrative on the value of capacity and capability developing activities delivered.
	Whaneke-tanga	Provide opportunities to profile and celebrate education leadership and initiatives aligned to the setting based approach. Provide opportunities for education leadership to share successes and learnings for the development of others in their sector.	• Type of key stakeholders engaged. • Type of engagement activities.		Narrative of evidence of leadership and success within settings. Narrative on value of stakeholder engagement.
Kotahi te tīma		Engage and maintain relationships with other health services/community organizations and seek a collaborative approach to working in the Education setting.			
Healthy Workplaces					
Kotahi te tīma	Whaneke-tanga	**Engagement:** Lead engagement and recruitment of businesses across Waikato rohe onto WorkWell program. Lead delivery of public health responses to workplace wellbeing enquiries from community and businesses across the Waikato rohe. Lead development of new and existing stakeholder relationships that are conducive to delivering workplace	**Number of:** • Workplaces engaged in workplace wellbeing program. • Communications with workplaces, by type. • Stakeholders engaged with.	**Proportion of:** • Registered workplaces meeting prioritisation level 1 or 2 criteria, as per targeted engagement strategy (TES).* *Our Workplaces TES works to address equity and accelerate Māori Health	Table depicting registered WorkWell businesses; industry, geographical location, number of staff and length of engagement / accreditation level). Narrative on value of engagement activities with non-WorkWell businesses.

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
		wellbeing initiatives across the Waikato rohe.		outcomes by targeting work with vulnerable communities (by TLA and NZDEP); low paying industries; industries with high numbers of Māori and Pacific peoples employed; and industries with minimal education levels required. • Participants who felt satisfied or very satisfied with the workplace wellbeing opportunity.	
Mā te iwi hei kawe	Oranga	**Productive Partnerships:** Lead and work in partnership with key stakeholders to promote workplace wellbeing in the employment sector to advocate for and enable workplaces that support healthy choices and behaviors.	• And type of productive partnership activities completed.		Narrative on value of stakeholder engagement and productive partnerships. Narrative on the public health issues identified as priority for businesses engaged in WorkWell.
	Pae taumata	**Plan and Implement:** Enable Waikato businesses to facilitate their own inquiry, planning and evaluation processes to develop a wellbeing program, using evidence based tools (such as WorkWell or Good 4 Work) and other health improvement strategies. (Lead). (Where businesses have sites located outside our Waikato DHB boundaries, work in partnership with corresponding Public Health Units to identify the best response and way of working).	• Workplace initiatives/ outcomes profiled in local, regional or national communications. • Workplace sector opportunities to share successes / learnings. • Local public health enquiry templates developed or updated by topic. • Public Health enquiries responded to.		Narrative on success and benefits of workplace wellbeing opportunities. Narrative on businesses moving through accreditation process.
		Lead the development of local, up to date, evidence based public health information and advice to employment industry, and /or key stakeholders, to develop their capability and capacity for health improvement.			
He atamai te whakara-upapa	Manaaki	**Build Public Health Capacity:** Lead and contribute to opportunities to profile and celebrate good industry/ workplace leadership and successful initiatives aligned to the setting based approach for the development of others in their sector.	• Businesses profiled		Narrative on enquiries for public health issues from non-registered businesses or outside of priority issues for WW businesses. Narrative on businesses profiled if applicable.
		Proactively feedback areas for Work Well and Good 4 Work development and improvement to Toi Te Ora (TTO) and HPA	• Feedback activities participated in or contributed to.		

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
		Develop systems to inform service achievement and improvement including evaluation of WorkWell delivery. Workplaces team members are regularly upskilled by attending learning and development opportunities as identified in their WorkWell training needs assessments (TNA) and supported by objectives set in annual performance review. Capacity of team is monitored and discussed with management. Client to staff ratios. TTO recommends 5 at pre Bronze/ Bronze, an additional 5 at silver and/or gold to a maximum of 10 workplaces per FTE. Waikato will see its first businesses achieve silver in 2019. New staff will undergo a comprehensive orientation to workplaces team to increase their individual and team capacity.	• Evaluation tool is used with businesses during accreditation process. • TNA's completed for each staff member (6 monthly). • FTE ratios with WorkWell businesses at each accreditation level. • Orientation used and feedback given for evaluation.	Evaluation of orientation process	Narrative from businesses responses in evaluation of WorkWell delivery. For example, satisfaction with product being delivered and advisor capabilities. Number and/or percentage of employees demonstrating SK, AO or BC. Narrative on the value of learning and development activities by staff. Narrative on staff levels and capacity.
Te whāinga hua me te tika o ngā mahi	Oranga	**Poverty as a determinant of health: Living Wage:** Continue to participate and support Poverty Action Waikato and National Living Wage Movement stakeholders to increase awareness and understanding and support businesses whose employees are experiencing areas of poverty.			
Kotahi te tīma		**Industry response beyond the scope of WorkWell delivered as originally intended:** Lead implementation of WorkWell on a national scale using a 'national approach'. This will involve engagement with priority industry (as defined per TES). Identifying a business to progress national	• Engagement activities • Worksites and employees national project covers • Employees trained as WorkWell advisors		Narrative on HI process, the development of and level of service delivery achieved thus far.

NZ Health Strategy	Waikato DHB Strategy	Activities	Key performance measures		
			How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
		approach and brokering a partnership/MOU. Training staff from priority industry to be WorkWell representatives for their own worksites. Linking the trained business representatives with their local WorkWell advisor form around New Zealand to support the business and complete accreditation at the appropriate stage.		• Trained advisors implementing program at their worksite.	

7. Health protection 2019/20

The Health Protection core function:

- Supports, monitors and enforces compliance with legislation.
- Identifies, assesses, and reduces communicable disease risks, including management of people with communicable diseases and their contacts.
- Identifies, assesses and reduces environmental health risks, including biosecurity, air, food and water quality, sewage and waste disposal, and hazardous substances.
- Prepares for responding to public health emergencies, including natural disasters, hazardous substances emergencies, bioterrorism, disease outbreaks and pandemics.

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Border Health Protection	Undertake surveillance of mosquitoes at appropriate frequency for time of year. Provide mosquito interception response situation reports to the Environmental and Border Health Team. Respond promptly to interceptions of pests with a human health significance. Ensure designated points of entry achieve and maintain core capacities as required by the International Health Regulations 2005; audit core capacities annually. Identify and monitor border health protection risks from biological chemical and physical hazards. Develop/maintain contingency plans to deal with border health risks; work with border stakeholders to support the inclusion of PH response plans within sea and airport emergency response plans. Respond promptly to requests for pratique, inspections and certification.	No. of: • Interceptions. • Incursions. • Responses to other organisms • Authorized or accredited persons under the Biosecurity Act 1993. • Inter-sectoral meetings. • Responses to border public health incidents. • Maritime pratiques issued. • Maritime pratiques issued on arrival. • Aircraft met on arrival. • Ship sanitation exemption, extension and control certificates issued.	Proportion responses initiated within 30 minutes of notification. Narrative report on mosquito surveillance and whether it is occurring at appropriate frequency. Narrative report on requirements of a competent authority met by PHU. 100% of current staff members involved in ship sanitation inspections who have completed the WHO on-line ship sanitation course.	No. and proportion of: • Exotic mosquitoes that have crossed the border and established in your region (CC, O). • International points of entry that meets requirements of annual verification assessment under International Health Regulations 2005 (BC, O).

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Attend border and other inter-sectoral meetings with relevant agencies and organisations Provide sound technical and professional advice on PH issues that are related to border health protection objectives. Provide public health training to air and sea port staff. Contribute to or lead the preparation of health impact assessments in relation to border health protection threats and eradication and control activities. Maintain on-call roster to ensure appropriately trained staff are available at all times for any border responses.	• Public health training (e.g. advice, update, event) to air and sea port staff.		
Communicable Diseases	Maintain an appropriate and efficient system for receiving, considering and responding to notifications and enquiries. Provide all information and manage the local operation of databases and information systems. Ensure there is a high level of accuracy and quality of data entered into databases and information systems and information is entered in a timely manner. Act on the deficiencies identified in the ESR Data Quality reports within two weeks of receipt of the reports. Conduct clinical review of completed case report forms by a Medical Officer of Health, Senior HPO or Communicable Diseases Nurse and feedback findings to staff. Enforce the Health Act 1956, Health (Infectious and Notifiable Diseases) Regulations 2016 and other relevant legislation.	No of: • Disease notifications received, including non-cases. • Significant outbreaks. • Confirmed and probable TB disease cases. • LTBI/cases on preventative treatment. • TB contacts followed up. • Vaccinator applications processed. • Authorised needle exchanges. • Observation visits. No of: • Large scale events provided	Proportion of: • Notifications entered into EpiSurv. • Significant outbreaks that are followed by a debrief. • Notified TB diseases cases (new and relapsed) that have been managed by the PHU. • TB contacts followed up. • Vaccinator applications processed according to Ministry of Health guidelines. • Authorisation visits completed using Ministry of Health-approved form. • Sore throats treated with appropriate antibiotic as per New Zealand Sore Throat Guideline, and	Narrative reporting: Describe whether debrief recommendations of significant outbreaks have/will be incorporated into future plans and Standard Operating Procedures, where applicable. Describe whether any longer term preventive measures are put in place to prevent similar outbreak/s. Narrative reporting: Describe outcomes of engagement in DHB Governance Group on Rheumatic Fever Prevention. Describe systemic issues or barriers that will be/are being

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Identify, investigate, assess, monitor, manage and report significant outbreaks and emergent risks to public health from communicable diseases. Take prompt and appropriate action to protect the public from communicable diseases. **Rheumatic Fever** Work with partners to raise public awareness about the importance of getting sore throats and skin infections checked and treated among the high risk population. Undertake gap analysis of notified rheumatic fever cases. Ensure that all diagnosed rheumatic fever cases are entered into the local rheumatic fever register. Engage with the DHB Governance Group to provide public health perspectives in relation to Rheumatic Fever Prevention. Work with the Child Health Action Group (CHAG) to advocate for a national register, and assist with implementation of regional or national register if initiated. Reporting on sore throat management to ascertain if processes in place are being effective **Tuberculosis** Provide BCG vaccination to children according to the Ministry of Health's eligibility criteria. Manage confirmed and probable TB disease cases. Manage and follow up TB contacts.	with advice and resources for rheumatic fever prevention. Specific narrative reporting: Describe nature of advice provided. Narrative reporting: Describe pro-active and reactive liaison with the mass media and on-line/social media, if applicable. No. of negative /positive throat swabs for Group A streptococcus	percentage given script on same day as positive result received.	addressed by various agencies to reduce rheumatic fever rates. Narrative reporting: Describe outcomes of the work you have carried out to support the delivery of the National Immunisation Schedule. Describe systemic issues or barriers that will be/are being addressed by various agencies to get the immunisation curve trending upwards. No. and proportion: • Vaccinators that are authorised to practise (CC, O). • Needle exchanges operating in accordance with regulatory requirements. Narrative reporting: Describe outcomes of engagement with sore throat management providers

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Emergency Response: Develop communicable disease Emergency Response Plan. Maintain, exercise and regularly review Emergency Response Plan for responding effectively to a range of PH emergencies and emerging threats. Take appropriate emergency actions, as the need arises. Maintain civil defence and PH emergency planning and response capacity, and ensure there are appropriate numbers of staff trained in emergency management/CIMS. Ensure key health messages are available and up to date in both educational and promotional materials.			
	Immunisation: Provide vaccinator and programme authorisations. Support your respective DHBs/Primary Care Organisations (PHOs) towards achieving the current immunisation health targets and performance measures as agreed with the DHB. Provide clinical advice to your respective DHBs/PHOs to support the delivery of the National Immunisation Schedule. With support from the Ministry, implement policy changes that will result in the national elimination of measles and rubella. Provide advice to the DHBs/PHOs on the management of individuals affected by cold chain failures and the local processes to address an immunisation provider's non-compliance to the requirements outlined in the National Standards.			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Authorise needle exchange persons/premises, as required by the Needle Exchange Regulations.			
	Undertake observation visits to ensure needle and syringe exchange services operate in accordance with regulatory provisions and framework.			
	Provide objective advice, information and education about communicable diseases control and its significance.			
	Encourage and assist primary care providers, Crown entities, iwi, local authorities, other agencies and stakeholders to develop and implement policies to minimise control communicable diseases through processes.			
	Plan, implement and evaluate project-based activities that are aimed at providing evidence of effectiveness of PH action addressing specific communicable diseases control concerns and issues.			
	Inform and liaise with the mass media and on-line/social media about communicable diseases control issues and antimicrobial resistance.			
Drinking water	Identify and investigate incidents, complaints and notifications of adverse DW quality (or adequacy)	No. of DW Assessor FTEs. No. of investigations related to incidents, complaints and notifications. No. of: • Water supplies surveyed in the annual review. • Water safety plans assessed. • Temporary drinking water	% DW Assessors that maintain accreditation. % network drinking water register entries verified or updated. % networked water supplies (by class of water supply) receiving at least one compliance inspection per annum with findings confirmed	No. / proportion of networked water supplies (broken down by class) compliant with sections 69V and 69Z of the Health Act 1956 (BC, O). Proportion of networked water suppliers serving more than 100 people with approved water safety plans. No. / proportion of water
	Undertake all duties and functions required by the Health Act 1956.			
	Certify the implementation of water safety plans.			
	Authorise organisations for the purposes of ensuring compliance with legislation, DW standards, and water safety plans			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Report serious drinking water incidents to the Ministry of Health within 24 hours. Report suspected or confirmed waterborne disease outbreaks to the Ministry of Health within 2 hours.	supplies assessed and approved. No. of authorisations No. of investigations related to enforcement No. of assessments related to requirements of the DW Standards	in writing. % water suppliers' water safety plans reported on within 20 working days 100% of network drinking water supplies with an approved WSP that have had an implementation completed in the last 3 years Proportion of networked water supplies (by class of water supply) where timely response was provided (transgressions, contamination or interruption)	supplies serving 1000 people that are fluoridated (CC, O).
	Undertake enforcement activities in consultation with, and at the direction of, the Ministry of Health.			
	Refer issues and concerns with self-supplies to territorial authorities as required.			
	Implement the requirements of the DW Standards for New Zealand			
	Ensure activities are integrated with the DW technical advice services for networked supplies serving up to 5000 people.			
	Provide technical advice and information on public health aspects of DW supplies.			
	Ensure that the public health effects of DW supplies are considered and managed by making timely submissions on Regional and district plans, TLA assessments of DW supplies and resource consent applications.			
	Provide advice on the benefits of water fluoridation when it becomes a significant issue in the community.			
	Carry out public health grading of drinking-water supplies at the request of drinking-water suppliers.			
Hazardous substances	Develop hazardous substances programme plans.	No. of: • Public health HSNO enforcement officers. • Cases of hazardous substances injuries that are notified by GPs, hospitals and others.	100% of debriefs/audits that show responses have been consistent with the Ministry's advice and guidelines. 100% routine applications for VTA permissions processed	Narrative reporting: Promotion of the HSDIRT reporting process to GPs, hospitals and others. No. of and proportion of audited VTA operations compliant with permit approval conditions (BC,
	Report all notifications of hazardous substances injuries to the science provider in the format required, including GP notifications.			
	Promote hazardous substances injury notifications by GPs.			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Participate in the Hazardous Substances Injury Surveillance System and other notifiable condition surveillance systems Investigate notifications of lead poisoning, poisoning from chemical contamination of the environment, and hazardous substances injuries. Process applications for Vertebrate Toxic Agent (VTA) operations that require public health permissions. Ensure that the conditions imposed by the public health HSNO enforcement officer granting permits for the use of controlled vertebrate toxic agents are complied with. Field or desktop audits of all permissions are required to ensure compliance. Audit compliance with, investigate breaches of, and where appropriate, enforce the relevant Acts and Regulations. Work with other HSNO enforcement agencies to support their regulatory roles and manage potential public health risk. Receive annual reports on methyl bromide fumigations. Maintain effective risk management strategies and response plans for hazmat incidents and emergencies. Represent public health interests at meetings of the Area Hazmat Coordination Committee. Promote public knowledge on the risks of environmental and non-occupational exposures to hazardous substances and products, including asbestos in the non-occupational environment.	• Applications VTA permission received • Applications for VTA permission issued. • Desk top audits of 1080 operations. • Field audits of 1080 operations. • Desk top or field audits of non 1080 operations. • VTA complaint investigations received and investigated. • VTA complaints referred to another agency. • Hazmat incidents or emergencies attended. • Hazmat exercises attended. • Response plans reviewed and revised, if necessary, following responses and exercises. • Area hazmat coordination committee meetings attended. • Investigations/activities undertaken, by type (e.g. crayons, face paint, chemical spills).	within 20 working days. 100% of 1080 operations with permissions audited, either by desktop or field audit, for compliance with permission conditions.	O). Narrative reporting: Outcomes of hazmat meetings and exercises. Narrative reporting: Outcomes related to whether Local Authorities have been responding appropriately to public health risks from contaminated land.

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Advise, encourage and/or assist territorial authorities and Regional Councils to: • Identify potentially contaminated sites and identify contaminants. • Implement HIA systems to ensure contaminated land is remedied. • Determine appropriate land use controls for contaminated sites. • Ensure appropriate advice is provided to manage any PH risk from sites and during any remediation processes.			
Illicit drugs and psychoactive substances	Employ statutory officers to identify, investigate, assess, monitor, manage and report significant and emergent risks to PH from psychoactive substances and the misuse of drugs.	No. of: • Psychoactive Substances Enforcement Officers. • Trainings attended. • Complaints referred to the appropriate agency for action. • Advice given to the public about psychoactive substances. • Healthy public policies / Local plans on psychoactive substances and the misuse of drugs being developed or in place.	Psychoactive Substances Enforcement Officers met and maintain competencies for statutory appointment including attendance at Ministry of Health training as required. Complaints are referred onto appropriate agency within a suitable timeframe. Advice, information and education provided to the public is consistent with Ministry of Health policy, objective and evidence-based.	Number of Psychoactive Substances Officers employed are adequate to deliver the work programme and respond to emergent issues in a timely manner. Formal system in place for receiving, considering and responding to complaints. Profiles established of activities, facilities or premises of significance to the psychoactive substances work programme. The level of advice, information and education provided to the public, including Māori, is maintained or increased. Reports are provided to the purchaser and regulator on psychoactive substances and
	Maintain a response capacity to respond to issues relating to psychoactive substances and the misuse of drugs.			
	Ensure sufficient staffs are trained to meet the criteria for statutory appointment under the Psychoactive Substances Act 2013 and Misuse of Drugs Act 2005 and maintain awareness of factors influencing PH from the use of psychoactive substances and the misuse of drugs.			
	Collaboration with relevant enforcement agencies to enforce the relevant provisions of the Misuse of Drugs Act 2005 and the Psychoactive Substances Act 2013 and to protect PH.			
	Maintain an appropriate and efficient system for dealing with complaints from the public about the use of psychoactive substances and the misuse of drugs.			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Maintain information systems for psychoactive substances and the misuse of drugs programme activity which has the capacity to serve as a basis for reporting to the purchaser and regulator and to assist with compliance audits.			the misuse of drugs programme activity. LAPPs in force.
	Provide objective advice, information and education to the public, including Māori, about issues relating to the use of psychoactive substances and the misuse of drugs and their significance and to allow appropriate participation in the development of legislation relating to the use of psychoactive substances and the misuse of drugs.			
	Support councils in developing policies on psychoactive substances.			
	Ensure interpretation and application of policies on reducing the harm from psychoactive substances and the misuse of drugs is consistent with Government policy, manuals and guidance.			
Public Health Emergency Planning and Response	Carry out all emergency management planning, preparedness and responses in collaboration with other relevant agencies.	No. of exercises	Proportion of: • Plans and Standard Operating Procedures updated each year (required 100%). • % plans tested, including emergency communications (required 100%). • Exercises and responses that are followed by a debrief	Narrative reporting: Outcomes of exercises. No. and proportion of health protection officers and medical officers of health graduated from CIMS 4 or CIMS (Health) training (SK, O) Narrative reporting: If not 100%, please report on when they
	There must be plans covering the following minimum areas - Border Health Response - Communicable Disease – Outbreak/Pandemic - Hazardous Substances. - Civil Defence/National Disaster.			
	Take appropriate emergency actions, as the need arises.			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Maintain, exercise and regularly review plans for responding effectively to a range of public health emergencies.		(required 100%). • Debrief recommendations that are incorporated into plans and SOPs.	would be completing this training.
	Maintain civil defence and public health emergency planning and response capacity, and ensure there are appropriate numbers of staff trained in emergency management/CIMS.			
	Ensure key health messages are available in educational and promotional materials.			
Sale and Supply of Alcohol Act 2012	Inquire into all on-, off-, club and special licence applications and provide Medical Officer of Health (MOsH) reports to District Licensing Committee (DLC) (for opposition or recommendations)	No. of: • Applications and renewals • Received for each type. • Those were inquired into. • Had matters in opposition identified. • On-, club- and off-licences visited to provide education. • Formal training sessions of Duty Managers participated in. • Event organisers supported • CPO operations supported (conducted by NZ Police). • Premises visited during CPO ops. • Monitoring visits as part of multiagency efforts. • Monitoring visits as PHU.	100% reports provided to the licensing committee within 15 days. % premises located in low socioeconomic area where education was delivered. (Does not include formal training sessions of Duty Managers) 100% of high risk special licence application supported and an alcohol management plan is submitted within 15 working days to DLC. % high risk premises visited during CPO operations. 100% of inspections are recorded and noted in assessment database	No./proportion of oppositions accepted No./ proportion licensee staff and volunteers report they know more about how to implement their responsibilities under Act No. / proportion special licence event organisers that adopted and implemented appropriate alcohol management plans or alcohol harm reduction practices No. / proportion of premises that are compliant at the time of CPO with the Act
	Provide education as part of re-licensing and new licensing processes to staff			
	Work with special licence event organisers and support them to adopt and implement appropriate alcohol management plans or alcohol harm reduction practices.			
	Collaborate in police-led CPOs to reduce sale of alcohol to minors.			
	Undertake or work with other agencies to undertake monitoring visits of high risk premises			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
Smokefree Environments Act 1990	Enforce the Smoke-free Environments Act 1990 and Smoke-free Environment Regulations 2007. Deliver tobacco control functions as per the Smoke-free Compliance and Enforcement Manual and advice and direction from the Ministry of Health.	No of: • Education/compliance visits per recorded tobacco Industry premise. • Controlled purchase operations (CPO) conducted. • Standard operating procedures are consistent with Ministry of Health tobacco control and smoke-free policies. • Media statements and advisories. • Complaints received. • Training sessions provided.	No. and proportion of: • Tobacco retailers that are compliant with Smokefree Environments Act. • Timeframes for summiting short form files to the Ministry in order for infringement notices to be issued in a timely manner are met. Regulatory activities, CPOs and smoke free compliance inspections are carried out in accordance with Ministry of Health Smoke free Compliance Act and Enforcement manual. Advice, information and education provided to the public are consistent with Ministry of Health policy, objective and evidence-based. Appropriate regulatory advice is given in accordance with legislation, manual and best practice guidelines. 100% complaints are responded to within 20 days.	90% retailers who are compliant with the SFEA. Number of tobacco retailer's compliance with the Smokefree Environments Act increases. The no. of media advisories and media statements on tobacco control and smoke-free issues is maintained or increased. Improve attitudes of communities to minimise tobacco-related harm. Formal system in place for receiving, considering and responding to complaints100%. FTE of trained staff meets geographical spread of activities. Smokefree regulatory officers successfully complete Ministry of Health Smokefree Enforcement officer training programme. No. and proportion of : • Staff with improved knowledge, skills and competencies as a result of
	Regulatory activities undertaken to support compliance: • Carrying out retailer education • Conducting controlled purchase operations in priority areas. • Assessment of smoking areas in licensed premises • responding to complaints • Advertising and promotion • Providing advice to the public.			
	Ensure interpretation and application of national tobacco control and smoke-free policies is consistent with Ministry of Health Manuals and guidance.			
	Audit compliance with smoke-free legislation and tobacco control policies			
	Inform and liaise with the mass media about tobacco control and smoke-free issues.			
	Maintain an appropriate and efficient system for receiving, considering and responding to complaints from the public.			
	Take prompt and appropriate action to protect public health, and increase compliance with the smoke-free legislation.			
	Employ Smoke-free Enforcement Officers and ensure they attend all Ministry of Health training sessions. Maintain a			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	response capacity. Regulatory training is undertaken by staff to increase knowledge of legal responsibilities under the SFEA. Training provided to ensure capacity to carry out smokefree and liquor regulatory activities. Maintain profiles of activities, facilities or premises importing, manufacturing and selling (e.g. large growers, retailers and wholesalers) tobacco products (the Industry). Maintain an appropriate and efficient system for ensuring all sellers; including importer and manufacturers, of tobacco (where they can be identified) receive at least one education visit and one compliance visit at least every five years (more where non-compliance has been identified). Maintain information systems for tobacco control programme activity which have the capacity to serve as a basis for reporting to the purchaser and regulator and to assist with compliance audits. Tobacco control database. Develop and maintain an up to date database of tobacco outlets to assist with planning of compliance and enforcement activities to be accessible by all partners.		100% training sessions that are aligned with Ministry of Health guidelines and requirements. Staff has the necessary best practice approaches, skills, attitudes and knowledge. Database up to date and maintained.	training. • Smoke-free Enforcement Officers employed and trained are adequate to deliver the work programme and respond to emergent issues in a timely manner. Profiles established of activities, facilities or premises of significance to the tobacco control programme.
Stakeholder Planning, Submissions and Resource Management	Encourage and assist Councils to develop and implement policies through processes, such as the review of district plans, including variations or plan changes or Council Long Term Plans that address the wider determinants of health.	No. of: • Applications/plans/ statements/standards assessed for public health issues.		Narrative reporting: Public Health impact (or expected impact) of submissions and/or proactive/upstream work with stakeholders (ie, key public health gains).

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Make timely and professional submissions on national and regional plans and policy statements, district long term and annual plans and, where appropriate, resource consent applications to ensure that the public health effects are considered and managed.	• Submissions made. • Hearings where evidence presented. Narrative reporting: Brief description of proactive/upstream work with stakeholders (who and what).		
	Monitor decisions made under the Resource Management Act 1991 to ensure that the health impacts of environmental hazards have been considered.			
	Make timely and professional submissions on local government assessments of sanitary works to ensure that the public health aspects are considered.			
	Comment, as appropriate, on territorial authority plans for sanitary works infrastructure planning.			
	Liaise and, where appropriate, undertake joint projects with consent authorities and affected communities to ensure that public health aspects of planning and resource management are considered.			
	Provide technical advice and information to regional councils and territorial authorities.			
	Inform other agencies and the public on the public health aspects of matters relating to sustainable resource management.			
Other Regulatory Issues	For the following PH issues: air quality; the disposal of the dead; environmental noise; ionising radiation; non-ionising fields; recreational waters; gaseous, liquid and solid waste and other environmental health issues; undertake the following: • Provide information and advice to other agencies, organisations and the public on their adverse effects.	No of: • Ionising radiation source transports overseen. • Requests for advice or information responded to. • Complaints referred to the appropriate agency for action	100% activities and advice related to ionising radiation undertaken in consultation and with approval of the Ministry's Office of Radiation Safety. % visits to commercial solaria operators six monthly	No. / proportion of known commercial solaria operators who report they are aware of the under-18 age ban (SK, S).

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	• Take appropriate action to minimise risks and protect from harmful exposure. • Monitor TLA actions. • Respond to public enquiries and investigate and/or redirect public complaints and queries on issues. • Support local government implementation of national policy statements and national environmental standards.	• Complaints investigated. • Sanitary surveys conducted by PHU. • Commercial solaria visited six-monthly – or at a frequency as determined by the Ministry • Pre-licensing inspections of early childhood centres. • Early childhood centre inspections undertaken as a result of complaints. Narrative report: Nature of any significant work not reported elsewhere e.g. beauty industry work such as nail bars.		
	Ensure applications for approvals are complete, and include the HPO's covering report and recommendations before forwarding to Ministry of Health for action.			
	Supervise disinterments as required.			
	Advise and assist applicants to export cadavers to ensure PH concerns are addressed.			
	Conduct six-monthly visits to commercial solaria to encourage compliance with best practice guidelines.			
	Conduct and report on pre-licensing inspections of ECE. Investigate/inspect and report on ECEs in response to complaints.			
	Survey the availability of high-power laser pointers at retail outlets, provide advice on compliance and take compliance action as required by the Ministry of Health.			
	Encourage local authorities to clearly identify, and publically notify, existing or potential recreational waters, which do not meet minimum microbiological water quality guidelines.			
	Encourage the grading of bathing beaches.			

Area	Activities	Key performance measures		
		How many (quantity of effort)	How well (quality of effort)	Is anyone better off (quantity and quality of effect)
	Respond to recreational water incidents and inquiries as required, including toxic shellfish poisoning.			
	For recreational waters, provide: • Input into regional and local activities associated with quality. • Public and stakeholders with appropriate advice.			
	Liaise with councils and providers to verify that sewage overflows that pose a significant public health risk are: • Adequately responded to. • Ensure overflows are appropriately managed • Reduce overflows to high risk areas. • Promote improvements in public sewage collection and disposal systems. • Investigate clusters/cases of illnesses associated with non-occupational exposure to sewage or other waste.			
	Provide advice to schools and early childhood centres during an outbreak investigation and response.			
	Where appropriate, advocate the use of health impact assessment.			
	Where appropriate, promote the Healthy Cities/communities concept.			

References

Ministry of Health, 2016. *New Zealand health strategy - Future direction,* Wellington: Ministry of Health.

Ministry of Health, 2018. *DHB Populations Projections 2018 update,* Wellington: Ministry of Health.

Statistics New Zealand, 2015. *Estimated resident population (ERP), subnational population by ethnic group, age, and sex, at 30 June 1996, 2001, 2006, and 2013,* Wellington: Statistics New Zealand.

Statistics New Zealand, 2017. *Subnational ethnic population projections, by age and sex, 2013(base)-2038.,* Wellington: Statistics New Zealand.

Waikato DHB, 2016. *Healthy people excellent care - Waikato District Health Board strategy,* Hamilton: Waikato District Health Board.

MEMORANDUM TO COMMUNITY & PUBLIC HEALTH AND DISABILITY ADVISORY COMMITTEE
10 APRIL 2019

AGENDA ITEM 5.4

TE PAE TAWHITI FEEDBACK

Purpose	For information

The Te Pae Tawhiti vision for change was presented to the CPHAC and DSAC meeting in February 2019.

At the time of that meeting we were yet to review and respond to the feedback. The committee requested that a summary of feedback and responses be brought to this meeting.

A summary of the feedback is attached.

Recommendation
THAT

The Committee receives the report.

TANYA MALONEY
EXECUTIVE DIRECTOR STRATEGY, FUNDING AND PUBLIC HEALTH

SUMMARY OF CONSULTATION FEEDBACK AND DHB RESPONSES/ACTIONS

Feedback theme	Response/action
There is lack of clarity about the purpose of the document which reads like an amalgamation of the other documents – is it a strategic directions document, a vision or a framework for change? Be more clear about the strategic directions.	The document is an amalgamation of other documents into a vision for the future. It is not intended to go beyond this to describe the strategic directions and priorities which will be stated in a subsequent document. The original version included some strategic priorities, enablers and next steps that go beyond the vision and beyond what was written in the original models of care. **Action: Remove the strategic priorities, enablers and next steps (for use in subsequent strategic directions document and commissioning roadmap) and rename the document "Te Pae Tawhiti Vision for Change". Re-write introductory sections to make the document's purpose clearer.**
The document should reflect other models or documents or include information that was not included in the original models of care (including He Ara Oranga which was released about the same time as Te Pae Tawhiti Framework for Change was issued for consultation).	This document was commissioned as a distillation of the key themes from TPT models of care, Creating Our Futures, the youth AOD model of care, and the wananga summary, in order to identify the shared vision for the future. The DHB does not wish to change this brief at this late stage. The TPT Vision for Change will itself inform • A strategic directions document • A commissioning roadmap setting out an implementation plan for the next three years • Service change plans Other relevant documents that did not inform the original models of care (like He Ara Oranga and Waikato DHB's Health Services Plan) will, alongside TPT Vision for Change, inform the DHB's strategic vision and priorities, commissioning roadmaps and DHB and other providers' service plans.
The vision needs to be clearer from the outset – how will it be in 2030?	**Action: write an executive summary that both explains the purpose of the document and summarises the future vision.**
The document lacks MH specific epidemiological and population data.	**Action: MH&A-specific data included.**
The strategy must capture not only the maintenance of good MH but also effective treatment of illness.	**Action:** **Added principle regarding effective interventions** **Added reference to access to effective treatments**

SUMMARY OF CONSULTATION FEEDBACK AND DHB RESPONSES/ACTIONS

Needs more of a cultural lens reflecting the priority of equity of outcome for Māori, e.g.: Pae Ora would be a better wellbeing model to use as a base (rather than the model cited from the international literature) Open with a whakatauki, explain Te Pae Tawhiti Use mission – ko te uaratanga, vision, ko te whakakitenga, values nga uara Call this a whānau model of care	**Action: re-write section on the wellbeing approach using Pae Ora as a foundation and delete reference to the international literature** **Action: add whakatauki and translation at the start** The mission, vision and values are those of the DHB and need to be consistent with other DHB documents. **Action: ensure whānau ora central to the vision for change**
Substantial feedback regarding what to do to make the vision a reality	**Action: develop a strategic directions and priorities document and a commissioning roadmap to set out the implementation path for Strategy and Funding. Retain feedback about implementation to inform these documents (see later).**
Update to include Me Kōrero Tātou findings	**Action: Findings included.**
Various suggestions for structure and wording	**Action: feedback considered and structure/wording revised where appropriate.**
No mention of other ethnic groups and the growing ethnic diversity in the region	**Action: added reference to Pacific people (3% of population) and regarding prevalence of conditions for Pacific people.** Retain reference in service principles to responsiveness to culture. Information on growing ethnic diversity not available.

SUMMARY OF CONSULTATION FEEDBACK AND DHB RESPONSES/ACTIONS

Comments to guide implementation planning:

The section below summarises the comments that are relevant to implementation planning and should inform the plans developed to implement the vision.

Need a clear implementation plan
What is the how? Who is accountable the individual or DHB? What does the step by step process look like? Good to have outcomes but what are the actions?
2030 is still some way off. Would be good to show a pathway along a timeline, and benchmarking milestones and achievements along the journey timeframe.

Service Configuration
Need a definition of what 'service configuration' will look like

Need resourcing to support change and collaboration
Some ambitious changes have been proposed here. We would like to see a clear pathway that will ensure sector collaboration as this should not be under estimated. This change will require buy-in from across the sector and appropriate resourcing.

Take care to adequately resource community delivery to avoid unwellness and family burnout
The models, approaches and contexts within this document illustrate components of wellbeing that are not new. While it may be preferable for a tangata whaiora to be cared for in a whānau and community context, if all resources needed for a suitable level of care are not provided, this may cause the attending whanau to experience carer burnout and become unwell. Therefore, it is important to have this model of care well thought out with regard to risk and safety of all involved.

Ensure sufficient funding for community providers and groups
With regard to community groups, insufficient funding causes disruption in care, which may have adverse effects on the tangata whaiora concerned, especially if they are isolated, or if the community groups hold point of difference in approach which the tangata whaiora identified with, and cannot easily provided or replaced.

Look to BOP for single wellness plan/shared care pathway
It is pleasing to see the commitment to "a single wellness plan" across all services. There is good research showing that implementation can be difficult as it requires both buy-in by participating services and a strong sense of partnership across the Mental Health and Addiction services. We understand that the BOPDHB CMH have for the past 4-5yrs been working on a Shared Care Pathway that is built around a Shared Support Plan. This model could be considered when developing a single wellness plan across all services.

SUMMARY OF CONSULTATION FEEDBACK AND DHB RESPONSES/ACTIONS

Better integration avoiding duplication
More concerted focus on end-to-end service provision to stop duplication or repetition of planning etc. Including single point of entry and/or robust electronic IT infrastructure that will support this

More peer contracts
Need to have more peer contracts in the Waikato.

IT changes ensure existing reporting requirements are met and consider low tech areas
A reminder to the TPT Project that any re-configuration of services resulting from the Vision for Change may embrace new technologies but this will not negate the ongoing need to fulfil requirements of current/possible future national data collections systems that are already in place – i.e. PRIMHD, HoNoS, ADOM etc.
A digital strategy would be needed to fully support this with integration across sectors. An agreed universal data system with BI capabilities would be a way forward. This would also need to take into consideration implementation in 'low tech' areas.

Pae Taumata: Workforce
Include service provider demographics and what is crucial to the service providers to adequately meet demands of the various user demographics.
How to achieve a competent and capable workforce, what is the process behind it all and how will it be implemented?
Māori want someone who understands, is knowledgeable and is respectful

Useful ways people can support their own wellbeing
Could use NZ approaches such as the Mental Health Foundation definitions on Wellbeing - also translated in Te Reo
https://www.mentalhealth.org.nz/home/ways-to-wellbeing-2/

Measurement
Commissioning is important, what is the baseline in relation to outcome measures.

Ongoing dialogue needed:

Feedback highlighted some difference of views that will need ongoing dialogue in order to move forward with achieving the vision. The two most striking of these were:

- The emphasis in model of care documents on prevention, promotion, addressing the social determinants of health and early intervention is widely supported but some feel that it has eclipsed mention of the need to provide effective treatments/ interventions for people who do experience mental illness or addiction.
- While there is a great deal of demand for both NGO and DHB services, there appears to be a sense on both sides that the model of care emphasises the other, highlighting the need for greater collaboration and integration.

MEMORANDUM TO COMMUNITY & PUBLIC HEALTH AND DISABILITY ADVISORY COMMITTEE
10 APRIL 2019

AGENDA ITEM 5.5

WAIKATO DRINKING WATER ASSESMENT SERVICE

Purpose	For information

The attached report provides an update on the Waikato Drinking Water Assessment Service (WaDWAS). The report includes relevant background and outlines some of the challenges faced over recent years (for example the loss of IANZ accreditation and ongoing staff shortages). It also updates the Committee regarding WaDWAS performance, and assistance which the Ministry of Health has contracted to provide support and review WaDWAS systems.

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

Some of the inequities faced by Māori in Waikato DHB relate to rurality. The provision of safe drinking water in the Waikato is a greater problem for rural populations than urbanised ones – supplies tend to be less secure and councils have less resourcing for improvements. WaDWAS aims to improve drinking water compliance across the Waikato, with particular emphasis on smaller rural supplies.

Recommendation
THAT

The Committee receives the report

TANYA MALONEY
EXECUTIVE DIRECTOR STRATEGY, FUNDING AND PUBLIC HEALTH

Waikato Drinking Water Assessment Service (WaDWAS) Update for CPHAC

Dr Richard Vipond – Medical Officer of Health and Drinking Water Portfolio lead.

Waikato Drinking Water Assessment Service (WaDWAS) is funded by the Ministry of Health to optimise the safety and quality of drinking water for public consumption across the Waikato. Specific tasks to support these aims include:

- Supporting implementation of the Drinking water Standards for New Zealand (DWSNZ)
- Auditing compliance with drinking water regulations (via an annual survey of all supplies)
- Escalation and enforcement regarding drinking water supplier duties regarding the Health Act 1956 Part 2A – Drinking water
- Responding to notifications of drinking water transgressions (including bacterial, chemical, and cyanobacterial contamination) to assist suppliers to investigate the cause of contamination and put in place measures to prevent the public from becoming unwell

These tasks are split into 4 scope items, detailed at the end of this paper for your information.

Waikato Drinking Water Suppliers

In the Waikato there are 10 Territorial Authorities and approximately 70 drinking water supplies. Many of these supplies are rural, and classed as small (101- 500 people), or minor (501- 5,000 people). There are a lesser number of medium drinking water supplies (5,001-10,000 people), or large supplies (>10,000 people).

In addition there are a number of private supplies covering neighbourhoods or sub-divisions, and supplies including rural schools. Contractual requirements regarding self-supplies such as schools, have changed over recent years, having been removed from DWA work, however assistance as required remains from a Drinking-Water Assistance Programme Facilitator (DWAPF) – a separate contract with the Ministry of Health.

Background

Historically WaDWAS had issues with a lack of resourcing (recruiting and retention of staff). A Drinking Water Assessor (DWA) is a designated (by the Director General of Health) officer and must be a Health Protection Officer also –which requires several years of training. This resulted in some difficulties maintaining a work plan across such a large geographical area and with so many councils and supplies to work with. A lack of DWA's was not a problem unique to WaDWAS, with many other assessment units amalgamating over recent years in an attempt to overcome staff shortages. The Havelock North Inquiry also made recognition of national DWA shortages.

The goalposts shifted however following the Campylobacteriosis outbreak in Havelock North secondary to probable contamination of the drinking water with sheep faeces in August 2016, which resulted in more than 5000 people falling ill. The fallout from the outbreak and subsequent inquiry undertaken by the Department of Internal Affairs continues, with a large number of recommendations made in order to improve the safety of drinking water – many of which are still being worked through or considered. Drinking water assessment units such as WaDWAS were instructed by the Ministry of Health to cease the 'softly softly' approach to drinking water standards enforcement.

It was in this environment that WaDWAS received its annual International Accreditation New Zealand (IANZ) audit (a requirement for assessment units is to maintain IANZ accreditation). In late 2017, Waikato DHB was informed that WaDWAS accreditation was being suspended, principally because of a lack of resources (staff) which would limit its ability to fulfil its statutory obligations. Ironically the loss of IANZ accreditation prevented WaDWAS from addressing our staff shortages, as we would no longer be able to have trainee DWAs complete training and be designated as officers, or be able to recruit DWAs from other regions as they could not become designated in the Waikato. Waikato DHB

therefore requested assistance from the Ministry of Health in early 2018, and met with the Ministry to discuss our request in April 2018.

Meanwhile WaDWAS had some further staffing issues. Despite contracting an external DWA to provide 0.5FTE, staff numbers were affected by the loss of the WaDWAS technical manager (also a DWA), and then the Drinking Water Assistance Program Facilitator (who was responsible for providing support and assistance to small and private supplies). WaDWAS was therefore left with 1.5 FTE (with the full time worker a trainee who was unable to be designated due to WaDWAS's lack of IANZ accreditation).

Despite this WaDWAS undertook a review and prioritisation of its work plan, and continued to build relationships with our 10 council suppliers. The 2017/18 Annual Drinking Water Survey reports were completed before any other assessment unit in the country, despite having more councils and supplies to review than most other units. Seven of the ten councils required escalation to a designated officer (the Medical Officer of Health) for potential non-compliances with the Health Act 1956 for several of their supplies. Each of these councils was followed up with a 'please explain' letter to CEOs, resulting in a series of timeframes and 'lines in the sand' which councils have committed to for when they will have compliant supplies. We also hired a new staff member, who has an operational knowledge of water treatment and is commencing the revised training requirements to become a DWA (the requirement to first be an HPO has been removed).

In early 2019 the Ministry of Health wrote to Waikato Public Health Unit to explain that without IANZ accreditation, they (the Director General) needed other means to ensure that WaDWAS processes and documents were robust- in order to allow our DWA to maintain designation for the Waikato and our service to continue. We were also informed that the Ministry of Health had contracted the services of Wai Comply, and that Waikato was one of three Drinking Water Units which had requested and would receive support from Wai Comply, for a period of 6 months (at Ministry expense), along with Wai Comply undertaking the review of WaDWAS regulatory processes.

The Waikato Public Health Unit met with Wai Comply in late January, and WaDWAS continue to meet with Wai Comply in order to agree a work plan, and optimal use of Wai Comply's time with WaDWAS. We have agreed on the following four key organisational tasks:

- Water Supplier engagement survey
- IANZ accreditation review and administration manual development (should WaDWAS request assessment for regaining IANZ accreditation)
- Drinking-water Work plan review and development
- Enforcement (escalation) procedural review

As well as some assistance with operational tasks:

- Support with Otorohanga and Waitomo councils
- Mentoring of our new trainee DWA
- Training (internal) regarding DWSNZ and Water Safety Plan framework updates
- Delivery of other operational drinking-water tasks as agreed.

It is my belief that Wai Comply will allow an external review of our systems and processes so that should IANZ accreditation remain a requirement for drinking water assessment units (there is a Bill going through due process currently which seeks to remove it as a requirement) WaDWAS is able to regain accreditation – admitting that resourcing issues will have to addressed first.

Wai Comply will be able to provide some support for some of our smaller councils who do not have the expertise to fulfil the requirements of the Annual Drinking Water Survey and hence do not comply. They should be able to comply with some training, which WaDWAS DWAs are not allowed to provide to them for reasons of impartiality (an IANZ requirement).

They will also be able to provide me (as Medical Officer of Health) some reassurance that the activities which I undertook following the escalations from the 2017/18 Annual Survey were justified and procedurally correct – in the absence of me having any other resources/guidance to draw on.
It is not clear what reporting arrangements Wai Comply have with the Ministry, it is my belief however that WaDWAS is currently performing very well, and I would welcome any review of our procedures in order to reassure the Director General that we are fulfilling our legislated responsibilities.

The future

It is not clear what the future will hold for WaDWAS, or the Ministry of Health, regarding the regulation of drinking-water supplies. It has been suggested that a new regulatory body may be established, although no discussions as yet regarding what may happen to drinking water assessment units within Public Health Units/DHBs have occurred.

The Ministry of Health in mid-February requested Medical Officer of Health representation from each region (our region being Midland) to assist with the Drinking Water Programme Working Group – which will develop proposals for the legislative framework of drinking-water. While the Terms of Reference for this group have not yet been developed, I am the representative for the Midland region.

There is a Bill before Parliament currently which seeks to remove the requirement for IANZ accreditation. Some District Health Boards have submitted in opposition of its removal (as there is belief there should be some measure of quality assurance). Waikato DHB submitted in favour of its removal providing it is replaced by a more fit for purpose quality assessment. If it is not removed, WaDWAS will probably seek to regain accreditation when able, although we could have been seen as a pilot/example of how a unit can function well without accreditation.

I have concerns regarding the sustainability of the service should the Ministry of Health retain drinking-water regulation (and contract to Waikato DHB). We currently have 1.5FTE, with the 0.5FTE being the only designated DWA. Should (when) he leaves, or if we suffer other staff loss, we currently have no contingency for how to complete our work programme.

Currently however, the unit is performing (I believe) very well. We are responding to water issues notified to us, and encouraging suppliers to improve safety and compliance of drinking water across the Waikato.

Key drinking water assessor activities are broken down into 4 areas/scope items

1. (Scope 1) Compliance with the Drinking Water Standards for New Zealand
   Scope 1 requires the Drinking Water Assessors (DWAs) to assess whether a drinking water supplier complies with the Drinking Water Standards (DWS) and specific sections of Part 2A of the Health Act 1956. This is done annually based on monitoring and sampling information provided by the water supplier.

2. (Scope 2) Assessing and Authorising the Competence of Persons performing analyses or calibration
   The assessment and authorisation process is necessary to verify that: the individual(s) who are to undertake the analyses and / or testing are competent to accurately and reliably undertake the relevant activities and / or the drinking-water supplier's calibration procedures are undertaken in accordance with the requirements of the DWSNZ and the equipment manufacturer's instructions. This is done every 3 years and must cover at least 3 water supply operators.

3. (Scope 3) Verifying Adequacy of Water Safety Plans (WSP)
   Approval of a WSP involves an assessment of the WSP document and any critical cross referenced material the supplier relies on to support the plan. WSP must be assessed and reported on within 20 working days as stated in the Health Act. A WSP must be revised and reassessed at a maximum interval of 5 years.

4. (Scope 4) Verifying Implementation of Water Safety Plans (WSP)
   Verification of WSP implementation is a process in which the DWA checks evidence to determine the level of operational implementation the supplier has made with their approved WSP. This assessment is critical to determine the supplier's practical application of the water safety planning process. An onsite assessment / inspection is required to show that a water

supplier’s approved WSP has been satisfactorily implemented onsite. The implementations are undertaken within 1 year of WSP approval and on a 3 year cycle.

MEMORANDUM TO COMMUNITY & PUBLIC HEALTH AND DISABILITY ADVISORY COMMITTEE
10 APRIL 2019

AGENDA ITEM 5.6

URGENT AND EMERGENCY CARE

Purpose	For information

Introduction

A review of Urgent and Emergency Care services has been undertaken to identify current issues in service provision, how access can be improved, and how acute demand for hospital services may be mitigated.

The review engaged provider stakeholders from across the sector, and across the district.

In conjunction with the review of the Primary Options for Acute Care (POAC) programme, this work has provided a critical understanding of the current coverage, performance and issues in managing acute care in the community. The effectiveness of these services has a direct bearing on Emergency Department demand, and therefore cost to the system.

The review document is attached to this report, and a presentation of the findings and recommendations will be provided at the CPHAC/DSAC meeting.

Findings

There is variability in the delivery of Urgent and Emergency Care services across the District, and there are a mix of barriers to access experienced by communities depending on their level of isolation, social deprivation and access to transport. Whilst GPs are responsible for the provision of after-hours services through the DHB's agreements with PHO's, there are concerning variances across the district in respect to hours of provision and location of those afterhours practices.

The DHB has entered into a number of different arrangements across the district to improve the provision of primary care after-hours services. These have ranged from additional services purchased by the DHB, through to the co-location of after-hours primary care and emergency services at some smaller hospitals. It should be noted that after 6.30 pm the DHB is the provider of last resort of urgent care through its Emergency Departments in some communities (e.g. Taumaranui and Te Kuiti). By default this has become the norm.

The review noted that it was appropriate to plan and deliver urgent and emergency services at a locality level, taking into account the specific characteristics of those

communities. Affordability, equity, workforce capacity and after-hours transport were also highlighted as areas for particular development.

Service Development

Strategy and Funding is currently working collaboratively with the sector to reconfigure services across Urgent Care and POAC to improve care options, better manage acute demand in the community.

The first phase of changes will occur in July 2019. Further enhancements will be phased over the following year.

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

The review has highlighted inequitable access to urgent care services for Māori across the district. Equity of access and outcome will be the paramount consideration in the redevelopment of services.

Recommendation
THAT

The Committee note the review and the presentation

TANYA MALONEY
EXECUTIVE DIRECTOR STRATEGY, FUNDING AND PUBLIC HEALTH

FRANCIS + HEALTH

URGENT & EMERGENCY CARE REVIEW
WAIKATO DISTRICT HEALTH BOARD

FEBRUARY 2019

FRANCIS HEALTH

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FRANCIS HEALTH

+ Executive Summary

URGENT & EMERGENCY CARE REVIEW

- Increasing demand is being experienced across the Waikato District Health Board (WDHB) Emergency Departments (ED) while Urgent Care Centre volumes remain relatively static. In order to identify what future service configuration or delivery models for urgent and emergency care needs to look like, this review was requested to understand the current availability of these services in both primary and secondary care in the Waikato region.

- Additionally this review will link where appropriate to the Acute Flow programme 'BEEM' (Beds Empty Every Morning) currently underway in Waikato Hospital ED and General Medicine departments, and a previous review of Primary Options for Acute Care (POAC) completed for WDHB Strategy and Funding in 2018, as all programmes are working to improve the future management of acute demand across the system. The Waikato region is unique with its high Maori and Pacific Island population, its large dispersed rural areas with high deprivation, and faces a range of current and future challenges for sustainable service provision, access to services and workforce.

- This review sought feedback from key stakeholders across the primary, secondary and community providers of urgent and emergency services and has collated this feedback grouped by locality. At the same time service data from 1 July 2016 to 30th June 2018 was provided by the DHB, Primary Health Organisations (PHO) and after-hours providers to gain an understanding of patient utilisation across the system to be able to compare and contrast as well as looking at trends over time.

CURRENT ISSUES IDENTIFIED INCLUDE:

- Lack of system wide view across the region for urgent and emergency services.
- Disconnected urgent and emergency service providers.
- Recent changes to St John service provision impacting on patient response times.
- Rural hospitals seeing high numbers of Triage 4 & 5 presentations which are growing in some areas.
- Rural sub-hub models that are effective but fragile because they are reliant on a future workforce less willing to provide 24/7 care.
- Access to timely advice from ED specialists for rural hospitals.
- Urgent Care and ED clinicians working in their 'own worlds' without having an overview of the whole emergency & urgent care system.
- Fragmented and siloed services supported by inflexible contracting arrangements.
- Technology available to support patients in their locality, but lacking of clinical engagement and contracting models to support this.
- HML nurse triage threshold for sending patients to 24/7 after-hours providers and hospitals appears low with feedback indicating liaison with General Practitioner (GP) or ED medical staff could defer consultation / presentation to daytime hours.
- After-hours fees for patients where there is no Hospital ED providing the service.
- Travel time to after-hours services.

All of the above issues are having an impact on the continuum of care for the patient while at the same time supporting siloed service development rather than a broader connected system approach.

"Younger patients don't have a relationship with their GP – they want convenience medical care"

FRANCIS HEALTH

+ Executive Summary cont.

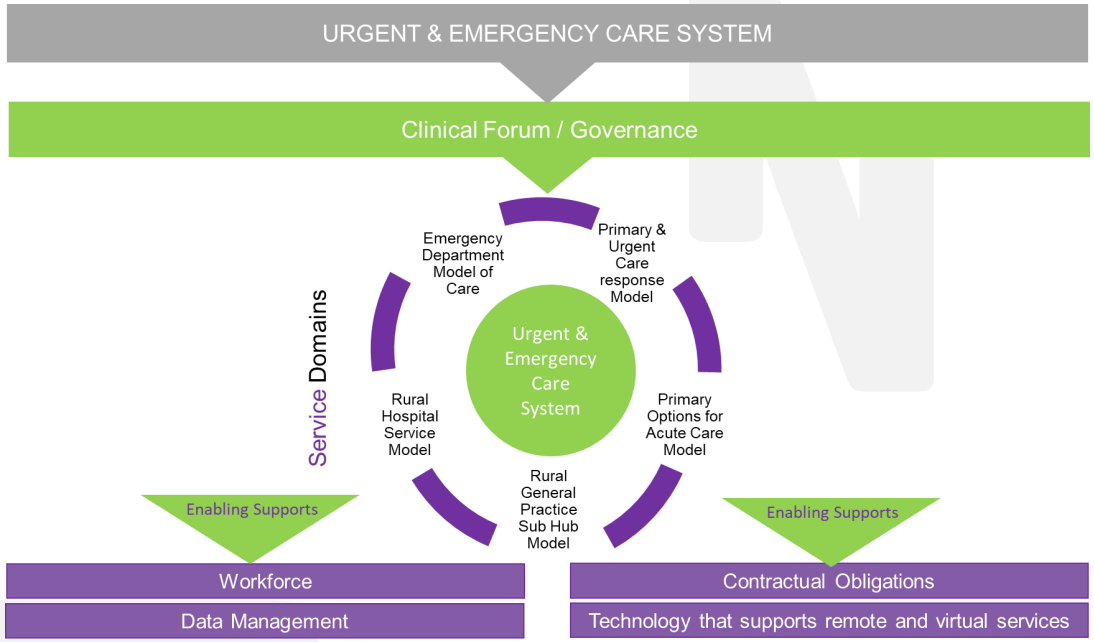
FUTURE URGENT & EMERGENCY CARE

The current states presents a picture of siloed services working without an overarching framework to guide a system wide approach to service improvement for acute demand. The challenge for WDHB will be to get the connectedness required for primary, community and secondary services to collectively work at improving access to healthcare closer to home for patients and reducing the acute demand on hospital emergency departments.

For Urgent and Emergency Care to meet or reduce future demand, identifying an overarching framework inclusive of design principles, service domains, an enabling support structure will guide future development work from a system and locality approach rather than from the current ad hoc reactive approach.

Additionally the future Urgent Care System has to meet the needs of each locality and their enrolled population, rather than a one size fits all. Each locality may look different – but where possible there should be consistency and alignment with core principles and system framework.

The following sections in the report will outline the high level system recommendations along with further detail provided at a locality level.



"Lot of wastage in Tokoroa due to multiple providers all funded separately"

FRANCIS HEALTH

+ Executive Summary - Recommendations

SERVICE DOMAINS

Rural Hospital Service Model

- Consider an integrated service model in Taumarunui and Tokoroa where the current approach fosters siloed services which sees multiple providers working with the same cohort of patients in a disconnected and inefficient model with limited capacity to have a long term sustainable workforce.
- Review all funding streams contributing to urgent and emergency care to understand how these could support an integrated service model in Taumarunui & Tokoroa.
- Continue to support the GP led service in Te Kuiti while looking to integrate the general practice and WDHB nursing services and workforce to reduce service duplication, improve workforce flexibility, and enhance care to the patients to support a sustainable future service.
- Agree principles and policy to guide the development and implementation of the 'single point of entry' (SPOE) model in Thames Hospital and in other localities where EDs and general practice services are co-located.
- Review options with St John to improve ambulance response times particularly in the rural areas that rely on a volunteer workforce.

Rural General Practice Sub Hub Model

- Continue to support the current rural general practice sub-hub model of after-hours, urgent and emergency care which demonstrates patients are seen in their local community and are low users of Hospital ED services or other After Hours clinics.
- Retain GP beds in rural areas to continue to support treatment of patients in their locality and reduce transfers to Hospital EDs.
- Work with rural providers and locality stakeholders to design a model that enables selected outpatient specialist clinics to be delivered in primary care settings using virtual health.
- Develop and implement a transparent rural funding formula that reflects local service delivery arrangements, including the role of rural hospital Eds supporting urgent emergency care, and provides system visibility.

Primary & Urgent Care Response Model

- Develop a model to rotate clinical staff across different parts of the emergency and urgent care system so they gain a better understanding of the whole system.
- Review the overnight Urgent Care service provided by Anglesea Clinic in Hamilton
- WDHB & PHOs to facilitate a more consolidated general practice model in Huntly and Te Kauwhata (a long term goal) to enable a more coordinated approach to extended general practice hours .
- Review data to understand frequent flyers at urgent care centres and develop plan for engaging with patients and primary care.

Primary Options for Acute Care Model

- Explore POAC options for St John so ambulance crews can transfer patients to urgent care centres rather than ED.
- Scope the establishment of observation beds at Anglesea Clinic to understand if these would reduce transfers to Waikato Hospital ED and improve the patient experience.
- Scope the opportunity of providing Point of Care testing (e.g. Troponin tests) for Urgent Care and Rural Models.
- Connect Nurse Specialist services in PHOs, primary care to urgent care centres.
- Connect ED into POAC model as high deprivation patients are both high users of ED and low users of POAC as access to POAC is through general practice.

Emergency Department Model of Care

- Introduce a 'triage to primary care" model in Waikato ED for Triage 4-5 patients to free up the department to focus on growing demand in other triage categories (BEEM PROJECT).
- Review Triage 3 presentations to understand the reason for the growth in this area.
- Support ambulatory GP referrals to present directly to AMU (BEEM PROJECT).
- Review Aged Residential Care transfers to ED to understand why these have spiked in the last 2 years and develop strategies to support acute episodes in the care facility.

+ Executive Summary - Recommendations

ENABLER SUPPORTS

Technology Strategy to support remote and virtual services

- Develop a digital strategy to improve the use of available technology to support timely access to consultant advice from Waikato Hospital, virtual ward rounds, and outpatient appointments to reduce transfers to Waikato Hospital and travel for the patients
- Explore the development of a 'virtual front door' to urgent care services as an alternative to 'face to face' presentations

Data Management

- Agreed primary & secondary data relating to after-hours, urgent and emergency care should be collected, analysed and shared on an ongoing basis in order to understand current system performance and inform future models

Contractual Obligations

- Audit the contractual obligations of PHOs for general practice to provide after hours and urgent care for their ESU's.
- Review and formalise arrangements where Rural Hospital EDs or Urgent Care Centres are providing after hours and urgent care services on behalf of the general practices

Workforce

- Work collectively across primary, secondary and community services in the at risk rural areas to recruit and retain medical and nursing staff including the option of developing a single integrated workforce in areas where future recruitment & retention will be critical

GOVERNANCE

Clinical Forum

- Introduce a clinical forum for emergency and urgent care clinical directors and senior nurse managers to support clinical networking to monitor and address system wide performance
- Rotate clinical staff across different parts of the emergency & urgent care system so they gain a better understanding of the whole system.

"Urgent Care and ED clinicians do not understand each others world"

"Redirect does not add value to the ED department"

"POAC has made a difference for ED – reduced demand on DVTs, cellulitis, respiratory"

FRANCIS HEALTH

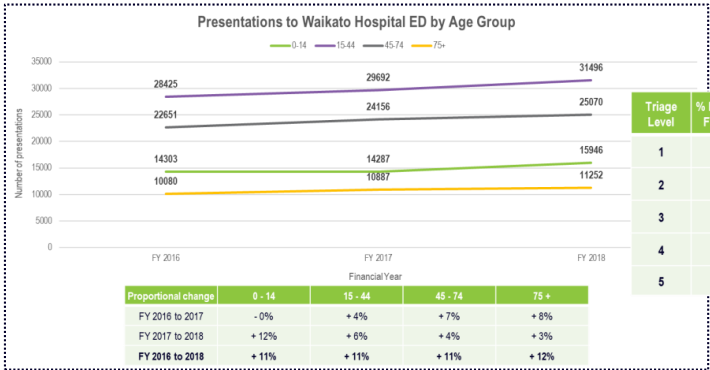
+ Background

PURPOSE

With increasing demand being experienced across the DHB's Emergency Departments as demonstrated in the graph below and pressure growing on existing general practice and urgent care centres, it is timely to identify what future service configuration needs to look like. Linking this to the Acute Flow review work currently underway and the Primary Options review recommendations will be critical in defining the new delivery models.

This review has assessed:

- Current and future demand and provision needs;
- The challenges and the opportunities across the system to develop efficient and outcome focussed models of care;
- How to increase access and ensure services are available at an appropriate level; and how to assure service coverage levels appropriate to localities



Proportional change	0 - 14	15 - 44	45 - 74	75 +
FY 2016 to 2017	- 0%	+ 4%	+ 7%	+ 8%
FY 2017 to 2018	+ 12%	+ 6%	+ 4%	+ 3%
FY 2016 to 2018	**+ 11%**	**+ 11%**	**+ 11%**	**+ 12%**

Triage Level	% Maori/PI FY 2016	% Maori/PI FY 2017	% Maori/PI FY 2018
1	31%	34%	35%
2	30%	34%	36%
3	31%	33%	36%
4	35%	32%	33%
5	32%	34%	34%

APPROACH

Using a combination of data analytics, stakeholder knowledge and insights, the approach this review took was to ensure:

- There is detailed understanding of the current contractual requirements, operating environment and trends over time.
- Using data analysis over a 3 year period (2016FY – 2018FY) and engagement with stakeholders across the localities to build a comprehensive view of service utilisation patterns, challenges and opportunities.
- Opportunities are identified to manage or shift demand to the most appropriate setting and reduce barriers to access that may be driving demand on Emergency Departments.
- Opportunities are identified at a locality level that match the demand patterns, and approaches to developing these services that make best use of existing services, workforce and technology options.
- Future approaches for continuous monitoring and improvement of service provision.
- For the purpose of this review we have used Triage 4 & 5 as a proxy primary care presentation. New Zealand EDs use the Australasian triage scale which has five triage categories; triage category 1 patients are very urgent, while triage category 5 patients are less urgent. For each triage category there is a specified maximum clinically appropriate time within which medical assessment and treatment should commence to ensure services continue to provide timely and appropriate care. (https://www.health.govt.nz/our-work/hospitals-and-specialist-care/emergency-departments/emergency-department-triage).

FRANCIS HEALTH

Waikato - After Hours, Urgent & Emergency Overview

TOTAL URGENT CARE & ED PRESENTATIONS

17/18 – 271,972 (ED 45% UC 55%)
16/17 – 271,376 (ED 43% UC 57%)

HOSPITALS

WAIKATO
TAUMARUNUI
TOKOROA
TE KUITI
THAMES

GP PRACTICES
77 PRACTICES

TOTAL ED PRESENTATIONS*

17/18 – 122,972
16/17 – 117,170
15/16 – 111,917

5% GROWTH year on year
*Waikato & T hospitals Triage 1-5
Admissions remained stable at 27%

U & E PRESENTATIONS*

17/18 – 149,000
16/17 – 154,206
15/16 – 97,751**

-3% GROWTH from 16/17 to 17/18
*Angelsea, Victoria & Tui
** No Tui data

ENROLLED POPULATION **393,131**
(data as at Q3 2018)

26% Maori PI
25% Quintile 5

64 % Hamilton City
36 % Rural Waikato

GENERAL PRACTICE ESUs PRESENTING FOR EMERGENCY CARE - 2018

14% On average 14% ESUs per practice presented at Waikato ED

13% On average 13% ESUs per practice presented at Rural Hospital ED

20% ESUs on average presented at Anglesea Clinic**

ESU = Enrolled Service user

** From practices with formal cover arrangements

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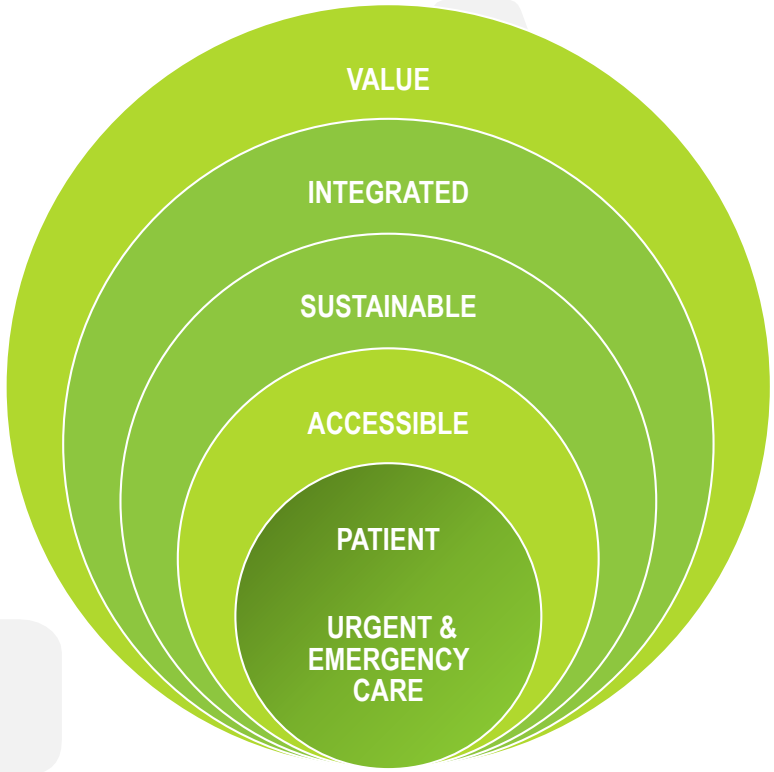
+ Framework for the Future

DESIGN PRINCIPLES

The future Urgent Care System needs to meet the needs of each Locality, rather than a one size fits all. The following principles are intended to guide the design of Urgent Care services in each Locality. The final model of care and service solutions developed in each locality may look different – but where possible they should be consistent with these design principles.

1. **Accessible** - People know how to access Urgent Care advice and where to find Urgent Care services in their Locality when they need them within reasonable travel times.
2. **Accessible** - Urgent Care providers have access to services and advice appropriate to the patient's needs and the locality care setting.
3. **Sustainable** - Urgent Care services are integrated within the Locality and across the district to provide continuity of care and long tern sustainability.
4. **Sustainable** - Urgent Care services are able to recruit and retain an appropriate workforce that can work across organisational and service silos to maximise capacity and capability.
5. **Integrated** - Urgent Care providers have access to relevant patient information and advice, enabled using technology, at the point of care.
6. **Value** - Urgent Care services are effective and affordable for patients, providers and the DHB.

Further detail can be found in appendix 1.



FRANCIS HEALTH

+ CURRENT STATE OVERVIEW

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+ Common Themes – from Stakeholder Interviews

Theme	Stakeholder Feedback
Anglesea Clinic	• Urgent Care and ED clinicians do not understand each others world and are critical 'the other' is not doing what they should be. • Anglesea Clinic 'hold on' to patients longer than they need to and don't refer back to the patient's primary care provider. This would free up Anglesea capacity for the more urgent patients. • Anglesea could manage more patients in the clinic, and reduce the number of transfers to Waikato ED, if they incorporated observation beds in their model. • Risk that Urban GPs will become less skilled managing acute patients if they do not work shifts at an Urgent Care Clinic.
Virtual Health	• Routine outpatient follow-ups could be delivered by the GP with a telehealth link to the specialist. GPs know their patients and this could enhance the specialist consultation. This option would be beneficial for rural patients where travel is difficult. • Consider localities and specialties that are suitable for telehealth consultations with the patient's GP – to maximize specialist's time for First Specialist Assessment (FSAs). Scope the cost benefit of this option. FSAs could be seen sooner; more shared responsibility between primary & secondary care; and supports upskilling of GPs in specialist areas. • All rural GPs see telehealth as 'the future' – although some areas are currently limited by internet connectivity. • Benefits could be achieved now ('quick wins') by using available technology rather than building new / expensive solutions.
Rural Model	• DHB working with PHOs & practices to consolidate after-hours and urgent care to ensure the long term sustainability of rural services. This would be easier to achieve if practices were affiliated with a single PHO in each rural locality. • Relationships between general practice and community services are variable across different localities. More could be done to integrate community and general practice in the rural localities with integrated contracts that enable this. • Rural GPs are more prepared to manage clinical risk because they do not have the benefit of a local rural hospital.

Theme	Stakeholder Feedback
Rural Model (Continued)	• Many rural hospital facilities (design/layout) do not support and enable integration and a single point of entry model. • Rural models work very well where GPs live locally and are part of their community. However, many rural models are fragile because the future workforce is looking for better work/life balance. Some areas are currently dependent on high turnover locum medical cover. • The ability to refer to GP beds is an important part of a rural urgent care delivery system and a great asset to the community. • St John service has declined in most rural areas with poor response times resulting in ambulance deployment from neighboring towns. After-hours is mainly crewed by volunteers. • HML generally does a good job triaging after-hours but often default to urgent care when the patient could wait to be seen by a GP. This could be improved with HML / GP triage and discussing the patient's needs with the on-call GP. • The Single Point of Entry (SPOE) model appears confused and not consistent across Rural Hospitals. Further work: • GPs raised concerns about access to Mental Health services in rural localities. • Streamline patient transfers to and from Rural Hospitals. This should be as easy as a ward to ward transfer.
ED	• ED needs a rapid triage process so that low acuity patients can be 'triaged to primary care' when they do not need to be treated in ED. GPs do not want their patients to go to ED for care that can be delivered by them in general practice. Many patients access ED because cost is a barrier to primary care. • ED could be by-passed by stable ambulatory medical patients that have been worked-up and referred by GPs.
Not grouped	• Specialist advice to GPs is valued and usually available by phone. Registrar advice can be variable. • Consumer Council concerns – linked to Health Services Plan (HSP) feedback. Navigation between primary and secondary is often difficult. Think about maintaining wellness – there is a divergence between holistic and formal. Enabling good lives is about integration using the whanau ora model (also an HSP theme).

FRANCIS HEALTH

+ Emergency Department Growth

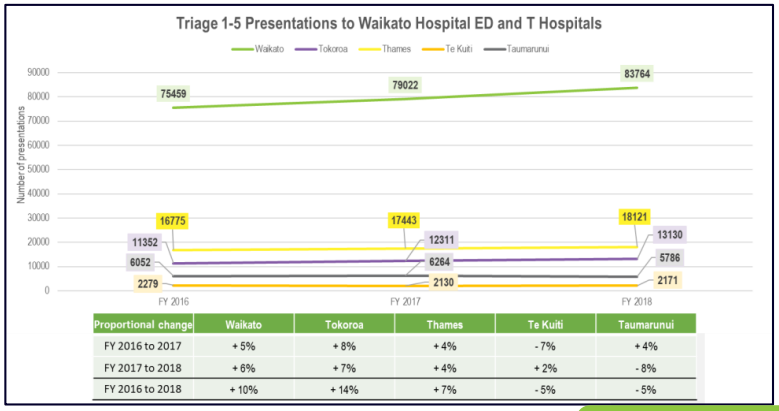
DISTRICT VIEW

There were 123,000 patient presentations across all Waikato Hospital EDs in 2018 which represented 10% growth over the last 3 years. This growth occurred in Waikato (10%), Tokoroa (14%) and Thames (7%) EDs with volumes decreasing in Te Kuiti and Taumarunui by 5%.

The growth in Waikato ED was in Triage 1-3, mainly in Triage 3. Triage Categories 4&5 have declined by 7% with admission rates for this group remained constant at 18%. This decrease mainly happened in the 0-24 age group with other age groups remaining relatively constant.

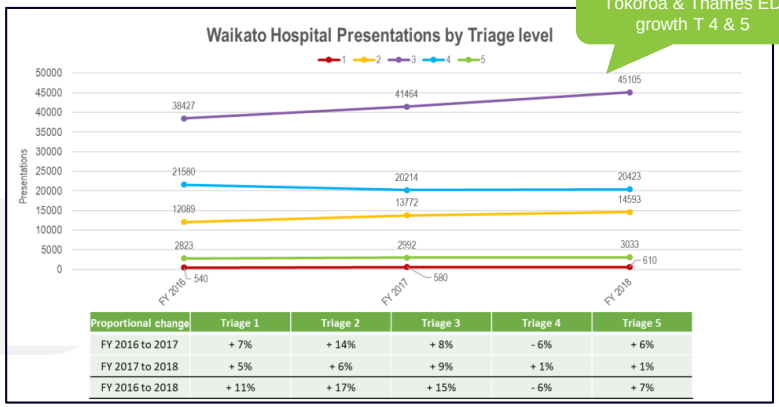
The growing presentations in Triage 1-3 at Waikato Hospital ED were across all ages. Demand on Waikato Hospital ED is increasing at a faster rate than population growth. Tokoroa ED volumes increased by 1,780 over the last 3 years with Triage 4-5 presentations increasing by 4,000 (80%). Thames ED presentations increased by 1,346 over the same period with Triage 4-5 increasing by 734 (55%).

Maori and Pacific (26% of the population) were high users of all EDs at 36% of Triage 4-5. High deprivation (Quintile 5) patients were also high users of EDs (65% of Triage 4-5).



Proportional change	Waikato	Tokoroa	Thames	Te Kuiti	Taumarunui
FY 2016 to 2017	+ 5%	+ 8%	+ 4%	- 7%	+ 4%
FY 2017 to 2018	+ 6%	+ 7%	+ 4%	+ 2%	- 8%
FY 2016 to 2018	+ 10%	+ 14%	+ 7%	- 5%	- 5%

Waikato ED growth - T 3
Tokoroa & Thames ED growth T 4 & 5



Proportional change	Triage 1	Triage 2	Triage 3	Triage 4	Triage 5
FY 2016 to 2017	+ 7%	+ 14%	+ 8%	- 6%	+ 6%
FY 2017 to 2018	+ 5%	+ 6%	+ 9%	+ 1%	+ 1%
FY 2016 to 2018	+ 11%	+ 17%	+ 15%	- 6%	+ 7%

FRANCIS HEALTH

+ Emergency Department Use

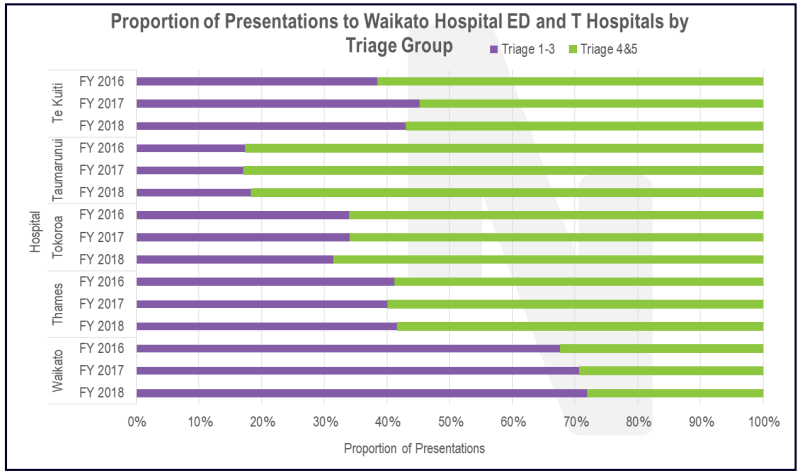
High proportion of T 4 & 5 presentations in Rural Hospitals

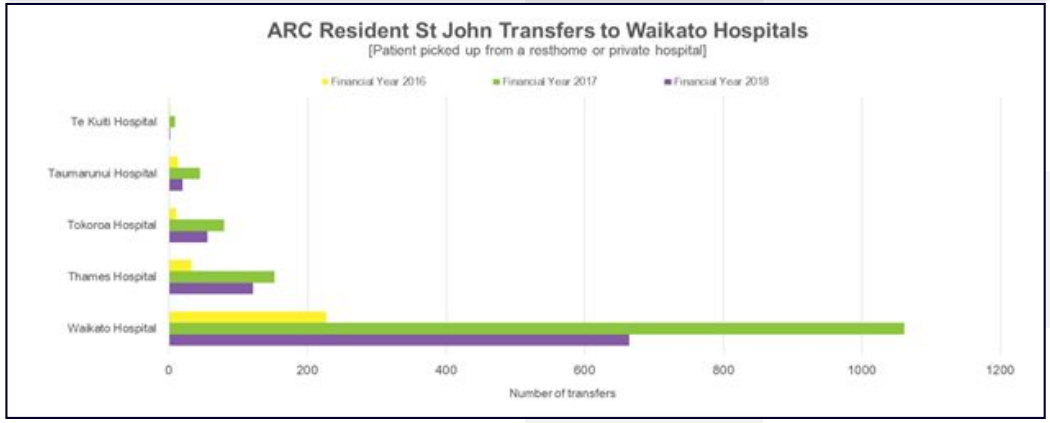
RURAL HOSPITALS

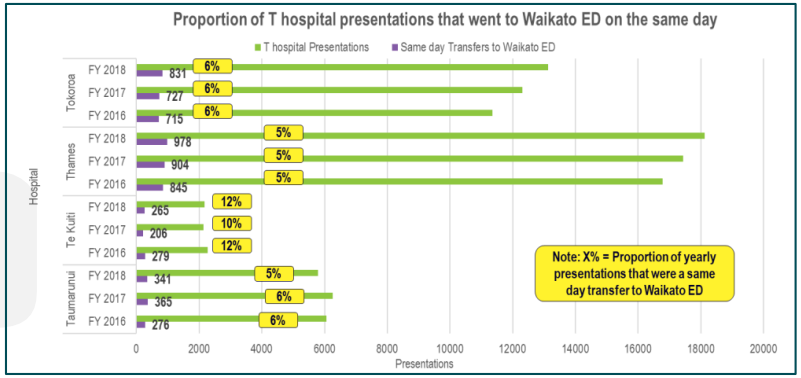
A high proportion of presentations at Taumarunui and Tokoroa EDs are Triage 4-5 where the ED is the default urgent care provider after-hours or when patients cannot get a primary care appointment in-hours. Te Kuiti had a lower proportion of Triage 4-5 presentations – possibly because ED and general practice is more clearly delineated, despite being delivered from the hospital site. Thames Hospital also had a lower proportion of Triage 4-5 presentations - possibly because it treats higher acuity patients than the other rural hospitals, however volumes are increasing.

Same-day patient transfers from the Rural Hospitals to Waikato Hospital was 11% for Te Kuiti Hospital and 5-6% for Tokoroa, Thames and Taumarunui. This rate has not changed over the last 3 years. The higher transfer rate by Te Kuiti could possibly be explained by the higher proportion of Triage 1-3 patients it sees but is unable to support due to the level of services provided.

Although the numbers are relatively low, there has been a significant increase in St John patient transfers from Aged Residential Care facilities to EDs. This number spiked in 2017 which is unexplained. Te Kuiti only has one rest home which could explain its low numbers.







FRANCIS HEALTH

+ Role of Urgent Care Centres

Urgent Care Centre Presentations

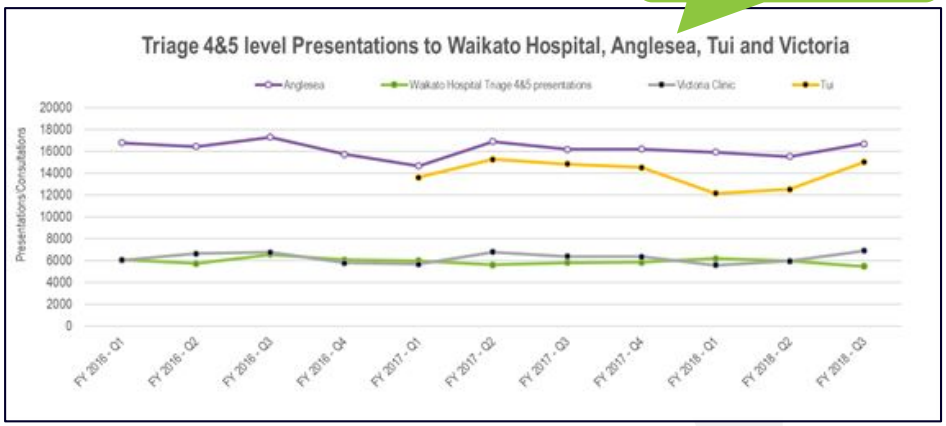
Patients in the Hamilton Locality generally go to the right place for urgent care. The 4 Urgent Care Centres see the majority of urgent care patients. Approximately 150,000 (86%) of patients were seen by Urgent Care Centres with 24,000 (14%) Triage 4-5 patients seen in Waikato Hospital ED. The volumes and proportion seen by each provider has remained static over the last 3 years. This market is not growing – possibly due to more GPs offering extended practice hours for their enrolled patients. Mahoe Medical data was not available.

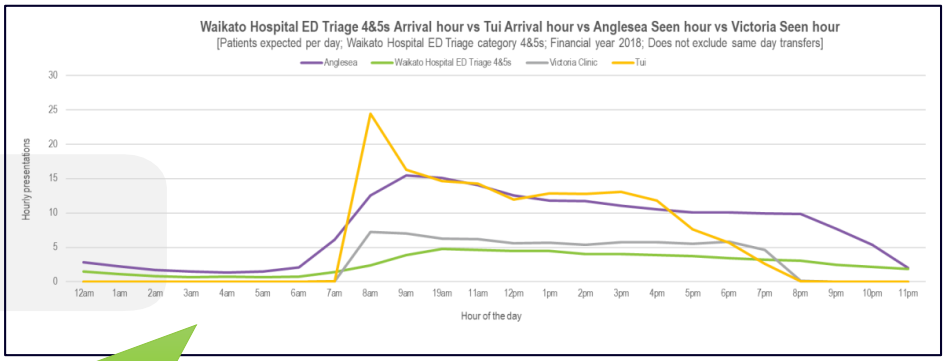
In-depth Look at Anglesea Clinic

On average, 20% of patients enrolled with Hamilton practices presented at Anglesea Clinic in 2018. Practices that did not offer extended hours generally had above-average utilisation of Anglesea as a proportion of their enrolled population. Anglesea is the only Urgent Care Centre funded to provide a 24/7 service. Of Triage 4-5 patients, 2 per hour presented to Anglesea and 1 per hour presented to Waikato Hospital ED between 11pm and 6am. ED sees a total of 4 patients per hour (Triage 1-5) over these hours. The Urgent Care market is highly competitive with increasing workforce costs (medical specialisation), price sensitivity (fees), and revenue constrained by fee-for-service income and static patient volumes. Anglesea in particular will be challenged as it operates in a mainly fee-for service environment unlike the other Urgent Care Centres who can offset this risk with capitation income.

Additionally Anglesea Clinic is the only 24/7 urgent care centre in the Hamilton Locality and provides very little detail of its services online for patients to access.

Volumes have been static over the past 3 years for all providers. Mahoe Med data not available





Between 11pm to 7am, an average of 2 patients per hour present to Anglesea Clinic & 1 patient per hour to Waikato Hospital

FRANCIS HEALTH

HAMILTON LOCALITY

TOTAL ESUs
250,088
24% Maori & PI
21% Quintile 5

17/18 ED Presentations
48% of total WDHB T4 & T5

Travel Time to Waikato Hospital
45 min max (Raglan)

DESCRIPTION OF LOCALITY & SERVICES

The Hamilton Locality includes Hamilton City, Cambridge, Te Awamutu, Kihikihi, Pirongia, Raglan and Ngaruawahia (on the border of the Northern Corridor Locality). It has a combined enrolled population of 250,088. (Enrolled Service User – ESU)

Emergency & Urgent Care services are provided by Waikato Hospital ED, Anglesea Clinic, Tui Medical Te Rapa Urgent Care, Victoria Clinic and Mahoe Med in Te Awamutu. The Locality has a total of 42 general practices with 31 in Hamilton City. Approximately 40% of practices offer extended hours. The longest travel time to Waikato Hospital is from Raglan (42 minutes).

The PHO Services Agreement requires that practices provide all service users with access to Urgent Care Services on a 24-hour, 7 day a week basis for 52 weeks a year - including face to face consultations if clinically indicated. The 4 ACC accredited Urgent Care Centres provide this service for general practices. Anglesea is the only 24/7 clinic. The remainder are open 8am-8pm 7 days/week (Mahoe is 9am-3pm on weekends). Apart from Anglesea, all urgent care providers also provide GP services and enrol patients.

Waikato Hospital ED had 84,000 patients presentations in 2018 compared with 150,000 patient presentations at Urgent Care Centres (excluding Mahoe). 86% of all Triage 4-5 presentations were delivered by Urgent Care Centres, with approximately 14% seen in ED, indicating that patients are generally going to the right place for their urgent care.

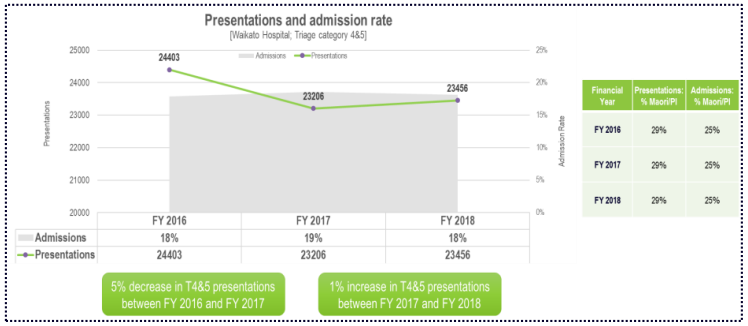
Anglesea is a cooperative provider with 140 affiliated GPs. It delivers 69,000 patient consultations per year (39% ACC and 61% medical). It is a significant provider of Primary Options and the only provider of ED patient redirection services (voucher system). Anglesea provides urgent care services for the majority of Hamilton practices until 8pm and for all practices from 8pm-8am. It also provides services to patients that require an appointment outside of their practice's opening hours and when practices do not have the capacity to see their enrolled patients in-hours. 42% of all patients seen by Anglesea are in-hours (51% ACC and 49% medical) – which could highlight a general practice capacity problem. Its operating hours, proximity to Waikato Hospital, and PHO/practice neutrality (non-enrolment) positions Anglesea as a key provider for reducing demand on ED services.

Tui Medical, Victoria Clinic and Mahoe Med provide urgent care services to all patients – not just their enrolled populations. Tui Medical is the largest GP provider with 36,321 ESUs enrolled across 4 clinics.

ISSUES – SYSTEM

Primary care can impact on Triage 4-5 patient presentations to ED. In 2018, 86% of all Triage 4-5 patients were seen in Urgent Care Centres with only 14% seen in ED. Of the 23,500 Triage 4-5 patients that presented to ED 4,200 (18%) were admitted and 19,300 were treated in ED. This group, which represents 23% of ED presentations or 53 patients per day, is the group that should be targeted for treatment in primary care to free-up ED capacity for the growing number of Triage 1-3 patients.

All parts of the urgent care system (ED, Urgent Care Centres and general practice) are busy. Patients referred to Anglesea after a long wait in ED can experience a long wait in Anglesea. Triaging away from ED to primary care is ad hoc. There are no virtual options for patients after-hours apart from HealthLine. St John is not able to access primary care treatment options - so can only treat a patient at home or transfer them to ED. Clinicians working in all parts of the emergency & urgent care system work in isolation from other providers. There is no clinical networking or joined-up governance that can address and monitor system-wide performance across urgent care providers and ED.



FRANCIS HEALTH

HAMILTON LOCALITY

TOTAL ESUs
250,088
24% Maori & PI
21% Quintile 5

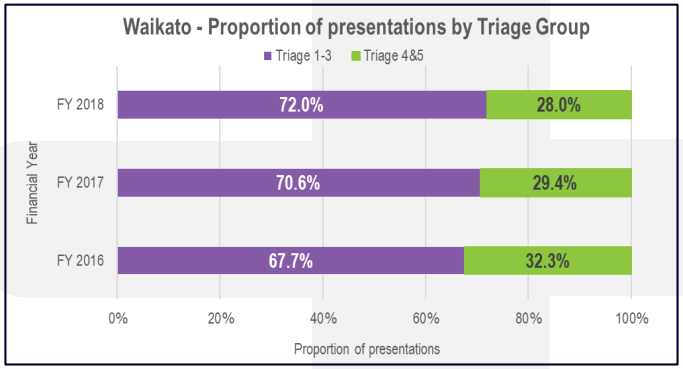
17/18 ED Presentations
48% of total WDHB T4 & T5

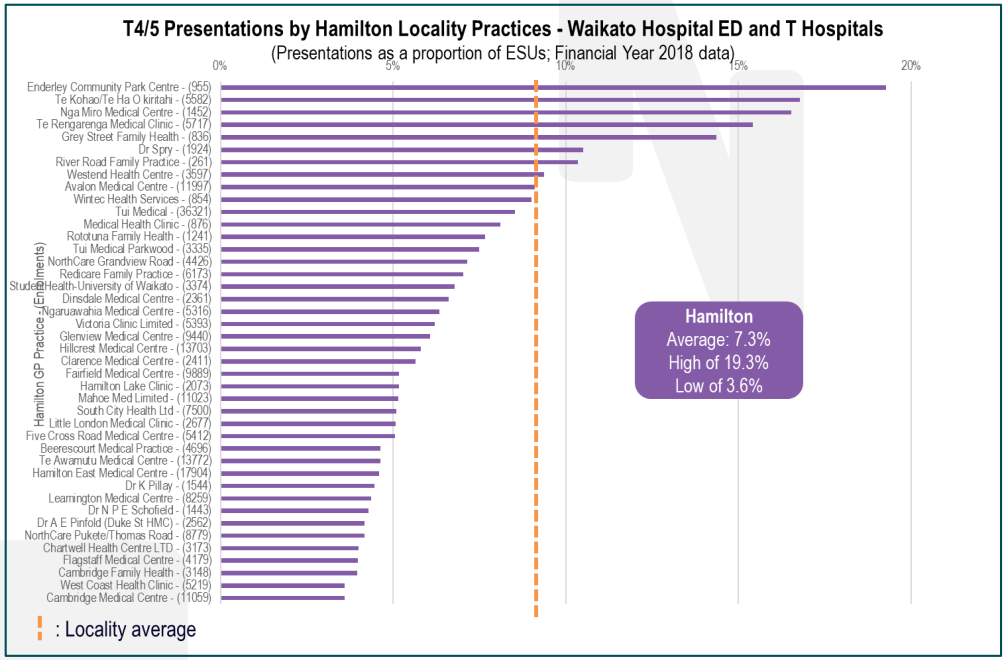
Travel Time to Waikato Hospital
45 min max (Raglan)

ISSUES – WAIKATO HOSPITAL ED

Waikato Hospital ED volumes are increasing at a rate of 6-7% p.a. against a population increase of 1% p.a. This growth is occurring in Triage 1-3 with Triage 4-5 (30% of presentations) trending downwards. ED admission rates are static at 36% of presentations. There has been a significant increase (>300%) in aged residential care transfers to all EDs over the past 3 years. Although numbers are relatively low (1100 p.a.) these patients require a lot of input. Maori and Pacific are high users of ED (36% of Triage 4-5). High deprivation patients are also high users of ED which suggests that cost remains a barrier to urgent care. 79% of Triage 4-5 patients were walk-ins (self and GP referred) and 14% arrived by ambulance. Frequent attenders (>6 presentations p.a.) numbers were relatively small at 0.6%.

POAC has made a significant impact on ED presentations for some conditions, e.g. DVTs & cellulitis, with very few of these patients now treated in ED. 6% of Anglesea patients were transferred to ED (11 per day ave.) and 17% of ED Triage 4-5 patients were redirected to Anglesea (also 11 per day ave.) in 2016. Redirection is a nurse intensive and cumbersome process and numbers have dropped to 11% (7 per day ave.) in 2018 as a result. Redirection is funded by ED so does not have system consistency or Strategy & Funding visibility.





HAMILTON LOCALITY

TOTAL ESUs
250,088
24% Maori & PI
21% Quintile 5

17/18 ED Presentations
48% of total WDHB T4 & T5

Travel Time to Waikato Hospital
45 min max (Raglan)

ISSUES – URGENT CARE CENTRES

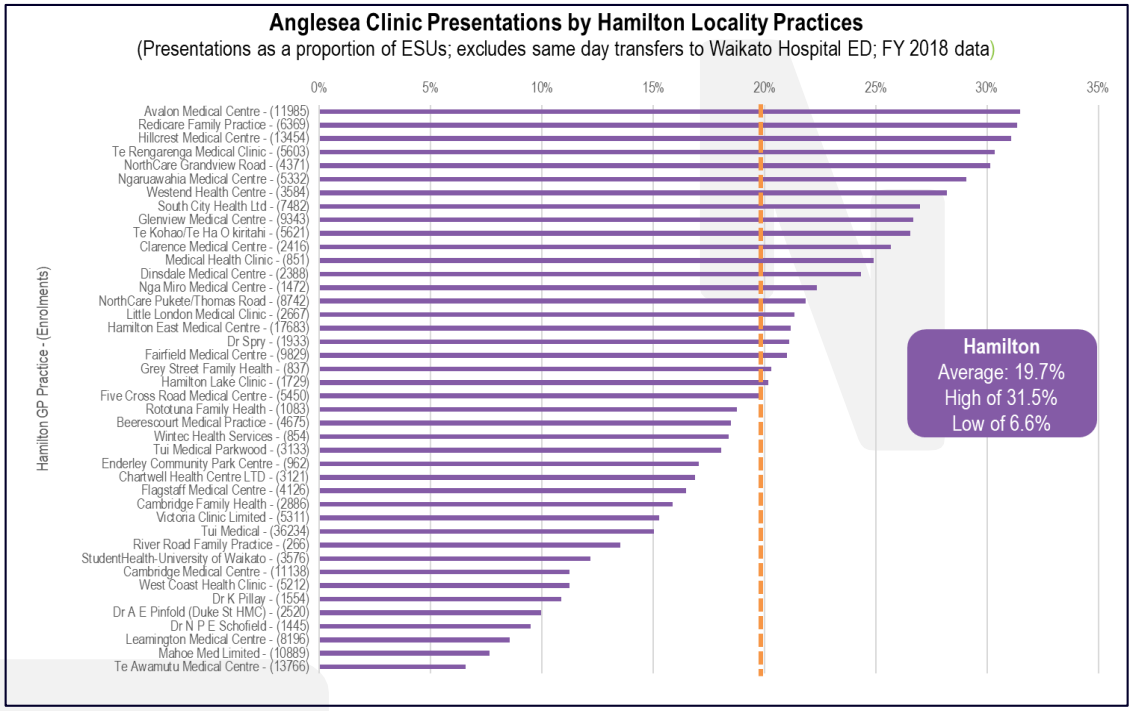
Urgent Care Centres are the biggest provider of urgent care services by patient volume. Presentations have remained static over the past 3 years (including under-13s Triage 4-5 presentations) probably due to more practices extending their opening hours. On average, 20% of Hamilton practices' ESUs presented at Anglesea in 2018 (range 7%-32%). 9 of the 12 practices with presentations above the average are VLCA funded which indicates high need populations and include practices with very small to large ESU numbers. Distance from Anglesea was clearly a factor for low-use practices.

Urgent Care Centres see a lot of patients in the 0-24 age group. Many young adults do not use general practice and prefer the convenience of an urgent care centre. They also do not treat many older patients (>65) as their needs are often complex and require access to social supports.

Anglesea is the only Urgent Care Centre that does not receive capitation income. The fee-for-service business model does not encourage investment in observation beds that could assist treating more patients in primary care. Patients with complex needs, e.g. frail elderly and mental health patients, require a huge resource input that is not covered by standard fees.

The Urgent Care market is highly competitive, with increasing workforce costs (medical specialisation), price/fees sensitivity and income constrained by fee-for-service revenue and static volumes. This could drive the market to fewer larger centres over time which are more financially sustainable and able to deliver more comprehensive services.

Very Low Cost Access funded practices are over represented in the above average groups in both presentations at Waikato ED and Anglesea Clinic which could indicate a capacity issue at their enrolled GP practice..



: Locality average

HAMILTON LOCALITY

TOTAL ESUs
250,088
24% Maori & PI
21% Quintile 5

17/18 ED Presentations
48% of total WDHB T4 & T5

Travel Time to Waikato Hospital
45 min max (Raglan)

RECOMMENDATIONS

1. Develop an ED operational framework for triaging low acuity patients to their GP or an Urgent Care Centre. In 2018FY, there were 19,300 Triage 4-5 patients treated in ED that were not admitted (23% of ED presentations or 53 patients per day) that could be targeted for triaging to primary care. This represents an 8.4% increase in Urgent Care Centre volumes and would free-up ED capacity for the growing number of Triage 1-3 patients. 'Triaging to primary care' (TTPC) requires rapid and consistent triage in ED and the ability for ED to facilitate a primary care appointment for the patient - either with their GP or at an Urgent Care Centre. This function could be performed by a primary care doctor and/or nurse, familiar with the primary care network, attached to ED. Direct booking capability will evolve in time. Primary care treatment should not be free to patients. However, options need to be available where patients cannot pay. A TTPC model should be funded directly through Strategy & Funding, rather than through ED's operational budget, to ensure system consistency. The current ED redirection service is funded by ED and only used for peak demand periods.
2. Consider the cost/benefits of continuing to fund the overnight urgent care service provided by Anglesea Clinic. Anglesea currently has 2 patient presentations per hour (average) between 11pm and 6am. ED has 4 patient presentations per hour over the same period (including 1 Triage 4-5). The cost of the Anglesea overnight service is $644,291 p.a. It may be more cost effective to fund a single overnight service and resource ED to provide primary care cover (2 additional Triage 4-5 patients per hour). This model is currently operating in a number of other DHBs with PHOs making a financial contribution in recognition of their 24/7 urgent care obligations. Consideration will need to be given to the "mixed message" this option sends to the public (only use ED for emergencies).
3. Explore the development of a 'virtual front door' in an urgent care setting to give patients an alternative to face-to-face consultations. Consider a business model that supports the sustainability of this service.
4. Consider direct admissions to the Acute Medical Unit for stable 'walk-in' medical patients that have been worked-up and referred by their GP (this is currently being tested as part of BEEM).
5. Explore intermediate care treatment options for St John so ambulance crews can transfer patients to Urgent Care Centres as an alternative to ED. St John currently either treats patients at home or transfers to ED.
6. Scope the cost/benefit for observation beds in Anglesea and the potential impact these could have on transfers to ED (>11 patients per day on average). Anglesea has an observation unit that has not been commissioned due to funding constraints. This unit would require capacity funding rather than fee-for-service.
7. Review Aged Residential Care (ARC) transfers to ED to understand why these numbers have spiked in the past 2 years and patient acuity trends. Consider intermediate care options, including using START and POAC, to better support ARC patients in care settings.
8. Introduce a clinical forum for emergency & urgent care Clinical Directors and senior nurses to support clinical networking and to consider and address system-wide performance issues. Rotate clinical staff across different parts of the emergency & urgent care system so they gain a better understanding of the whole system.

"I don't want my patients going to ED. Give ED the option of booking patients into a Primary Care appointment (GP)"

FRANCIS HEALTH

THAMES / COROMANDEL LOCALITY

TOTAL ESUs
52,544
21% Maori & PI
27% Quintile 5

17/18 ED Presentations
22% of total WDHB T4 & T5

Travel Time to Thames Hospital
93 minutes max (Colville)

DESCRIPTION OF LOCALITY & SERVICES

The Thames Locality extends from Waihi in the south to the top of the Coromandel Peninsula in the north. It has a combined enrolled population of 52,544 with an estimated 498,000 visitors over the summer holiday period.

There are 12 general practices located in the towns of Waihi, Paeroa, Ngatea, Whangamata, Thames, Tairua/Pauanui, Whitianga, Coromandel and Colville. In addition to these practices, Te Korowai has clinics located in Thames, Coromandel, Whitianga, Paeroa & Te Aroha. Thames Hospital provides 24/7 ED and provides after hours, urgent and emergency care and is free for the patients.

Thames Medical Centre is contracted by WDHB to deliver a 6 hour Saturday GP clinic from Thames Hospital ED which reduces the low acuity workload on ED. Only a few practices offer extended hours appointments. The practices in Paeroa & Hauraki Plains participate in the Te Aroha after hours roster. 24/7 urgent care services are available in Whangamata, Whitianga, Coromandel and Colville and are accessed through the HML nurse telephone triage service. 24/7 PRIME services are available from Whangamata, Coromandel and Colville. PRIME trained staff (medical & nursing) are rostered to attend emergencies with the ambulance. Locum GPs are employed in all areas over the summer holiday period to provide extra cover. In most rural areas St John use volunteers to crew ambulances after-hours.

Travel times to Thames Hospital are; Colville 1h 33mins., Whitianga 1h 22mins. and Whangamata 54mins. These times can be considerably longer during holiday periods. Travel time from Waihi to Waikato Hospital is 1h 19mins. Road travel between Thames and Waikato Hospitals is 1h 22mins. GP Beds are available in Waihi, Whangamata, Whitianga and Coromandel.

Plans are underway to lease the wing opposite ED in Thames Hospital to Te Korowai. A service improvement group is considering how co-locating Te Korowai GP and Whanau Ora services on site could reduce presentations at ED and improve outcomes for the community. This will involve introducing a single point of entry (SPOE) as trialled in other rural hospitals for patients attending ED and redirecting low acuity (majority of Triage Category 4&5) patients to Te Korowai.

ISSUES

The geography and travel times across the Thames Locality are challenging. The urgent care model relies on dedicated GPs and nurses who are committed to their communities. It is a fragile model that is dependent on the future clinical workforce for its sustainability. Whilst practices are currently able to attract locum doctors, the demands of rural rosters are not attractive to younger GPs who are looking for work/life balance. The workforce is the biggest future risk for urgent care in the Thames locality. Currently, each practice is responsible for recruiting locum cover for its area.

A decline in St John services after-hours is a common issue across rural areas. Big demands are placed on St John volunteers resulting in recruitment and retention problems. In areas like Coromandel, response times can be up to 2 hours for urgent cases and it was indicated the Rescue Helicopter is being used more to compensate for a decline in ambulance services.. These issues are compounded in summer when visitor numbers swell.

It is unclear whether Te Korowai practices are meeting their after-hours urgent care obligations under the PHO services agreement. Similarly, Thames Medical Centre's (TMC) after-hours urgent care obligations are being met by the Hospital ED. Although TMC is contracted by WDHB to deliver a Saturday clinic from ED, which is free for patients, the doctors are remunerated for this service via rural funding rather than it being part of an agreed contribution to the after-hours or urgent care delivered by the DHB for TMC patients.

Practices in rural towns highlighted poor integration with DHB Community Services, even where services were in close proximity, and availability of Mental Health services was also raised as a problem. Some areas also highlighted the constraints around contracting "silos" across similar services that were delivered by the same rural workforce. Commissioning for outcomes would provide more contracting flexibility e.g. palliative care package of care funding for multiple visits, managing symptoms and supply of medications – rather than current funding for clinic visits only.

Using video conferencing / tele health for routine outpatient appointments was also highlighted as a potential benefit for patients in remote areas.

The proposed ED/Te Korowai SPOE model at Thames Hospital needs careful consideration with respect to patient fees, GMS claw-backs and patient enrolment policy. This has implications for other Localities where SPOE models are in place or being considered. Thames ED currently sees 10,600 T4-5 patients and the Thames Hospital Te Korowai service would need to have substantial capacity to treat the majority of these patients.

FRANCIS HEALTH

THAMES / COROMANDEL LOCALITY

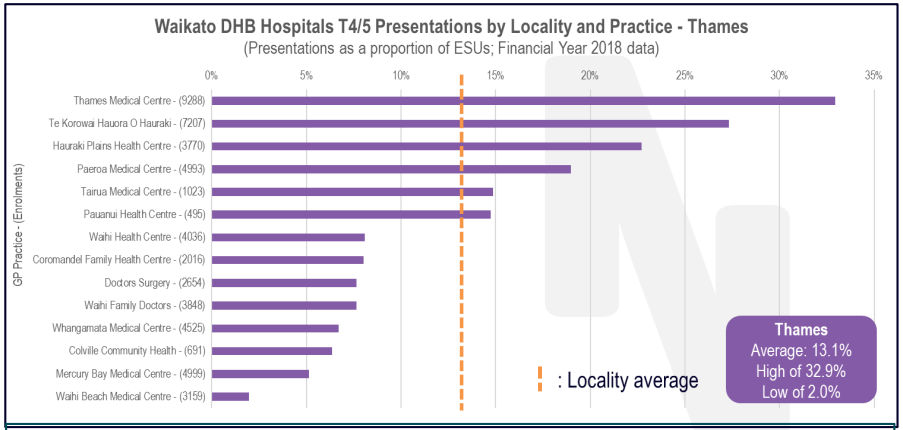
TOTAL ESUs
52,544
21% Maori & PI
27% Quintile 5

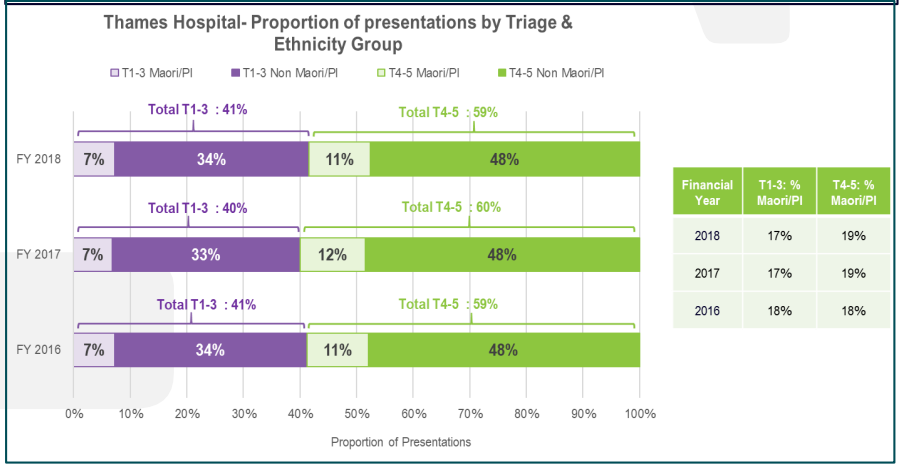
Practice Name	# ESUs	VLCA Funding	After-hours Roster	After-hours Telephone Nurse Triage	Rural Funding
Colville Community Health Centre	691	Y	Y	Y	Y
Doctors Surgery Whitianga	2,654	N	?	Y	Y
Paeroa Medical Centre	4,993	Y	Y	Y	Y
Te Korowai o Hauraki (Thames, Coromandel, Paeroa & Te Aroha*)	7,207	Y	?	Y	Y
Waihi Family Doctors	3,848	Y	N	Y	Y
Waihi Health Centre	4,036	Y	N	Y	Y
Waihi Beach Medical Centre	3,159	N	N	Y	N
Coromandel Family Health Centre	2,016	Y	N	Y	Y
Mercury Bay Medical Centre	4,999	N	Y	Y	Y
Tairua Medical Centre	1,023	N	Y	Y	Y
Pauanui Health Centre	495	N	Y	Y	N
Thames Medical Centre	9,288	N	N	Y	Y
Whangamata Medical Centre	4,525	N	Y	Y	Y
Hauraki Plains Health Centre	3,770	N	Y	Y	Y

PHO's
NHC
HPHO
PMHN

RECOMMENDATIONS

1. Audit PHO/practice obligations to provide after-hours urgent care for their ESUs and negotiate local arrangements where the DHB is providing this service for practices. As part of this audit, review the Saturday GP clinic being delivered by Thames Medical Centre in Thames Hospital ED to determine its value and whether this service should be funded by the DHB or Thames Medical Centre as part of an urgent care agreement.
2. Develop an operational framework and policy for the proposed Single Point of Entry (SPOE) at Thames Hospital ED to determine how patients access ED or Te Korowai services on site, or are referred to their general practice. This framework should be consistent across all Localities where general practice is collocated with ED.
3. Scope the opportunity to deliver selected routine outpatients using video conferencing.
4. Explore options with St John to improve ambulance response times (applies to all rural settings where this has been highlighted as an issue).
5. Scope the cost benefit of point of care testing (e.g. Troponin tests) in the rural sub-hub areas.
6. Consider commissioning for services in rural localities to provide more flexibility across contracted services that are delivered through the same workforce.
7. DHB & PHOs collaborate to develop a long term workforce strategy for both Medical & Nursing staff in challenging rural areas to balance both resourcing requirements and service delivery.
8. Consider a more centralised approach, possibly through PHOs, to recruit rural locums to cover peak holiday periods.
9. Explore opportunities to better integrate general practice sub-hub and DHB Community Services in rural sub-localities to improve outcomes for patients that interact with both services.





Financial Year	T1-3: % Maori/PI	T4-5: % Maori/PI
2018	17%	19%
2017	17%	19%
2016	18%	18%

FRANCIS HEALTH

MATAMATA LOCALITY

TOTAL ESUs
33,042
13% Maori & PI
13% Quintile 5

17/18 ED Presentations
4.5% avg. to Waikato ED T4 & T5

Travel Time to Waikato Hospital
45 mins to 1 Hour

DESCRIPTION OF LOCALITY & SERVICES

The Matamata Locality includes the towns of Matamata, Morrinsville and Te Aroha. It has 5 General Practices, plus a small marae-based clinic in Waharoa, with a combined enrolled population of 33,042. The 4 main practices are privately owned and affiliated with 2 PHOs. The marae clinic is owned by Raungaiti Marae.

Health Te Aroha, Paeroa and Ngatea GPs have an after-hours roster until 10pm Mondays-Thursdays. A 2-hour clinic is provided in Paeroa and Te Aroha on Saturdays-Sundays with a GP on-call until 2pm. Te Korowai GPs do one night on-call but no weekend call. Anglesea Clinic (45 minutes travel) provides after hours cover outside of these hours. Health Te Aroha GPs are able to access GP Beds at Te Aroha & District Community Hospital so that acute patients can be managed locally.

Matamata is served by a single practice which is co-located with Pohlen Hospital and provides GP cover to the marae clinic. The practice delivers a full 24/7 on-call sub-hub service. Urgent care 'walk in' clinics are available for 2 hours on Saturdays and Sundays and outside these hours via HML telephone triage. GPs can admit patients into GP Beds in Pohlen Hospital which is owned and run by a Community Trust. Pohlen has 33 beds and contracts with WDHB for maternity, GP Beds, aged residential care, transitional care, palliative & end of life care, and respite carer support. It also hosts private and DHB visiting specialist clinics. A Radiographer is available on-call after-hours. St John can contact the duty GP for advice and patient information.

Morrinsville has 2 general practices. These do not provide extended hours at all . After hours cover is provided by Anglesea Clinic in Hamilton (30 minutes travel).

ISSUES

Urgent care across the Locality generally works well. In particular, the Matamata model is comprehensive, integrated across multiple providers and provides a good service to the local community. Its success is reflected in low ED presentation rates for Triage 4 & 5's. However the GP owners indicated these models may not be sustainable in the future as younger GPs demand greater work/life balance. Patients accessing after hours care are charged a service fee slightly higher than a standard consultation.

Morrinsville is the only area that does not offer extended hours general practice. Both practices utilise Anglesea clinic as their after hours provider with average utilisation.

GPs stakeholders indicated that more patients appear to be accessing care after hours for convenience rather than need. GP Beds in two areas are highly valued by GPs and their patients. Paeroa patients access Te Aroha beds when required which is an inconvenience although preferable to a referral to Waikato Hospital.

Urgent care call-outs on the Te Aroha after hours Roster between 8-10pm are low. Any Patients accessing after hours care are charged a service fee. GPs highlighted the decline in St John services with slow response times and non-availability of the local crew necessitating the deployment of crews from neighbouring towns.

Point of care testing was also seen as an opportunity to reduce transfers to Waikato ED. Consumables are expensive but potentially cost effective compared with an ED admission.

Mental Health patients can place a big demand on after hours services and getting support from the appropriate service across all providers is time consuming.

"The more people that can be kept out of ED the better. ED over investigates. Rural GPs are more willing to manage clinical risk (GP)"

FRANCIS HEALTH

MATAMATA LOCALITY

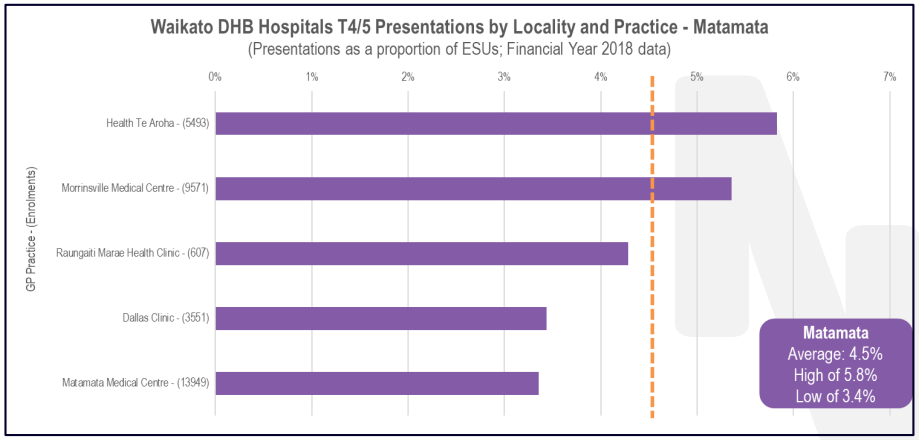
RECOMMENDATIONS

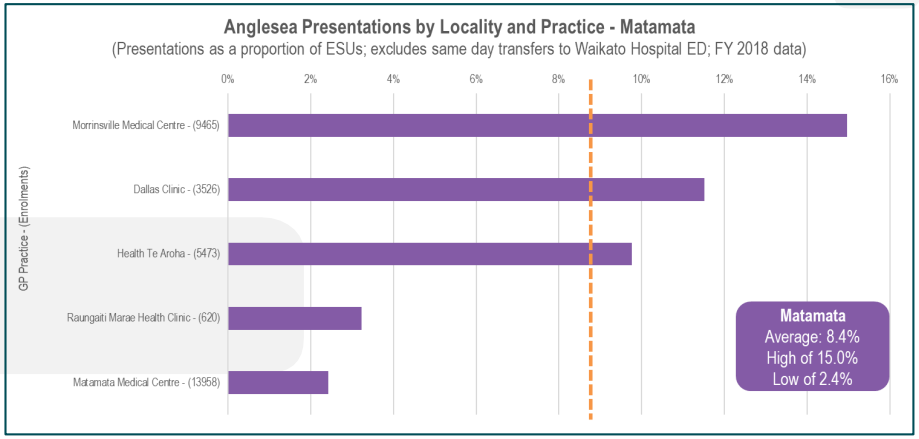
1. Continue to support the current urgent care model within the Locality.
2. Consider re-allocating some GP Beds from Te Aroha to a suitable Paeroa provider so these are more accessible to the Paeroa population.
3. Scope the cost benefit of point of care testing (e.g. Troponin tests) in the Matamata sub-hub.
4. Review Te Aroha urgent care utilisation and consider reducing the Monday-Thursday on-call hours from 10pm to 8pm in return for extended clinic hours during the weekends.
5. Explore options with St John to improve ambulance response times (applies to all rural settings where this has been highlighted as an issue).

TOTAL ESUs
33,042
13% Maori & PI
13% Quintile 5

Practice Name	# ESUs	VLCA Funding	After-hours Roster	After-hours Telephone Nurse	Rural Funding
Matamata Medical Centre	13,949	N	Y	Y	Y
Raungaiti Marae Health Clinic	607	Y	Y	Y	Y
Te Korowai o Hauraki - Te Aroha*	*	Y	Y	Y	Y
Dallas Clinic	3,551	N	Anglesea	N	N
Morrinsville Medical Centre	9,571	N	Anglesea	N	N
Health Te Aroha	5,493	N	Y	Y	Y

PHO's
NHC
HPHO
PMHN





: Locality average

TOKOROA LOCALITY

TOTAL ESUs
21,025
47% Maori & PI
55% Quintile 5

17/18 ED Presentations
18% of total WDHB T4 & T5

Travel Time to Waikato Hospital
1 Hour

DESCRIPTION OF LOCALITY & SERVICES

The Tokoroa locality includes Tokoroa, Putaruru and surrounds. It has a Rural Hospital in Tokoroa and 3 General Practices with an enrolled population of 21,025. The practices are affiliated with 2 PHOs and all independently owned with 2 practices located on the Tokoroa hospital site and 1 practice located in Putaruru.

Tokoroa Medical Centre provides extended hours to 6pm Monday-Thursday and Putaruru & Tirau provides extended hours to 6pm 1 evening per week. All 3 practices participate in a Saturday clinic roster located at Tokoroa Hospital. Mangakino Health Services also participates in the Saturday clinic roster although aligned and funded via Lakes DHB.

The hospital provides all other After-Hours, Urgent and Emergency services and at times also the default provider for in-hours primary care. Triage 4 & 5 presentations have steadily increased from 16% in 2016 to 18% in 2018 of the total Waikato Hospital presentations for these categories.

On average 67% of total presentations to Tokoroa ED, from 2016 – 2018, were Triage 4 & 5.

"The opportunities of co-location with GPs have not been realised. There is a lot of wastage due to multiple providers all funded separately"

ISSUES

Local services appear to be siloed as there is no obvious collaboration in service provision. Although 2 of the practices are co-located on the hospital site they work independently of each other and of ED. It was indicated there were no joint on-site meetings of the services for general updates, sharing of information or education purposes. An ED redirect project has recently been initiated and this appears to be the first joint activity.

From a primary care perspective the general practices have no requirements to participate in an after hours roster during the week. Weekly Saturday clinics are held in ED although this has recently changed with one of the on-site practices holding these clinics in their practice rather than ED. It is not clear how these clinics are advertised and how patients know where to access the service with the change.

ED is the default after hours, Urgent & Emergency provider of services and is free to patients. There are no funding arrangements with practices or consequence if patients access services at the hospital either in-hours or after-hours. A project to redirect patients from ED back to their general practice was recently introduced, as used in other localities, but with different processes for the patient depending on which practice they are enrolled with. Anecdotally, there is a long history of patients using the ED as their default primary care provider for a variety of reasons and ED stakeholders indicated those patients with more complex health needs were using ED more for convenience and for better continuity of medical service.

There is no after hours pharmacy available which stakeholders believe influences patients to attend ED.

Recruitment of the general practice workforce continues to be a challenge. Both the hospital and primary care providers are competing in the same rural market that has difficulty recruiting and retaining a full workforce. Many of the GPs live outside the Locality or are employed for defined contractual periods which can have an impact on the capacity to deliver patient services and continuity of care.

FRANCIS HEALTH

TOKOROA LOCALITY

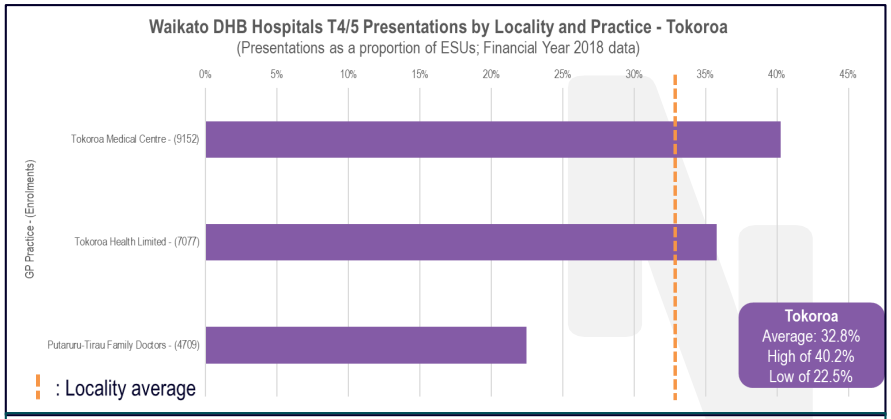
TOTAL ESUs
21,025
47% Maori & PI
55% Quintile 5

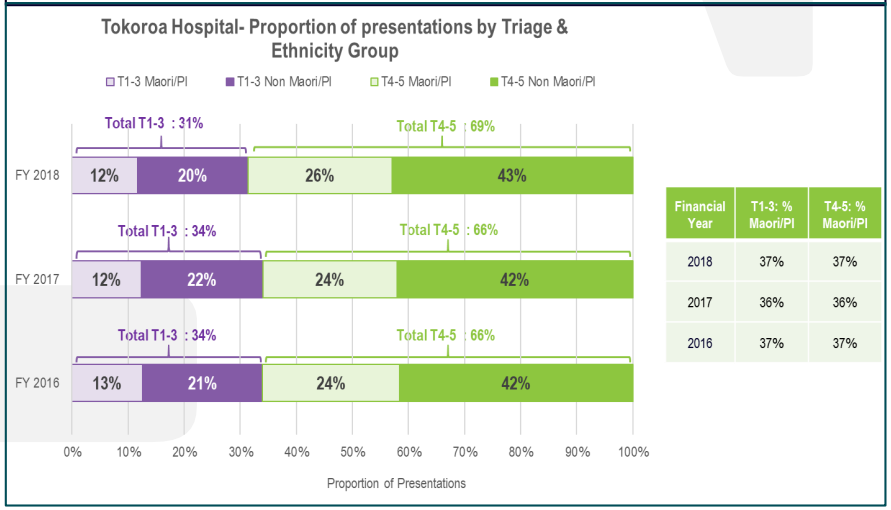
Practice Name	# ESUs	VLCA Funding	After-hours Roster	After-hours Telephone Nurse	Rural Funding
Tokoroa Family Health	7,077	Y	Y	Y	Y
Tokoroa Medical Centre	9,152	Y	Y	Y	Y
Putaruru-Tirau Family Doctors	4,709	N	Y	Y	Y

PHO's
NHC
HPHO
PMHN

RECOMMENDATIONS

1. Implement a fully integrated single service model at Tokoroa Hospital that delivers primary and secondary care including: in-hours primary care, community services, after-hours urgent care and emergency care. This service could be delivered by either a private provider (e.g. the Te Kuiti model) or by the DHB (the West Coast model). A fully integrated single service model will help secure the future workforce and improve outcomes for patients that currently interact with multiple services. This is a long term goal that will need to be planned and implemented with current providers.
2. Develop an operational framework and policy for a Single Point of Entry (SPOE) to determine how patients access general practice services, for which there will be a fee, and free hospital services. This framework should be consistent across all localities regardless of whether GP services are delivered by a private provider or the DHB.
3. Designate the Tokoroa Locality as a special needs area, due to its high deprivation and large Maori population, and offer reduced co-payments or free primary care for certain patient groups e.g. CSC holders. This policy would need to be extended to other general practices within the Locality.
4. Explore opportunities in the short term to better integrate general practice, ED and DHB Community Services to improve outcomes for patients that interact with multiple services. This could include commissioning for services to provide greater workforce flexibility across contracted services. It could also include SPOE for urgent care (although the current layout of Tokoroa Hospital could be a barrier to this).
5. Develop a strategy to improve the use of technology for virtual consultations with secondary services to reduce patients having to travel to Waikato Hospital for outpatient clinics or hospital transfers.
6. Explore how more timely advice from consultants at Waikato Hospital ED could be provided to the rural hospitals to reduce patients having to travel or transfer to Waikato hospital.
7. DHB & PHOs collaborate on recruitment and retention of Medical & Nursing staff to balance both resourcing requirements and service delivery.





Financial Year	T1-3: % Maori/PI	T4-5: % Maori/PI
2018	37%	37%
2017	36%	36%
2016	37%	37%

FRANCIS HEALTH

TAUMARUNUI LOCALITY

TOTAL ESUs
7,136
48% Maori & PI
55% Quintile 5

17/18 ED Presentations
10% of total WDHB T4 & T5

Travel Time to Waikato Hospital
2 Hours

DESCRIPTION OF LOCALITY & SERVICES

The Taumarunui locality has a Rural Hospital, 3 General Practices and an enrolled population of 7,111. The practices are affiliated with 2 PHOs with 2 practices owned by Kokori Trust and 1 independently owned. 2 practices are located in the township and 1 practice located on the hospital site.

The hospital is the default provider of After Hours, Urgent and Emergency services and at times it is also the default provider for in-hours care when practices cannot see their patients. The ED service is a free service for GP patients and there is an expectation it is always available. Triage 4 & 5 presentations at the ED have remained relatively stable since 2016 to 2018 being 10% - 11% of the total Waikato Hospital presentations for these categories.

On average 83% from 2016 - 2018 of total presentations to Taumarunui ED are Triage 4 & 5 and the highest of all T hospitals.

ISSUES

The local services appear to be siloed as there is no obvious collaboration in service provision. GP practices provide no extended hours and there is no requirement for the GPs to participate in an after-hours roster. The practices decide their operating hours with no consequences from a funding perspective if the patients access services at the hospital either in-hours or after-hours.

ED is the default After Hours, Urgent and Emergency provider of services and is free to the patients. Anecdotally there is a long history of patients using the ED as their default primary care provider for a variety of reasons such as; no available appointments, unable to attend appointment during working hours, cost, casual patient not enrolled at a practice. The data supports this with on average 83% of total presentations being Triage 4 & 5 category. The ED nursing team will always see patients quickly to ensure a backlog doesn't occur so emergencies can be managed in a timely manner. This in turn provides an efficient alternative general practice provider.

A WDHB-led Single Point of Entry (SPOE) service is being trialled in ED as a way to manage and re-direct primary care patients back to their enrolled GP but the policy and operational framework for this service is unclear.

Recruitment of both medical and nursing workforce continues to be a challenge as many live outside the region or come for defined contractual periods which has an impact on continuity of care for the patients and the capacity to deliver services as required.

From a funding perspective where the population is relatively small, the ongoing siloed contracted services within primary, community and hospital services continues to support a fragmented approach as services work independently of each other, but with the same cohort of patients.

Patient transfers to Waikato Hospital can take a 5 hour round trip with a team coming down from Waikato. Staff and patients would prefer treatment to be provided locally, but at times it is difficult to get ED specialist advice by phone in a timely manner as there is no dedicated resource for the T hospitals.

"People are used to coming to ED and turn up regardless of whether there is an appointment or not"

FRANCIS HEALTH

TAUMARUNUI LOCALITY

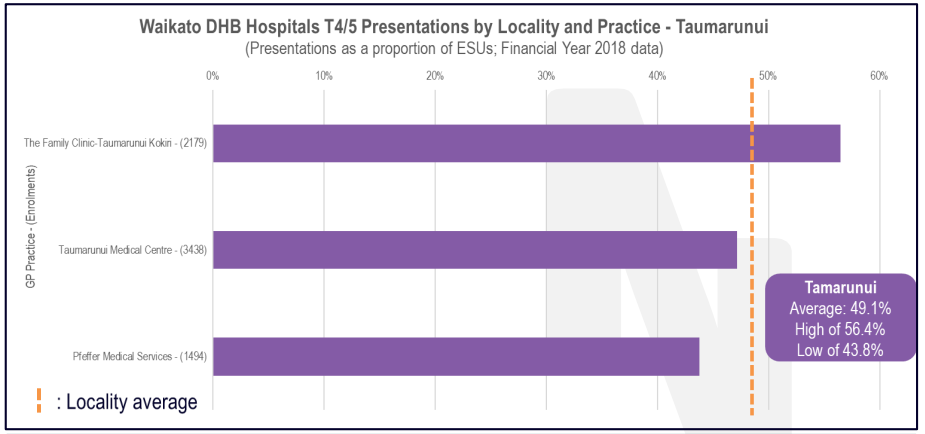
TOTAL ESUs
7,136
48% Maori & PI
55% Quintile 5

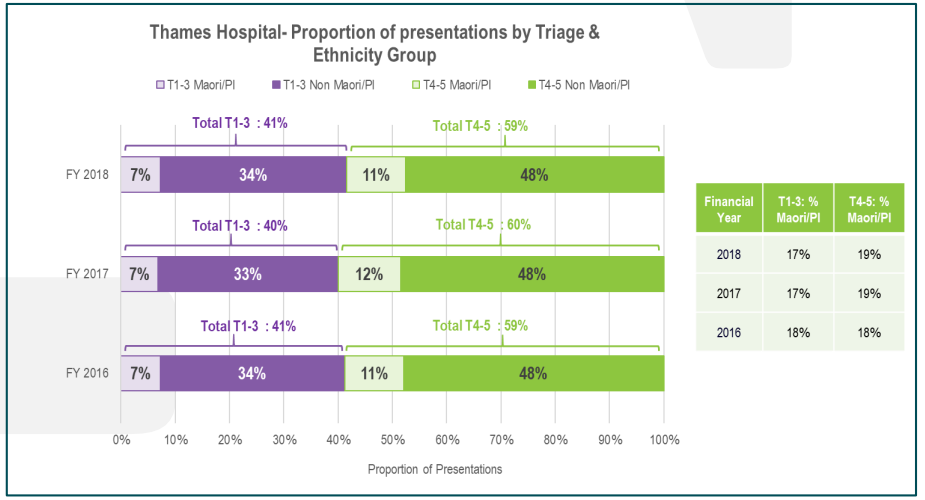
Practice Name	# ESUs	VLCA Funding	After-hours Roster	After-hours Telephone Nurse	Rural Funding
Taumarunui Medical Centre	3,438	Y	N	Y	N
The Family Clinic - Taumarunui Kokiri	2,179	Y	N	Y	Y
Pfeffer Medical Services	1,494	Y	N	Y	N

PHO's
NHC
HPHO
PMHN

RECOMMENDATIONS

1. Implement a fully integrated DHB-run service model at Taumarunui Hospital that delivers primary and secondary care including: in-hours primary care, community services, after-hours urgent care and emergency care. With the relatively small locality population (7,136), and the high number of ED Triage 4 & 5 presentations (on average 83%), a fully integrated single service model will help to secure the future workforce, provide a sustainable service model and improve outcomes for patients that currently interact with multiple services. This is a long term goal that will need to be planned and implemented with current providers.
2. Develop an operational framework and policy for a Single Point of Entry (SPOE) to determine how patients access general practice services, for which there will be a fee, and free hospital services. This framework should be consistent across all localities regardless of whether primary care services are delivered by a private provider or the DHB.
3. Designate the Taumarunui Locality as a special needs area, due to its high deprivation and large Maori population, and offer reduced co-payments or free primary care for certain patient groups e.g. CSC holders.
4. Develop a strategy to improve the use of technology for virtual consultations with secondary services to reduce patients having to travel to Waikato Hospital for outpatient clinics or hospital transfers.
5. Explore how more timely advice from consultants at Waikato Hospital ED could be provided to the rural hospitals to reduce patients having to travel or transfer to Waikato hospital.





Financial Year	T1-3: % Maori/PI	T4-5: % Maori/PI
2018	17%	19%
2017	17%	19%
2016	18%	18%

TE KUITI LOCALITY

TOTAL ESUs
16,061
43% Maori & PI
38% Quintile 5

17/18 ED Presentations
3% of total WDHB T4 & T5

Travel Time to Waikato Hospital
1 Hour

DESCRIPTION OF LOCALITY & SERVICES

The Te Kuiti Locality includes the towns Te Kuiti, Otorohanga and Kawhia. It has a GP led Rural Hospital, 4 General Practices and an enrolled population of 16,06. The practices are affiliated with 2 PHOs and all independently owned with 1 practices located on the hospital site in Te Kuiti, 1 in Te Kuiti township, 1 in Otorohanga and 1 in Kawhia.

Te Kuiti Medical Centre provides both General Practice Services and is contracted to provide GP led Medical Services for the hospital 24/7. The hospital provides all After Hours, Urgent & Emergency services and where appropriate triages patients back to general practice the same or next day. Triage 4 & 5 presentations have remained steady since 2016 at 3% of the total Waikato Hospital presentations for these categories.

On average 58% of total presentations (from 2016 – 2018) to Te Kuiti ED were Triage 4 & 5 with increased numbers in 2018.

The Te Kuiti model has been operating for 25 years and is significantly different to all the other Rural Hospitals and primary care communities in the Waikato DHB region due to the medical workforce being GP led. The model is well regarded by the community, providers and the DHB.

"This model is challenging for future GP partnerships however new ones seem to adapt"

ISSUES

Te Kuiti Medical Centre is contracted to provide After Hours and Urgent & Emergency services which is free to the patient if they access the hospital services. Urgent Care across the locality generally works very well. In particular the Te Kuiti model is a strong example of primary care led medical services integrating with secondary services at a locality level. GP stakeholders indicated they have a model that works well for the workforce and patients. Patients understand how to access after-hours and emergency services and use general practice and hospital services appropriately.

Recruitment and retention of medical and nursing staff in the rural areas continues to be a challenge, however, this has not been such a challenge in Te Kuiti as doctors enjoy working across general practice and hospital settings in an integrated way. Although the medical workforce is fully integrated, the nursing workforce is not with practice nurses, hospital and District Nurses working in separate areas under different employers. Lack of nursing flexibility can create issues when trying to cover both hospital and general practice at peak times. Weekends are generally staffed by locums doctors booked 6 months in advance with local GPs supporting the gaps. Local GPs do overnight on-call 1 night per week.

The model is robust but dependent on the GPs. It is not future proofed due to the ongoing need for 24/7 on-call cover and weekend rosters as the younger workforce coming through indicate this does not provide the work/life balance they expect. It can be also challenging to get GPs with the experience to cover both hospital and primary care services.

Access Waikato ED Specialist phone advice can be challenging and patients are often transferred to Waikato when GPs cannot get advice in a timely manner. Te Kuiti Hospital is seen as a separate hospital rather than being a ward of Waikato Hospital as patients are discharged from Waikato and admitted to Te Kuiti or vice versa. Telehealth is not used as well as it could be to keep patients in their local community and reduce the number of transfers.

Recent changes within St John have impacted on after hours patient transfers as communication is not always occurring with GP on-call before transporting which can create double handling.

Multiple service contracts and providers create working silos in the small community as they are all working with the same cohort of patients but without the knowledge of what other services are doing e.g. District Nursing, Clinical Nurse Specialists, Public Health Nurses.

FRANCIS HEALTH

TE KUITI LOCALITY

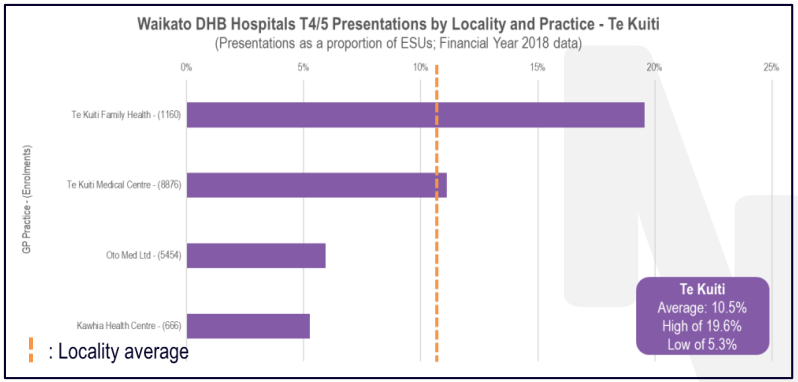
TOTAL ESUs
16,061
43% Maori & PI
38% Quintile 5

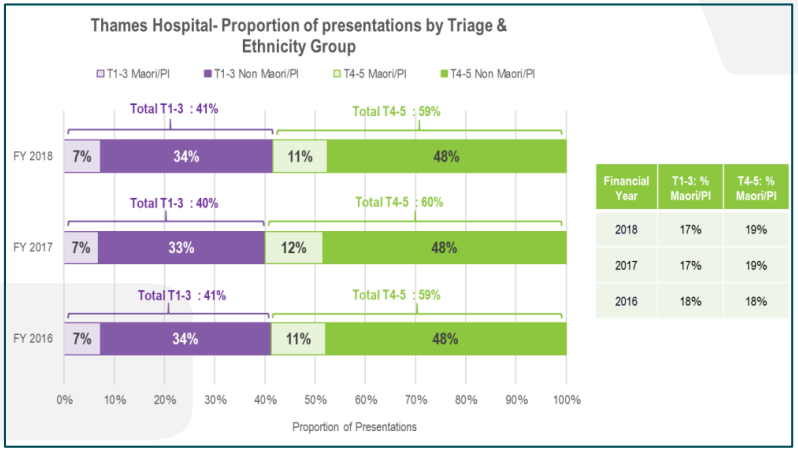
Practice Name	# ESUs	VLCA Funding	After-hours Roster	After-hours Telephone Nurse	Rural Funding
Te Kuiti Medical Centre	8,876	Y	Y	Y	Y
Te Kuiti Family Health Whanau Ora Centre	1,160	Y	?	Y	N
Otorohanga Med Ltd	5,454	Y	N	Y	Y
Kawhia Health Centre	666	Y	Y	Y	Y

PHO's
NHC
HPHO
PMHN

RECOMMENDATIONS

1. Implement a single nursing workforce that works across general practice, community services and the hospital (i.e. that mirrors the integrated medical service) to reduce duplication, increase workforce flexibility and improve service integration.
2. Explore options to better integrate other services in the current model such as district nursing, public health nurses, clinical nurse specialists to reduce duplication and enhance services in the locality.
3. Develop a strategy to improve the use of technology for virtual consultations and ward rounds with secondary services to reduce patients having to travel to Waikato Hospital for outpatient clinics or hospital transfers.
4. Explore how more timely advice from consultants at Waikato Hospital ED could be provided to the rural hospitals to reduce patients having to travel or transfer to Waikato Hospital.
5. Audit the PHO and Otorohanga Medical Centre's contractual obligations to provide after-hours care for their ESUs as neither Anglesea Clinic or Te Kuiti Medical Centre have any formal arrangement to provide this.





Financial Year	T1-3: % Maori/PI	T4-5: % Maori/PI
2018	17%	19%
2017	17%	19%
2016	18%	18%

NORTHERN CORRIDOR LOCALITY

TOTAL ESUs
12,386*
40% Maori & PI
44% Quintile 5
***Tui ESUs not included**

17/18 ED Presentations
7% avg. to Waikato ED
T4 & T5

Travel Time to Waikato Hospital
30 mins to 1 Hour

DESCRIPTION OF LOCALITY & SERVICES

The Northern Corridor Locality stretches from north of Ngaruawahia to Meremere on the boundary of Waikato and Counties Manukau DHBs. It extends from the west coast north of Raglan to Maramarua in the east. The Locality has 5 practices in Huntly (including a small iwi owned practice) and one practice in Te Kauwhata with a combined enrolled population of approximately 15,000 (Tui ESU numbers are not available). Practices are affiliated with 2 PHOs. Te Kauwhata Health Centre is the northern most practice and only 15km from the DHB boundary. It provides an outreach clinic in Meremere and medical cover for the local rest homes.

Approximately 40% of Te Kauwhata Health patients access urgent care services in Pukekohe (30 minutes travel) with 60% traveling to Anglesea.

The Huntly practices utilise Anglesea Clinic below the average per-ESU rate which would indicate that distance and/or cost may be a barrier to urgent care. Te Kauwhata Health is a low user of Anglesea, even factoring in patients that access urgent care in Pukekohe, which supports the GP's view that they are able to accommodate acute patients in-hours. It could also indicate that distance is a barrier.

ISSUES

General practice in Huntly is fragmented with 5 practices for around 12,000 ESUs (Tui ESUs not known). A more consolidated general practice model would enable coordinated rostering of extended practice hours to better serve this community.

Unlike other localities where there is no Rural Hospital, none of the general practices provide extended hours or weekend clinics. All enrolled patients need to travel to Hamilton for Urgent Care either at Anglesea Clinic, Victoria A & M or Tui Medical Te Rapa A & M. Patients accessing care at these clinics would be charged a casual consultation fee. Alternatively they could present at Waikato ED and this would be a free serviced for the patient. Travel times to Hamilton are 45 minutes from Te Kauwhata and 30 minutes from Huntly.

Some GPs interviewed were happy to consider evening week-day clinics but were not interested in weekend clinics.

More resources to better support frail and complex rest home patients after-hours is seen as a high priority by some GPs as after-hours admissions to hospital are expensive. ED data identified a big increase in aged residential care presentations to ED via St John.

Franklin District and North Waikato will undergo considerable population growth in the next 10-20 years. The future development of a South Auckland Hospital by CMDHB, possibly located in Drury, will have an impact on how people living in the northern part of the Locality access urgent care.

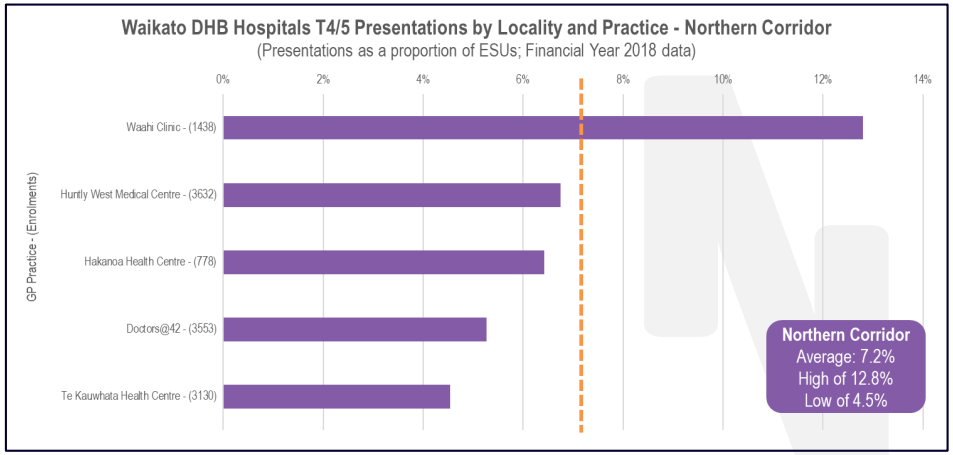
"Rural practices tend to see most of their acute flow patients. The biggest challenge is safe and affordable 24/7 rest home cover"

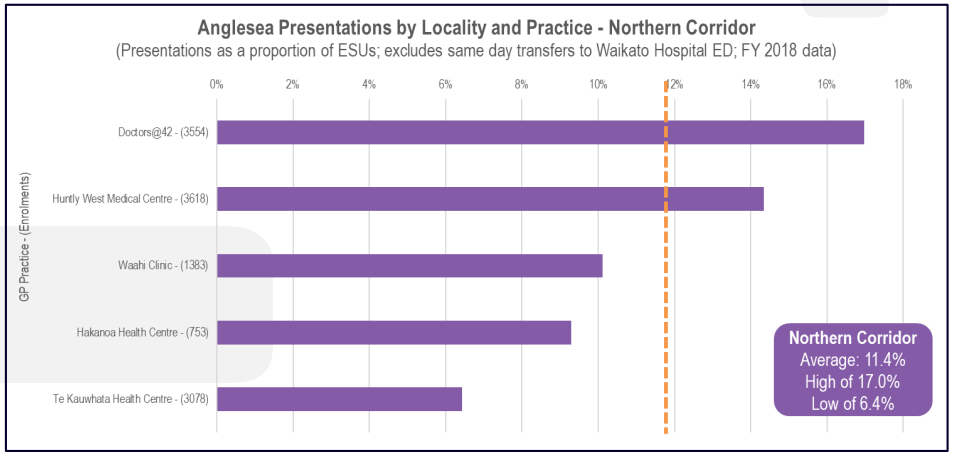
FRANCIS HEALTH

NORTHERN CORRIDOR LOCALITY

RECOMMENDATIONS

1. The DHB and local providers consider a future integrated service model which incorporates primary care, community services, and extended weekday and weekend hours urgent and emergency care into one service hub to support the high need population in this locality. This is a long term goal that will need to be planned and implemented with current providers.
2. DHB and PHOs to facilitate a more coordinated general practice model in Huntly and Te Kauwhata to deliver rostered extended hours general practice and improve patient access to after-hours and urgent care services.
3. Work with PMHN to explore extended week-day hours with Te Kauwhata Health Centre.
4. Review ARC after hours admissions to Waikato Hospital and consider options to better support frail older adults in residential care.
5. Work with CMDHB to jointly plan urgent care services for the growing South Auckland/Northern Corridor population.





: Locality average

TOTAL ESUs
12,386
40% Maori & PI
44% Quintile 5

PHO's
NHC
HPHO
PMHN

Practice Name	# ESUs	VLCA Funding	After-hours Roster	After-hours Telephone Nurse Triage	Rural Funding
Doctors @ 42, Huntly	3,553	Y	Anglesea	Y	Y
Raukura Hauora O Tainui - Waahi	1,438	Y	Anglesea	N	N
Tui Medical - Huntly	*	Y	Anglesea	N	N
Hakanoa Health Centre	778	Y	Anglesea	N	Y
Huntly West Medical Centre	3,632	Y	Anglesea	N	Y
Te Kauwhata Health Centre	3,130	N	Anglesea	N	Y

* ESUs not available separately

RURAL FUNDING

Waikato DHB is investing a considerable amount into Rural services, including rural urgent care, but cannot see where this is going at a Locality & Practice level and whether it is getting value. Some practices are using Rural Hospital EDs to provide their Urgent Care and are not contributing to their PHO obligations.

The total DHB investment in all components of rural services (excluding DHB delivered services) is $4.30m p.a. PHO rural funding ($2.54m) is based loosely on historical Ministry of Health rural funding formula "silos". The PHO allocation of both rural and Sub Hub funding ($3.02m) is determined by the Rural Service Level Alliance Team. However, the DHB has no visibility of how this funding is distributed by PHOs to rural practices.

All of the DHB's rural Hospital EDs provide overnight urgent care and overflow primary care services to practices within the locality. These arrangements are historical and not specified in agreements between the DHB and PHOs/practices. Because rural contracts are based on historical funding "silos", it is difficult to determine value for the investment at a locality level. For example, the Matamata sub-hub model is an effective integrated model that is valued by the community - but the DHB cannot determine whether it represents value for money.

Contract	Organisation	Contract Funding	Total Thames GPs in ED	Total Rural Funding	Total Rural Sub-Hubs	Total HML Nurse Triage	Total Anglesea	Total GP Beds
GP Clinics in Thames ED	Midlands Health Network	43,498	43,498					
Rural Funding	Midlands Health Network	1,443,576						
Rural Funding	National Hauora Coalition	46,599		2,543,969				
Rural Funding	Hauraki PHO	1,053,794						
After Hours - rural sub hubs	Hauraki PHO	204,817			475,724			
After Hours - rural sub hubs	Midlands Health Network	270,907						
Telephone Nurse Triage - HML	Hauraki PHO	68,195						
Telephone Nurse Triage - HML	Midlands Health Network	77,459				149,619		
Telephone Nurse Triage - HML	National Hauora Coalition	3,965						
General Medical (overnight access contract)	Anglesea Clinic	644,291					935,581	
Free after-hours primary healthcare 0-14	Anglesea Clinic	291,290						
Rural Inpatients - GP visits - Matamata	Pohlen Hospital Trust Board	37,661						
Rural Inpatients - GP visits - Te Aroha	Te Aroha & District Health Hospital	23,786						
Rural Inpatients - GP visits - Waihi	Waihi Hospital (2001) Ltd	5,964						152,149
Rural Inpatients - GP visits - Whangamata	Moana House Trust	56,987						
Rural Inpatients - GP visits - Whitianga	Oceania Care Company Ltd	19,822						
Rural Inpatients - GP visits - Coromandel	Phoenix House Rest home Hospital	7,929						
	Total Rural & Urgent Care Funding:	**4,300,540**						
	Total Midlands Health Network:	1,835,440						
	Total Hauraki PHO:	1,326,806						
	Total National Hauora Coalition:	50,564						
	Total Anglesea:	935,581						
	Total GP Bed Providers:	152,149						

RURAL ESUs
143,043
40% Maori & PI
44% Quintile 5

RECOMMENDATIONS

1. Rural Funding is integrated to remove historical silos which currently fund the same services.
2. A transparent formula is developed for Rural Funding which reflects services provided by general practice and local rural hospitals (in localities where these are located).
3. Contracts are developed for integrated locality rural services that clearly set out provider requirements and can demonstrate value for the DHB's investment.

FRANCIS HEALTH

VIRTUAL HEALTH

CURRENT STATE

Waikato DHB has proportionally more people living in rural, remote and deprived areas which poses challenges in service delivery and access to health services. To address these challenges, the DHB has a strategic focus on delivering innovative solutions needed to solve its biggest health care issues which will see a variety of changes in the way that health care and services are delivered. Virtual health will provide the foundations to treat people closer to home, enable more efficient use of clinicians' time, and give people more accountability and control over their own health. Virtual health involves the application of technology within the healthcare setting to improve information flow, service delivery and health outcomes (Waikato DHB Virtual Health Care Strategy Refresh 2018).

This review highlighted clinicians' readiness, particularly in rural areas, to embrace virtual health tools in order to reduce travel for patients, improve access to specialist advice and services, and enable better primary/secondary integration. However, virtual health opportunities were not highlighted by stakeholders in urban areas where services are more accessible and the prevailing model of care is still centred on face-to-face interactions.

Developing a 'virtual front door' to the urgent and emergency care system, e.g. based at Anglesea Clinic, would enhance services to the public. However, this model could challenge the current Urgent Care Centre business model by reducing demand on a sector that already has static patient volumes. Virtual health tools could support a rapid triage process in ED, for low acuity patients, and triaging these patients to primary care treatment options.

RECOMMENDATIONS

1. Explore the development of a 'virtual front door' in an urgent care setting to give patients an alternative to face-to-face consultations. Consider a business model that supports the sustainability of this service.
2. Work with rural providers and locality stakeholders to design a model that enables selected outpatient specialist clinics to be delivered in primary care settings using virtual health.

"Virtual consultations – Oh Yeah! Ridiculous that this isn't being used; patients traveling/taking time of work for an appointment that could have been done virtually".

"Internet speed a real issue in rural areas".

FRANCIS HEALTH

+ In Summary

The current states presents a picture of siloed services working without an overarching framework to guide a system wide approach to service improvement for acute demand. The challenge for the DHB will be to get the connectedness required for primary, community and secondary services to collectively work at improving access to healthcare closer to home for patients and reducing the acute demand on hospital emergency departments.

For Urgent and Emergency care to meet or reduce future demand, identifying an overarching framework inclusive of design principles, service domains, an enabling support structure will guide future development work from a system and locality approach rather than from the current ad hoc reactive approach.

Key stakeholders across the primary, secondary and community providers of urgent and emergency services were interviewed and provided feedback which has been grouped at a locality level. At the same time service data was provided by the DHB, PHO's and after-hours providers to gain an understanding of patient utilisation across the system to be able to compare and contrast as well as looking at trends over time.

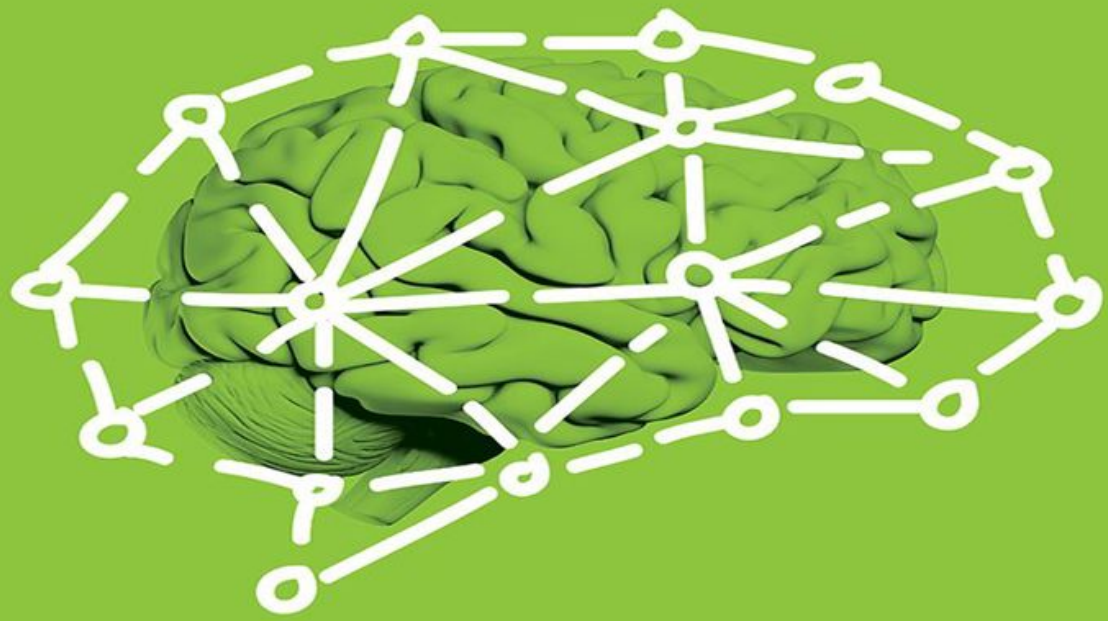
The Emergency Departments in all hospitals and Urgent Care centres across the Waikato had 273,000 presentations in 2018. The growth in presentations over the last 3 years is higher in the hospital EDs, in particular, Waikato (10%), Tokoroa (14%) and Thames (7%). In comparison the number of urgent care presentations per annum are relatively static. In Hamilton, approximately 150,000 (86%) of patients were seen by Urgent Care Centres with 24,000 (14%) Triage 4-5 patients seen in Waikato Hospital ED. This indicates there is a clear need for Urgent Care Centres in the future Hamilton locality model however as recommended it requires closer alignment with the Emergency Department service at the hospital.

Rural localities present a more varied picture with the needs of some populations being met almost completely by primary care while other areas are dependent on Rural Hospital EDs. The future rural response model may look different depending on the health needs of the local population but should be based on the guiding principles as outlined below. Each locality may look different – but where possible there should be consistency and alignment. For example, the patient demographics and health needs in Matamata look very different to those in Taumarunui or Hamilton City, therefore the response model should reflect this.

1. **Accessible** - People know how to access Urgent Care advise and where to find Urgent Care services in their Locality when they need them within reasonable travel times.
2. **Accessible** - Urgent Care providers have access to services and advice appropriate to the patient's needs and the locality care setting.
3. **Sustainable** - Urgent Care services are integrated within the Locality and across the district to provide continuity of care and long tern sustainability.
4. **Sustainable** - Urgent Care services are able to recruit and retain an appropriate workforce that can work across organisational and service silos to maximise capacity and capability.
5. **Integrated** - Urgent Care providers have access to relevant patient information and advice, enabled using technology, at the point of care.
6. **Value** - Urgent Care services are effective and affordable for patients, providers and the DHB.

A number of recommendations are outlined in the report at both a high service domain level and broken down further at a locality level. By working with the principles, the service domains and enabling supports as demonstrate there is a basis to guide the future development of the WDHB urgent and emergency care system. The recommendations at the system and locality level provide both long and short term opportunities to feed into the improved design and management of future acute demand.

+ APPENDICES



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+ Appendix 1 - Design Principles

Service design principles		What locality design teams need to consider
Accessible	People know how to access Urgent Care advise and where to find Urgent Care services in their Locality when they need them	• Availability and location of urgent care services is communicated in many forms in all localities e.g. websites, practices, phone apps e.g. emergency Q • Appropriate care settings are considered for people with urgent care needs (including virtual health) • A consistent patient journey – including a Single Point of Entry at rural hospitals with clear triage guidelines and fees policy • Cost is not a barrier to patient's accessing Urgent Care in the most appropriate setting • Triaging appropriate patients from ED to primary care e.g. the patient's enrolled General Practice or an Urgent Care centre
Accessible	Urgent Care providers have access to services that are appropriate to the patient's needs and the Locality care setting	• Laboratory services • Radiology services • Point of Care testing vs. centralised diagnostics • Pharmacy • GP Beds for local observation & care • Urgent Care observation beds • Primary care treatment options (as an alternative to ED)
Sustainable	Urgent Care services are integrated within localities and across the district to ensure a long term model to provide continuity of care.	• Clinical governance across all Urgent & Emergency Care providers to monitor measures of system and clinical performance • Clinician networks that foster an understanding of the Urgent Care system across professional and organisational boundaries • Joint clinical education that can be accessed virtually by rural practitioners • Seamless patient transfers between all Waikato hospitals • Integrated contracts and funding that focus on achieving outcomes for the Locality (Urgent Care Commissioning)
Sustainable	Urgent Care services are able to recruit and retain appropriate workforce	• Urgent Care staff rotated across different parts of the Urgent Care system to build relationships and systems knowledge • Staff working across organisational and service silos to maximise workforce capacity and capability – particularly in rural settings where there is a shortage of clinical staff • Simplify organisational structures where this is a barrier to local service integration
Integrated	Urgent Care providers have access to relevant patient information and advice enabled using technology, at the point of care	• Electronic clinical notes including recent test results • Patient's clinical history • Active care plans • Relevant clinical information shared across providers • Technology works across all information system platforms
Value	Urgent Care services are effective and affordable for patients, providers and the DHB	• Integrated contracts and funding that focus on achieving outcomes for the need of the locality • Services are integrated in localities where there is high need to help secure the future workforce and improve outcomes for patients that currently interact with multiple services • Historical contractual arrangements are reviewed and future contracts monitored to understand service need and investment

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+ Appendix 2 – Grouped recommendations by locality

LOCALITY	RECOMMENDATIONS
HAMILTON CITY	1. Develop an ED operational framework for triaging low acuity patients to their GP or an Urgent Care Centre. In 2018FY, there were 19,300 Triage 4-5 patients treated in ED that were not admitted (23% of ED presentations or 53 patients per day) that could be targeted for triaging to primary care. This represents an 8.4% increase in Urgent Care Centre volumes and would free-up ED capacity for the growing number of Triage 1-3 patients. 'Triaging to primary care' (TTPC) requires rapid and consistent triage in ED and the ability for ED to facilitate a primary care appointment for the patient - either with their GP or at an Urgent Care Centre. This function could be performed by a primary care doctor and/or nurse, familiar with the primary care network, attached to ED. Direct booking capability will evolve in time. Primary care treatment should not be free to patients. However, options need to be available where patients cannot pay. A TTPC model should be funded directly through Strategy & Funding, rather than through ED's operational budget, to ensure system consistency. The current ED redirection service is funded by ED and only used for peak demand periods. 2. Consider the cost/benefits of continuing to fund the overnight urgent care service provided by Anglesea Clinic. Anglesea currently has 2 patient presentations per hour (average) between 11pm and 6am. ED has 4 patient presentations per hour over the same period (including 1 Triage 4-5). The cost of the Anglesea overnight service is $644,291 p.a. It may be more cost effective to fund a single overnight service and resource ED to provide primary care cover (2 additional Triage 4-5 patients per hour). This model is currently operating in a number of DHBs with PHOs making a financial contribution in recognition of their 24/7 urgent care obligations. Consideration will need to be given to the "mixed message" this option sends to the public (only use ED for emergencies). 3. Explore the development of a 'virtual front door' in an urgent care setting to give patients an alternative to face-to-face consultations. Consider a business model that supports the sustainability of this service. 4. Consider direct admissions to the Acute Medical Unit for stable 'walk-in' medical patients that have been worked-up and referred by their GP. (this is currently being tested as part of BEEM). 5. Explore intermediate care treatment options for St John so ambulance crews can transfer patients to Urgent Care Centres as an alternative to ED. St John currently either treats patients at home or transfers to ED. 6. Scope the cost/benefit for observation beds in Anglesea and the potential impact these could have on transfers to ED (>11 patients per day on average). Anglesea has an observation unit that has not been commissioned due to funding constraints. This unit would require capacity funding rather than fee-for-service. 7. Review Aged Residential Care (ARC) transfers to ED to understand why these numbers have spiked in the past 2 years and patient acuity trends. Consider intermediate care options, including using START and POAC, to better support ARC patients in care settings. 8. Introduce a clinical forum for emergency & urgent care Clinical Directors and senior nurses to support clinical networking and to consider and address system-wide performance issues. Rotate clinical staff across different parts of the emergency & urgent care system so they gain a better understanding of the whole system.

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GROUPED RECOMMENDATIONS BY LOCALITY – cont'

LOCALITY	RECOMMENDATIONS
THAMES / COROMANDEL	1. Audit PHO/practice obligations to provide after-hours urgent care for their ESUs and negotiate local arrangements where the DHB is providing this service for practices. As part of this audit, review the Saturday GP clinic being delivered by Thames Medical Centre in Thames Hospital ED to determine its value and whether this service should be funded by the DHB or Thames Medical Centre as part of an urgent care agreement. 2. Develop an operational framework and policy for the proposed Single Point of Entry (SPOE) at Thames Hospital ED to determine how patients access ED or Te Korowai services on site, or are referred to their general practice. This framework should be consistent across all Localities where general practice is collocated with ED. 3. Scope the opportunity to deliver selected routine outpatients using video conferencing. 4. Explore options with St John to improve ambulance response times (applies to all rural settings where this has been highlighted as an issue). 5. Scope the cost benefit of point of care testing (e.g. Troponin tests) in the rural sub-hub areas. 6. Consider commissioning for services in rural localities to provide more flexibility across contracted services that are delivered through the same workforce. 7. DHB & PHOs collaborate to develop a long term workforce strategy for both Medical & Nursing staff in challenging rural areas to balance both resourcing requirements and service delivery. 8. Consider a more centralised approach, possibly through PHOs, to recruit rural locums to cover peak holiday periods. 9. Explore opportunities to better integrate general practice sub-hub and DHB Community Services in rural sub-localities to improve outcomes for patients that interact with both services.
MATAMATA	1. Continue to support the current urgent care model within the Locality. 2. Consider re-allocating some GP Beds from Te Aroha to a suitable Paeroa provider so these are more accessible to the Paeroa population. 3. Scope the cost benefit of point of care testing (e.g. Troponin tests) in the Matamata sub-hub. 4. Review Te Aroha urgent care utilisation and consider reducing the Monday-Thursday on-call hours from 10pm to 8pm in return for extended clinic hours during the weekends. 5. Explore options with St John to improve ambulance response times (applies to all rural settings where this has been highlighted as an issue).
TOKOROA	1. Implement a fully integrated single service model at Tokoroa Hospital that delivers primary and secondary care including: in-hours primary care, community services, after-hours urgent care and emergency care. This service could be delivered by either a private provider (e.g. the Te Kuiti model) or by the DHB (the West Coast model). A fully integrated single service model will help secure the future workforce and improve outcomes for patients that currently interact with multiple services. This is a long term goal that will need to be planned and implemented with current providers. 2. Develop an operational framework and policy for a Single Point of Entry (SPOE) to determine how patients access general practice services, for which there will be a fee, and free hospital services. This framework should be consistent across all localities regardless of whether GP services are delivered by a private provider or the DHB. 3. Designate the Tokoroa Locality as a special needs area, due to its high deprivation and large Maori population, and offer reduced co-payments or free primary care for certain patient groups e.g. CSC holders. This policy would need to be extended to other general practices within the Locality. 4. Explore opportunities in the short term to better integrate general practice, ED and DHB Community Services to improve outcomes for patients that interact with multiple services. This could include commissioning for services to provide greater workforce flexibility across contracted services. It could also include SPOE for urgent care (although the current layout of Tokoroa Hospital could be a barrier to this). 5. Develop a strategy to improve the use of technology for virtual consultations with secondary services to reduce patients having to travel to Waikato Hospital for outpatient clinics or hospital transfers. 6. Explore how more timely advice from consultants at Waikato Hospital ED could be provided to the rural hospitals to reduce patients having to travel or transfer to Waikato hospital. 7. DHB & PHOs collaborate on recruitment and retention of Medical & Nursing staff to balance both resourcing requirements and service delivery.

GROUPED RECOMMENDATIONS BY LOCALITY – cont'

LOCALITY	RECOMMENDATIONS
TAUMARUNUI	1. Implement a fully integrated DHB-run service model at Taumarunui Hospital that delivers primary and secondary care including: in-hours primary care, community services, after-hours urgent care and emergency care. With the relatively small locality population (7,136), and the high number of ED Triage 4 & 5 presentations (on average 83%), a fully integrated single service model will help to secure the future workforce, provide a sustainable service model and improve outcomes for patients that currently interact with multiple services. This is a long term goal that will need to be planned and implemented with current providers. 2. Develop an operational framework and policy for a Single Point of Entry (SPOE) to determine how patients access general practice services, for which there will be a fee, and free hospital services. This framework should be consistent across all localities regardless of whether primary care services are delivered by a private provider or the DHB. 3. Designate the Taumarunui Locality as a special needs area, due to its high deprivation and large Maori population, and offer reduced co-payments or free primary care for certain patient groups e.g. CSC holders. 4. Develop a strategy to improve the use of technology for virtual consultations with secondary services to reduce patients having to travel to Waikato Hospital for outpatient clinics or hospital transfers. 5. Explore how more timely advice from consultants at Waikato Hospital ED could be provided to the rural hospitals to reduce patients having to travel or transfer to Waikato hospital.
TE KUITI	1. Implement a single nursing workforce that works across general practice, community services and the hospital (i.e. that mirrors the integrated medical service) to reduce duplication, increase workforce flexibility and improve service integration. 2. In the short term explore options to better integrate other services in the current model such as district nursing, public health nurses, clinical nurse specialists to reduce duplication and enhance services in the locality. 3. Develop a strategy to improve the use of technology for virtual consultations and ward rounds with secondary services to reduce patients having to travel to Waikato Hospital for outpatient clinics or hospital transfers. 4. Explore how more timely advice from consultants at Waikato Hospital ED could be provided to the rural hospitals to reduce patients having to travel or transfer to Waikato Hospital. 5. Audit PMHN and Otorohanga Medical Centre's contractual obligations to provide after-hours care for their ESUs as neither Anglesea Clinic or Te Kuiti Medical Centre have any formal arrangement to provide this.
NORTHERN CORRIDOR	1. The DHB and local providers consider a future integrated service model which incorporates primary care, community services, and extended weekday and weekend hours urgent and emergency care into one service hub to support the high need population in this locality. This is a long term goal that will need to be planned and implemented with current providers. 2. DHB and PHOs to facilitate a more coordinated general practice model in Huntly and Te Kauwhata to deliver rostered extended hours general practice and improve patient access to after-hours and urgent care services. 3. Work with PMHN to explore extended week-day hours with Te Kauwhata Health Centre. 4. Review ARC after hours admissions to Waikato Hospital and consider options to better support frail older adults in residential care. 5. Work with CMDHB to jointly plan urgent care services for the growing South Auckland/Northern Corridor population.

MEMORANDUM TO COMMUNITY & PUBLIC HEALTH AND DISABILITY ADVISORY COMMITTEE
10 APRIL 2019

AGENDA ITEM 5.7

REACH (REALISING EMPLOYMENT THROUGH ACTIVE COORDINATED HEALTHCARE)

Purpose	For information

Introduction

REACH (Realising Employment through Active Coordinated Healthcare) is a service established to support clients aged between 18-65 who have been medically excluded from work for between 1 and 3 years. It focuses on helping them return to wellness, achieve work-ready status, and eventually return to employment.

REACH is a voluntary service for clients and their income-support payments are not affected if they decline or withdraw from the programme.

The service uses an interdisciplinary team approach to bring together all of the parties involved in the client's care, so there is a coordinated approach to their rehabilitation.

The service uses a Cognitive Behavioural Therapy approach to support the client to realise personal goals and a return to wellness. The ultimate goal for the client is a return to work or work ready status.

- Clients are identified by the referring agency.
- They are invited to take part but participation is optional.
- People who are invited may have personal challenges, chronic health issues, poor lifestyle choices, possibly domestic issues or have responsibilities caring for others.
- The REACH service works alongside the client and family, referring agency, GP, support person and any other services they're working with.
- Clients are supported to solve problems and change their thinking and behaviours that could be getting in the way of them being independent.
- The type of tasks and activities that people engage in depends on their goals and needs but may include things like exercise to address their pain and build strength, working on odd jobs around the house and preparing a CV. They may also as be supported to access other services, and to become more active in their communities.

Despite the fact that the clients of the REACH service experience some of the most significant barriers to employment and well-being, the service is having some considerable success.

During the initial conversations with Ministry of Social Development these clients were described as having little or no chance of returning to sustainable employment and a figure of only 2-3% returning to the workplace.

So far the team have achieved:

- 22% of clients returning to the workplace and remaining in work for 90 days and longer
- 10% of clients in part time work
- 7% of clients in full time study
- 12% of clients in regular voluntary work

The service works alongside the client's social network and whanau, in order to bring about a change for these clients their whanau need to engage and support. What we have seen evidence of, as a success of the programme, is that friends and whanau have adopted similar lifestyle changes. When one person actively engages in REACH, this leads to an impact on more than one individual in improved lifestyle choices and opportunities.

An overview of the service, its successes and opportunities will be presented to the Committee.

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

28% of the clients that have accessed the REACH service are Māori. Whilst MSD's motivation is a return to the workplace, the core component is a return to wellness that facilitates this. During the development of the service consultation was undertaken and advice provided by Te Puna Oranga. Ongoing advice regarding service delivery has been provided by Disability Support Link's Maori NASC team. While the clients entering the REACH service have the same characteristics and lifestyles that will eventually lead to long term chronic health conditions such as diabetes and COPD. This early intervention aims to prevent the development of these conditions along with reducing presentation to ED.

A randomised controlled trial of the service is underway and will provide evidence of how effective this approach has been.

Recommendation
THAT

The Committee note the presentation

GRAHAM GUY
SERVICE MANAGER

Work Schedule

CPHAC Schedule for 2019/20

February

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

April

- Draft Health System Plan (incorporating the Care in the Community Plan)
- Addressing Urgent and Emergency Care – Findings from the Review
- Te Pae Tawhiti feedback
- Drinking Water Compliance
- REACH

June

- Understanding the Determinants of Health
- Disability Responsiveness Plan
- Dental Health Services Overview – Status of Oral Health
- 2019/20 Annual Plan
- Our approach to Community Engagement and Partnering with Māori

August

- Immunisation – Performance and Service Overview (including HPV update)
- Older Peoples Services – Comprehensive Model of Care
- Disability Support Services – Overview
- Addressing Acute Demand
- Prevention and Management of Long Term Conditions – Diabetes Services Overview

October

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

December

- Mental Health Services – Investment and Service Overview
- Understanding Unmet Need
- Smoking Cessation Plan (refresh)
- Palliative Care
- Other

General Business

Date of next meeting
12 June 2019