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

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	13 February 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:	10 April 2019	
Contact Details:	Phone: 07 834 3622	Facsimile: 07 839 8680

www.waikatodhb.health.nz

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

Waikato District Health Board

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; 12 December 2018
    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 Community & Public Health and Disability Advisory Services Committee; No minutes available. Meeting 7 February 2019

4. **DISABILITY SERVICES**
    4.1 Disability Responsiveness Plan Update

5. **PAPERS FOR DECISION**
    5.1 Review of Position Statements
        • Immunisation
        • Urban Environments
        • Housing
        • Land Transport

6. **PAPERS FOR INFORMATION**
    6.1 Rural Health – A Waikato Perspective
    6.2 Waikato DHB Annual Plan 2019-2020
    6.3 Te Pae Tawhiti Update

7. **PRESENTATIONS**
    7.1 Mental Health and Addictions System

8. **WORK SCHEDULE**
    8.1 Work Schedule for 2019/20

9. **GENERAL BUSINESS**

10. **DATE OF NEXT MEETING**
    10.1 10 April 2019

Apologies

Interests

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

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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	

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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,			

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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

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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 and Public Health Advisory Committee and Disability Support Committee held on 12 December 2018 commencing at 1.00pm

Present: Dr C Wade (Chair)
Ms T Hodges
Ms C Beavis
Mrs P Mahood
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
Dr D Tomic, Clinical Director Primary and Integrated Care
Mr W Skipage, Strategy and Funding
Mrs MA Gill, Waikato DHB Board member
Mr M Gallagher, Waikato DHB Board member

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

ITEM 1: APOLOGIES

Apologies were received from Mr M Arundel, Ms S Mariu, and Mr R Vigor-Brown.

Resolved
THAT
The apologies were received.

ITEM 2: INTERESTS

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

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

ITEM 3: MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

3.1 **Waikato DHB Community and Public Health Advisory Committee; 8 August 2018**

The opportunity of a joint media smoking cessation campaign with Lakes DHB will be explored.

An outcome of the Strategy and Funding Team review was that the Public Health Unit would be subject to a separate review in 2019.

Resolved
THAT
The minutes of a meeting of the Waikato DHB Community and Public Health Advisory Committee held on 8 August 2018 be confirmed as a true and correct record.

3.2 **Lakes DHB Community and Public Health Advisory Committee; 8 August 2018**

Ms P Mahood highlighted agenda item 1.5 of the Lakes DHB minutes regarding the presentation on a very successful immunisation programme.

Resolved
THAT
The minutes of a meeting of the Lakes DHB Community & Public Health Advisory Committee held on 8 October 2018 were noted.

3.3 **Lakes DHB Disability Support Advisory Committee; 5 November 2018**

Resolved
THAT
The minutes of a meeting of the Lakes DHB Disability Support Advisory Services Committee held on 5 November 2018 were noted.

3.4 **Bay of Plenty DHB Combined Community & Public Health Advisory Committee / Disability Advisory Services Committee Members; 3 October 2018**

Ms MA Gill recommended the presentation "First 1000 Days – Unbroken Chain of Care"

Resolved
THAT
The minutes of a meeting of the Bay of Plenty Combined Community & Public Health Advisory Committee / Disability Advisory Services held on 3 October 2018 were noted.

ITEM 4: DISABILITY SERVICES

4.1 Disability Responsiveness Plan Update

The newly appointed Director of Māori Health and Equity (Ms Rachel Poaneki) would be leading the development of the Disability Responsiveness Plan.

Mr D Sloane and Ms J Small were part of the Reference Group. Members suggested the inclusion of conditions such as diabetes and Cystic Fibrosis in the Plan.

Resolved
THAT
The Committee noted the Draft Disability Responsiveness Plan will be brought to the April 2019.

ITEM 5: PAPERS FOR DECISION

5.1 Draft Committee Schedule

A draft committee schedule for 2019/20 was discussed by members with the following inclusions/ changes suggested;

- A deep dive into the effects of dental health. Information to be provided on thresholds for coverage under the public system for over 18 year olds, data on how poverty links with dental health, and consideration of research from areas such as Taumarunui.

- Diabetes to be included under the topic "Prevention and Management of Long Term Conditions. It was suggested Justina Wu provide a presentation. Members requested a whole of system approach be included as part of this topic which should cover how the DHB was working with PHOs.

- Establish which DHB Board/Committee was appropriate to received feedback from other initiatives such as Waikato Plan, Te Pae Tawhiti and the other numerous plans and reviews underway.

- "Our approach to Community Engagement and Partnering with Māori" is scheduled for April to allow time to clarify framework across the organisation. Management suggested this topic could be brought to an earlier committee meeting for open discussion.

Resolved
THAT
The Committee accepted the draft schedule for 2019/20 with the inclusion of the above discussion points.

ITEM 6:   PAPERS FOR INFORMATION

6.1   Immunisation Coverage Update and Actions to Improve Coverage

An update was provided on immunisation coverage and the challenges in addressing improvement. Management acknowledged that whilst some service configuration had been changed, a more holistic approach was required if radical improvement in the health of the most at risk was to be realised. This approach required the vulnerable population to be better identified; and then working alongside the at risk population in a whānau ora way. This should not only include opportunistic activities (like pharmacists being able to immunise) but required the DHB to develop a fundamentally different approach to Māori health. It was expected that the Care in the Community Plan would help identify how this can be addressed in a holistic way.

It was highlighted that a significant amount of babies which are not immunised were not enrolled in a PHO.

Te Puna Oranga had completed some work on Did Not Attend figures which identified that often it was because notification of the appointment had not been received. Consideration should be given to the fact that it may not just be an access issue but rather the way we are engaging with whānau

Further work may be required on identifying vulnerable families.

Resolved
THAT
The Committee received the report.

6.2   Waikato DHB Submission Draft 2018-2028 Waikato Regional Draft Transport Plan

Dr Richard Vipond attended for this agenda item.

The Waikato DHB September submission on the Waikato Regional Council's Draft Public Transport Plan was submitted for the Committee's information.

Of note:
- Mr M Gallagher highlighted his support to encourage Hamilton City Council to provide free transport for people with disabilities.
- The CEO and some board members had met with Waikato Regional Council staff to advance the case for better public transport for patients and staff.
- The geographical area covered by Waikato DHB and Waikato Regional Council differed.
- The inclusion of radical improvements for Māori Health would have strengthened the submission presented and should be included in future all future DHB submissions.

Resolved
THAT
The Committee noted the report.

6.3 **Waikato DHB Submission on Strategy to Prevent and Minimise Gambling Harm 2019/20 to 2021/22**

Mr Richard Wall attended for this agenda item.

The Waikato DHB August 2018 submission on the Strategy to Prevent and Minimise Gambling Harm was reported to the Committee for information.

Of note:

- The relocation of pokie machines was not part of the revised document as it would be considered separately.
- On-line gambling could benefit from further research.

Resolved
THAT
The Committee noted the report.

6.4 **Waikato DHB submission on Healthy Homes**

Dr Richard Vipond attended for this agenda item.

The Waikato DHB September submission on Healthy Homes was submitted for the Committee's information.

It was agreed that item 3.2.3.1 of the submission should be re-worded to note that unflued gas heaters are not acceptable heating devices.

Resolved
THAT
The Committee noted the f the report.

6.5 **Waikato DHB Submission on the Reform of the Residential Tenancies Act 1986**

Dr Richard Vipond attended the meeting for this agenda item.

The Waikato DHB September submission on the Reform of the Residential Tenancies Act 1986 was reported to the Committee for information.

Resolved
THAT
The Committee noted the content of the report.

ITEM 7: PRESENTATIONS

7.1 Review of Waikato DHB Position Statements on Tobacco Control, Alcohol Harm, and Psychoactive Substances

Presented by Dr Richard Hoskins, members were provided with an overview of the purpose of position statements and an updates to three Waikato DHB position statements.

Of note:
- Recognition that the DHB will not achieve the smoke free target on our own by 2025, but was getting closer.
- Vaping outlets can only be controlled if nicotine is being sold.
- Evidence is currently not available regarding the effects of vaping however grave concerns arising regarding moisture being inhaled into lungs.

Resolved
THAT
The Committee noted the presentation.

Mr M Gallagher left the meeting at 2:30pm.

7.2 Waikato Health System Plan (HSP) Update

Presented by Mr Danny Wu, HSP Programme Director, the Committee were provided with an update on the Health System Plan.

Of note:

- The Long Term Investment Plan is due in July but would be updated every two years.
- Due to the collaborative approach used for the HSP, the process has taken longer than normal.
- A draft plan would be brought to the CPHAC members prior to it being publically released.

Resolved
THAT
The Committee received the report.

7.3 Tamariki and Rangatahi Health and Wellbeing

Presented by Dr Damian Tomic, members were provided with an over view of current services and investment in child and youth services by the Waikato DHB.

Of note:
- Data capture only portrays where the population are living not necessarily how the population is made up so would not necessarily identify those with disabilities. It was acknowledged that it is hard to capture what it is that makes a person identify as having a disability especially if intellectual.

- The new public sector reform process currently underway is about joined up services. It was intended that the Health System Plan and Care in the Community Plan would provide this context. It was expected that a whole system approach would be completed for Child Health similar to what Te Pae Tawhiti approach was for Mental Health

Resolved
THAT
The Committee noted the report.

ITEM 8: GENERAL BUSINESS

There were no general business items raised.

ITEM 9: DATE OF NEXT MEETING
13 February 2019

Chairperson: _____

Date: _____

Meeting Closed: 3:40 pm

Disability Services

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
13 FEBRUARY 2019

AGENDA ITEM 4.1

DISABILITY RESPONSIVENESS PLAN UPDATE

Purpose	For information

Strategy and Funding is progressing the work to develop a Disability Responsiveness Plan that will provide direction to achieve our strategic priority to 'remove barriers for people experiencing disabilities'. It is our intention to work in partnerships with consumers and disabled communities in the development of this plan.

A key step in this process was a community stakeholder meeting to jointly develop the aspirations and focus of the plan. The meeting was held at the end of January 2019 with attendees from the Waikato DHB Consumer Council, particularly members involved in the *Disability Roopu* as well as members of the *Disability Core Group* which supports the Consumer Council. Nominated Community and Public Health Advisory Committee (CPHAC) members and Waikato DHB staff attended to contribute and support the day, with appropriate cultural support from Matua Hemi Curtis.

The key directions developed in the workshop are currently being collated and will be shared with workshop participants for feedback during February. The indicative directions will be provided in the verbal report with this paper.

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

It is acknowledged that Māori are disproportionately represented in the disability population and the plan will have a focus on meeting the needs of Māori whānau.

Recommendation
THAT

The Committee receives the report.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

Papers for
Decision

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH COMMITTEE
13 FEBRUARY 2018

AGENDA ITEM 5.1

REVIEW OF POSITION STATEMENTS ON IMMUNISATION URBAN ENVIRONMENTS HOUSING AND LAND TRANSPORT

Purpose	For approval

Background

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

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

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

Several position statements have been reviewed, four are presented today: immunisation, urban environments, housing, and land transport.

Changes since the last review

Waikato DHB Position Statement on Immunisation

Waikato DHB's position on immunisation remains largely unchanged in that it continues an equity focused approach to improve immunisation rates for Māori and Pacific children, and supports the national health target of 95% of infants being up to date with their scheduled immunisations by eight months of age.

Waikato DHB Position Statement on Urban Environments

The DHB's position on Urban Environments has been strengthened to support a stronger focus on productive partnerships and collaborative action to ensure health is taken into account in the planning, build and renewal of urban infrastructure; alongside recognition of the effects of climate change and natural hazards.

Waikato DHB Position Statement on Housing

The DHB's position on Housing has been strengthened to reflect the government's priority to ensure New Zealander's have access to warm, dry homes that are affordable and secure.

<u>Waikato DHB Position Statement on Land Transport</u>

The DHB's position statement on Land Transport has been updated to reflect the change in government direction for land transport which is articulated through the Government Policy Statement[1]. The position statement places stronger emphasis on the value of collaboration in land transport planning and advocates for post-crash care to be embedded into road safety policy at all levels of government as the fifth pillar of the Safe System approach to road safety.

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

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

Recommendation
THAT

The Committee approves the reviewed position statements.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

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[1] The Government Policy Statement for Land Transport prioritises a safer transport system free of death and injury, accessible and affordable transport, reduced emissions, and value for money.

Attachments

1: Immunisation Position Statement
2: Urban Environments Position Statement
3: Housing Position Statement
4: Land Transport Position Statement

POSITION STATEMENT

IMMUNISATION

Introduction

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

Source: NZ Health Strategy (2016)

Immunisation is an effective preventative intervention which reduces burden and suffering, and can potentially eradicate disease.[1]   Increasing regional immunisation rates, as identified within the national health targets, is important because immunisation is a key public and personal health activity. National health targets 2017/18 aim for 95% of infants to be up to date with their scheduled immunisations by eight months of age.[2]

The Waikato District Health Board's Position

The Waikato DHB will:
1. Agree that immunisation is an effective strategy to reduce inequities and will promote initiatives that can help raise the immunisation rates of Māori and Pacific Island children, and those living in areas of deprivation.

2. Support both the National Immunisation Programme and the National Immunisation Register.

3. Support and encourage activities that lead to an increased number of fully immunised people within the Waikato DHB region (i.e. "opportunistic immunisation shall be offered where possible" highlighting the positive effects that integration between services can have on overall immunisation coverage). It is important that children receive their vaccinations on time, as per the New Zealand schedule, in order to provide protection while they are most vulnerable.

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Adopted by Waikato District Health Board: TBC		Page 1 of 3

4. <u>Support employees of the Waikato DHB to comply with the Waikato DHB immunisation policy</u>[1], and not to propagate information that conflicts with the Waikato DHB immunisation policy. The organisation will actively seek to distribute accurate information on immunisation and vaccine preventable diseases to the community.

5. <u>Support the continuation of the making of submissions</u> to all levels of government and organisations as appropriate to ensure opportunities to optimise health, wellbeing and equity outcomes at the population level, occurs.

Key information

The World Health Organisation states that immunisation is one of the most successful and cost effective ways of preventing disease and improving health.[1] Immunisation works by utilising the natural defense mechanisms of the body - the 'immune response'. Once the immunised person's resistance has been built up against a disease, if in future they come in contact with the disease their immune system will be more resilient against that disease.[3] Immunisation can provide protection for the individual and the community.

In New Zealand, vaccines that are a part of the national immunisation schedule[2] contribute to New Zealand's National Immunisation Programme which offers free vaccinations to people from eligible groups[3].

Targeting historically low immunisation rates among Māori and Pacific Island children over recent years saw marked improvements. However, there are current concerns that inequity in coverage based on ethnicity is increasing.[4]

Investing in outreach services has improved coverage among those living in deprivation. Improving immunisation rates in these groups will help prevent disease and reduce health inequalities [3]. Some inequity remains regarding coverage at 8 months and lower levels of immunity among those aged 10-29 years of age is associated with recent outbreaks of measles and mumps in the Waikato and nationally.

New Zealand has a computerised information system: The National Immunisation Register (NIR). The NIR holds immunisation details of New Zealand children born after birth cohort June 2005, as well as children immunised with the MeNZB™ vaccine and/ or Human papillomavirus (HPV) vaccine as part of the Meningococcal B and Human papillomavirus Immunisation programmes.

The NIR is a key tool that assists New Zealand to monitor and improve its immunisation rates, helps to ensure immunisations are given at appropriate times and enables authorised health professionals to quickly and easily find out what vaccines a child has been given (this includes children from families that are more mobile, or accessing multiple healthcare providers). [5]

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[1] Waikato DHB Immunisation Policy. Retrieved from
https://intranet.sharepoint.waikato.health.govt.nz/site/pol/published/Immunisation.pdf#search=DHB%20immunisation%20policy
[2] A list of the vaccines that are a part of the national immunisation schedule are available at :
http://www.moh.govt.nz/moh.nsf/indexmh/immunisation-schedule
[3] Eligible groups are different for each vaccine.

Date Issued: November 2017	Review date: June 2020	Version 1.0
<mark>Adopted by Waikato District Health Board: TBC</mark>	Page 2 of 3	

References

[1]   World Health Organisation, "Immunization," Retrieved from the World Organisation website http://www.who.int/topics/immunization/about/en/index.html, 2009.

[2]   Ministry of Health, "Health Targets: Increased Immunisation. Retrieved from the Ministry of Health's website https://www.health.govt.nz/new-zealand-health-system/health-targets/about-health-targets/health-targets-increased-immunisation." 2018.

[3]   Ministry of Health, "Immunisation. Retrieved from the Ministry of Health wesite https://www.health.govt.nz/our-work/preventative-health-wellness/immunisation" 2018.

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Waikato District Health Board

Position Statement

URBAN ENVIRONMENTS

Introduction

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

Figure 1: NZ Health Strategy (2016)
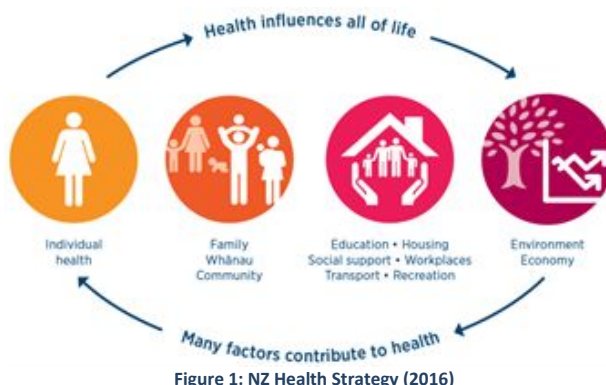
The way we plan our cities and towns affects the health of New Zealanders. There is a strong link between urban design and aspects of poor health that place disproportionate burden on our communities and health services. Cities and towns can be designed in ways that will improve health and reduce demand for health service costs.

The Waikato DHB is committed to reducing health inequities and supports urban environment improvements that are effective in this regard for key people including Māori, people with a disability, and those living in rural parts of the Waikato DHB area.[1]

Waikato District Health Board's Position

The Waikato DHB will:
1. Develop and support formal collaborative approaches to planning and policy development across all levels of government and iwi at governance, management and operational levels where there is potential to maximise health gain, reduce inequalities, and realise co-benefits for all. This aligns with the Health in All Policies Approach recognised by the World Health Organisation. This includes engagement with key stakeholders at an early stage of planning, and providing public health advice and evidence as required to optimise environmental conditions.

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2. <u>Advocate for and support neighbourhood characteristics and design that are most consistently associated with decreased non-communicable disease risk factors</u>. These include to:
   o increase residential density and provide multiple transport choices for improved liveability,
   o provide greater green space to enable improved physical and mental health outcomes,
   o improve access to essential social services such as schools and supermarkets,
   o optimise land-use mix e.g. mixed land use planning which can reduce vehicle kilometres travelled,
   o enable social capital and create places for social interaction,
   o improve walking and cycling and public transport infrastructure and services, and transport accessibility to enable access to essential services for all, and
   o improve urban environment design, quality, amenity and safety.[2, 3]

3. <u>Work with other sectors to ensure access to health and other essential services is not compromised</u> in urban environment planning processes.

4. <u>Raise awareness of and provide information and evidence to help ensure communities in urban environments are less vulnerable and more resilient to natural hazards, and the effects of climate change</u>. Globally and locally, the negative impacts of climate change will be disproportionally borne by the poor and the vulnerable. The human health impacts and health co-benefits of climate mitigation strategies are well documented in the literature.[4, 5]

5. <u>Support and promote the use of the impact assessment tools</u> to support the development of urban environments that promote good health, and to enable community participation in urban environment policy development and planning.[6]

6. <u>Support the continuation of the making of submissions</u> to all levels of government and organisations as appropriate to ensure opportunities to improve population health, wellbeing and equity outcomes are optimised.

Key information

Urban environments are a key determinant of health and wellbeing. The determinants of health are the social factors and physical conditions in the environment that influence where people are born, where they live, learn, play work and age; the opportunities they have and the choices they make. These circumstances are shaped by how money, power and resources are distributed at the global, national, regional and local levels and can contribute to health inequities.

Although genetics and personal behaviour play a strong part in determining an individual's health, up to half of what affects this is determined by our social and physical environment.[2]

Identified public health risks associated with sub- optimal urban environments include a lack of integrated land use and transport planning which limit opportunities for physical activity and safe recreation which in turn lead to declining rates of physical activity and increased chronic disease risk e.g. heart disease.[3]

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Positive impacts on health and overall wellbeing or mental wellbeing can come from provision of and access to greenspace, and improved social connectedness. Land use mix can result in issues related to general access to public amenities. Proximity between home, work and community services can also impact on health.[7]

Poor health outcomes, associated with the urban environment, can lead to economic and social costs. A study completed in 2016 identified that physical inactivity in the Auckland, Waikato and Wellington regions, where about half the country's population live, costs $648 million a year, of which Waikato accounted for $106 million.[8]

We have growing evidence about the long-term life costs as our population grows and/or ages and is exposed to health risks associated with an unhealthy urban environments, especially in regard to chronic conditions such as diabetes and heart disease. Improved health is strongly linked to sustainable development. Many interventions which promote better human health at the same time also promote better environmental health.[3]

The major influences on the health of people in communities lie outside the health sector. Given this, productive partnerships within and outside of the health sector is a Waikato DHB strategic imperative. As part of our strategic commitment to productive partnerships/whanaketanga, we will work alongside other organisations that plan and develop urban environments to identify shared agreed goals that help protect and improve community health and wellbeing outcomes.[1]

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Waikato District Health Board   **Position Statement**

HOUSING

Introduction

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

Source: NZ Health Strategy (2016)

Housing is a key determinant of health, and inequities. To deliver optimal health and wellbeing outcomes, houses need to become homes that are warm, dry, affordable, secure and meet the needs of people of all ages, ethnicities, and levels of disability.

The public health risks and benefits associated with housing and housing policy are broad and complex [1].

The Waikato DHB is committed to reducing health inequities and supports housing improvement that is effective in this regard for key populations including Māori, people with a disability, and those living in rural parts of the Waikato DHB area [2].

The Waikato District Health Board's Position

The Waikato DHB will:

1. Advocate and support the position that the quality, affordability, safety, and suitability of housing and security of housing tenure are all key determinants of health and wellbeing outcomes, and important mediating factors in reducing health inequities [3], [4] [5].

2. Recognise the responsibility Government has in improving housing availability, affordability, and suitability, especially for Māori as outlined in te Tiriti o Waitangi provisions [6].

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3. <u>Recognise</u> that greater investment and more comprehensive housing policy is needed to improve housing quality, affordability, safety and suitability particularly targeting those at highest public health risk [7].

4. <u>Advocate for and support</u> the position that Māori, Pacific peoples, older people, children, those with pre-existing medical conditions and people with disabilities are at higher risk of negative health impacts associated with poor quality housing or housing insecurity [8].

5. <u>Advocate for and support</u> evidence-based initiatives and existing programmes that improve housing quality standards, as well as access to suitable and affordable housing, particularly where they target those at highest public health risk, and help address issues associated with housing [9].

6. <u>Advocate for and support</u> planning for housing that allows residents/future residents to walk, cycle, or travel by public transport to work, services, and amenities [10].

7. <u>Advocate for and support</u> the provision of affordable, quality and secure social housing for populations at higher health risk such as Māori, Pacific peoples, the homeless, elderly, low income families, and people with disabilities [11].

8. <u>Advocate for and support</u> education for home owners and tenants about health risks associated with housing including the benefits of maintaining a healthy home and effective management of housing-related costs [12].

9. <u>Advocate for and support</u> the position that housing quality, affordability, safety, and suitability initiatives can be cost-effective measures to improve population health and reduce avoidable hospital admissions [13].

10. <u>Advocate for and support</u> recognition by local and central government of the importance of housing to community health and wellbeing.

11. <u>Support</u> the continuation of the making of submissions to all levels of government and organisations as appropriate to ensure opportunities to improve population health, wellbeing and equity outcomes are optimised.

Key information

Housing is a key determinant of health and wellbeing [14]. The determinants of health are the social factors and physical conditions in the environment that influence where people are born, where they live, learn, play, work, and age; the opportunities they have and the choices they make. These circumstances are shaped by how money, power, and resources are distributed at the global, national, regional, and local levels and can contribute to health inequities [15].

The social and physical environment in general and housing in particular are significant determinants of health, along with a person's genetic makeup and personal behaviour [16].

The concept of a healthy home brings together three key aspects: the physical conditions of the house, the suitability and security of the house for its occupants, and the affordability of owing and running the house. Evidence identifies housing as a significant determinant of our health and wellbeing.

Unhealthy homes can impact on health in many ways. Poorly maintained houses increase the risk of injury, and cold, damp, and mouldy homes are associated with illnesses such as asthma, respiratory infections, anxiety, and depression [17]. Additionally, cold indoor

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temperatures (below 18°C) increase the risk of acute cardiovascular events [18]. When hazardous physical conditions or injury risks are present in a home the health of its inhabitants can be affected in both the short and long term [19]. Household crowding increases the risk of infectious disease transmission [20].

New Zealand-based research has shown that improving housing quality improves self-rated health and self-reported wheezing, and reduced days off school and work, visits to general practitioners, and hospital admissions for respiratory conditions; for children with asthma, it significantly reduced their symptoms, days off school, and healthcare visits [21].

We are aware that many people in the Waikato do not have access to suitable, safe, warm, dry, affordable, and secure housing; all of which are essential for physical and mental health and wellbeing. The high cost of housing is leading to household crowding, increased risk of infectious disease transmission, and increased rates of homelessness. The 2013 Census found that New Zealand has the highest rate of homelessness across OECD countries [22].

In particular, we acknowledge the effects that pressures on housing can have on Māori and other groups at higher risk of poor and inequitable health outcomes. These groups are likely to have higher negative health impacts related to housing e.g. higher rates of rheumatic fever [23]. This could be in part due to Māori being more commonly affected by issues related to housing insecurity and overcrowding.

Whare Ora is one of nine Healthy Homes Initiatives in New Zealand and operates within Waikato DHB district boundary. The programme brings together multiple agencies to create safe healthy warm homes for children and whanau. Key components of the Whare Ora Programme are Advocacy, Healthy Home education, and Intervention supply and coordination (insulation referrals, beds, bedding, curtains, handy man services, on referral services etc). In 2015 only five of the 400 children in the Whare Ora Programme who were admitted to hospital returned the following year[1].

A crucial part of Government, local government and third parties responses must focus on helping more people from high need population groups such as those highlighted into housing that is suitable, safe, warm, dry, affordable, and secure (including security of tenure). There are opportunities to partner with third party organisations and/or iwi in this [24].

Crowded, cold, damp, and unaffordable housing can affect physical and mental health and wellbeing [25]. However, housing interventions such as the Warm-up New Zealand Heat Smart Programme and Healthy Housing Programmes have shown promising results in improving health and reducing avoidable hospitalisations. An economic evaluation of the Warm-up New Zealand Heat Smart Programme revealed that implemented housing interventions demonstrated a benefit-cost ratio of 3.9 [26]. Furthermore, having secure housing tenure and housing that enables connection with local community promotes and supports mental health and wellbeing.

Conclusion

Waikato DHB recognises the importance of working alongside other sectors to optimise housing. We will work alongside and support local government and other organisations in initiatives aimed at improving population health and wellbeing and equity outcomes through housing policy development, planning and implementation.

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Position Statement

LAND TRANSPORT

Introduction

The following is a position statement on land transport prepared by Population Health for the Waikato District Health Board (Waikato DHB).

Transport is a key social determinant of health whose influence on public health is much broader than the traditional considerations of noise and air pollution. Transport policy plays a key role in combating sedentary lifestyles by reducing reliance on cars, increasing walking and cycling, expanding public transport options and improving post-crash care.

The Waikato District Health Board's Position

The Waikato DHB will:

1. Support the Government Policy Statement on Land Transport through its four key priorities; a safer transport network free of death and injury, accessible and affordable transport, reduced emissions, and value for money.[1]

2. Advocate for post-crash care to be embedded into road safety policy at all levels of government as a fifth pillar of the Safe System approach to road safety.

3. Recognise that land transport policy ensures all people have equal opportunity to fully participate in life through access to the goods, services and social services

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they need through transport, can create positive health and wellbeing outcomes and reduce inequalities via access to the determinants of health.

4. <u>Support a broad range of initiatives through continuous effective collaboration, strong governance, and collective advocacy</u> to create a transport system that better promotes and protects all of the people of its region.

5. <u>Advocate for and support equity in transport planning</u> to ensure people living in rural communities have a range of travel options available to them so they can access a full range of health services and attend appointments including specialist appointments.

6. <u>Advocate for and support transport policy</u> that reduces barriers for people experiencing disability.

7. <u>Support transport policy</u> that provides safe active transport options that increase opportunities for and levels of physical activity.

8. <u>Mitigate indirect health hazards related to transport such as air and water quality pollution, emissions and noise</u>.

9. <u>Provide for the safety of all staff and others specifically authorised to drive Waikato DHB provided vehicles</u> through a comprehensive policy aimed at enhancing the reputation of the DHB, encouraging good driving such as prohibiting speeding, and complying with relevant legislation.

10. <u>Reduce our transport-based carbon footprint</u> where possible by promoting and resourcing active transport in the workplace, and exploring means of providing staff with public or group transport options to mitigate solo vehicle occupancy.

11. <u>Support the continuation of the making of submissions</u> to all levels of government and organisations as appropriate to ensure land transport investment is equitable and inclusive.

Key Information

Legislative overview

The Land Transport Management Act 2003 (LTMA) provides the principle legal framework for managing and funding land transport activities. The purpose of the LTMA is to contribute to the aim of achieving an affordable, integrated, safe, responsive and sustainable transport system. [2]

Under the LMA, the Government's strategic transport priorities are set out in a number of documents including the Government Policy Statement on Land Transport (GPS) and Safer Journeys 2010-

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2020. The GPS on Land Transport guides land transport investment for a 10-year period.[1] National priorities help to guide the regional policy direction and investment priorities for road safety.

The Waikato Regional Road Safety Strategy 2017-2021 sets out a framework for the coordinated delivery of multiple agency interventions to reduce deaths and serious injuries on the Waikato region's transport network.[3]

Transport impacts on health

Access to goods and services

Transport is critical to participation in society. Transport policy and planning decisions impact every aspect of our lives. Transport enables people to be mobile and to access the goods and services they need for their day-to-day living. Goods and services include workplaces; shops and markets; educational and health facilities; leisure and sport facilities, and places of worship. Those with limited access to transport are likely to experience multi-dimensional disadvantage including poor health outcomes, social exclusion, isolation and reduced wellbeing.[4]

Land transport policy that targets communities with limited access can create positive health and wellbeing outcomes and promote a reduction in inequalities. Key strategies that can improve equity in transport planning include providing more system diversity to increase travel options for those disadvantaged through age, impairment and/or location, and giving a broader range of community stakeholders more influence and say in transport planning opportunities.[5] More than 925,000 working age New Zealanders have a disability/disabilities.[6]

Safety

Road safety has become one of the government's top transport priorities articulated through the Government Policy Statement 2018/19-2027/28; the Safer Journeys Strategy 2010 - 2020[1], and the operative Waikato Regional Land Transport Plan 2011-2041.

Road traffic injury is one of the leading causes of premature death and disability in New Zealand. [7] Provisional figures from the Ministry of Transport show that as at 9 January 2019, there were 379 road deaths from 333 fatal crashes in 2018. This is the worst annual figure since 2009 when 384 people died on our roads.[8]

Road safety in the Waikato region is a nationally significant issue with road deaths and serious injuries accounting for nearly 20% of the national toll each year at a social cost well in excess of $500m per year. [3]

The Waikato region is among the worst for all regions in terms of the average total number of all and fatal and serious crashes by year.[9] In the five-year period between

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[1] The Ministry of Transport is currently leading the development of a new 10-year road safety strategy with a focus on measureable targets, outcomes and performance measure and be developed alongside an action plan that considers interventions from across the road safety system. The government is investigating setting a target of 'zero road deaths'.

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2011 and 2015, more people died on Waikato roads than in any other region; 280 fatalities compared with 228 in Auckland, 202 in Canterbury, and 134 in Manawatu/Whanganui.[9] In 2018, 67 people died on Waikato roads.

The direct cost of road crash trauma to Waikato DHB in 2017 was $4.96 million.[10]

The five-pillar approach to improving road safety

Improving the outcome of crash victims by facilitating their journey from the crash site to the hospital door has become a global topic of road safety discussion for the past decade.

The World Health Organisation and United Nations promote post-crash response as one of the five pillars of the Global Plan for the decade of action for road safety 2011-2020. In New Zealand, post-crash response is being discussed in road safety circles as the proposed fifth pillar of the Safe System approach to road safety.[11]
New Zealand's Safe System approach delivers road safety in four quadrants; safe roads, safe speeds, safe vehicles, safe road users.[12]. The Safe System approach does not include the 5th pillar of road safety; post-crash care.

There is a significant population burden from death and injury due to road traffic crashes. Nationally, 52% of injury between 2016 and 2017 resulted from road traffic crashes. Midland region has the highest rates of road traffic related injuries; 62% compared with 51% in the northern region; 48% in the central region and 50% in the southern region.[13]

Time is recognised as an important variable in patient survival. Nationally, 65% of patients were transported from the scene to the first hospital within two hours. Thirty-five percent of patients within the Midland region were transported from the scene to a hospital between 1 and 2 hours.[13]

The National Road Safety Strategy 2020-2030 is currently under development and affords an opportunity for the fifth pillar of road safety (post-crash care) to be embedded into the Safe System approach.

Waikato regional transport stakeholders have developed an agreed advocacy position and recommend post-crash care be embedded into the National Road Safety Strategy 2020-2030.[14]

Physical activity

One of the major health impacts of transport policy is its relationship with physical activity. The public health gain is likely to be substantial if people are encouraged to participate in 30 minutes per day of moderate physical activity such as walking and cycling as their daily means of transport.

Frank et al (2004) reports that each additional hour spent in a car is associated with a 6% increase in the likelihood of obesity. Conversely, each additional kilometre walked per day is associated with a 4.8% reduction in the likelihood of obesity.[15] Physical inactivity, after smoking, is the second most important risk factor for ill health in

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industrialised countries and is related to around two million deaths per year worldwide.[16]

The cost of physical inactivity in the Waikato region was around $106 million. The cost for New Zealand as a whole was estimated at $1.3 billion or 0.7% of total GDP in 2010. [17]

Policies that encourage increased safe use of active transport have the greatest impact of all transport related strategies on the health of the population.[18]

Public Transport

Public transport plays an important role in developing environmentally and socially sustainable means of travel. Good access to public transport can also influence an increase in active transport as most trips on public transport begin and end with a period of walking. A US study found that 29% of those using public transport achieved the recommended 30 minutes of physical activity daily as a result of walking to and from public transport.[19]

Emissions

Degraded air quality has a negative impact on public health. The primary air contaminant of concern nationally, and within the Waikato region, is small airborne particles known as PM_{10}. PM_{10} signifies particles less than 10 microns in size, which are easily inhaled into the lungs resulting in adverse health effects such as restricted activity days and premature death. Those most at risk include the elderly, children, infants and those with pre-existing respiratory conditions and/or cardiovascular disease. [20]

Approximately 85% of the degraded air quality in the Waikato region is attributed to domestic home heating sources. Motor vehicle emissions, outdoor burning and industry contribute the rest. [21]

Motor vehicles produce carbon dioxide, a major greenhouse gas which contributes to global climate change. Agriculture was New Zealand's largest greenhouse gas emitting sector in 2016, contributing 49.2% of total emissions or 38.7 million tonnes of carbon dioxide equivalent ($MtCO_2$-e). Energy emissions (transport and electricity production) is the second largest contributor of New Zealand's gross emissions contributing 39.8% to total emissions or 31.3 million tonnes of carbon dioxide equivalent.[22] The potential health impacts of climate change in New Zealand include the effects of floods, storms and droughts, as well as an increased risk of gastrointestinal disease and vector borne disease. New Zealand's transport related greenhouse gas emissions are small in comparison to many other countries, however global cooperation of all countries is required to prevent climate change.

The government has progressively introduced measures to reduce the health and environmental impacts of vehicle emissions. Significant measures include amending the Vehicle Exhaust Emissions Rule in 2012 and investigating the impacts of vehicle age on safety and level of harmful emissions.[23]

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Noise

Noise is known to have an adverse impact on health, particularly for communities close to major traffic routes, airports or noisy industries.[24] Health impacts can include impaired communication, disturbed sleep, impaired school and work performance, annoyance, aggression and depression.[25] To help ensure transport noise is managed in an effective and efficient manner Standards New Zealand developed a Road Traffic Noise Standard (*Acoustics-Road Traffic Noise-New and Altered Roads NZS 6806:2010*) with support from NZ Transport Agency and the Ministry of Transport. The Ministry of Health was part of a wider committee involved in drafting the standard.[23]

Summary

Transport is a key social determinant of health whose influence on public health is much broader than the traditional considerations of noise and air pollution. Transport policy can play a key role in combating sedentary lifestyles by reducing reliance on cars, increasing walking and cycling, expanding public transport options and improving post-crash care.

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Papers for Information

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH COMMITTEE
## 13 FEBRUARY 2019

AGENDA ITEM 6.1

RURAL HEALTH – A WAIKATO PERSPECTIVE

Purpose	For information and discussion

Background

The Waikato DHB Strategic plan has a number of priorities including radical improvement in Māori health outcomes and secondly to eliminate health inequalities for people in rural communities. This paper is focussed on the issues facing rural communities within the Waikato District health Board. Some of these inequities are inextricably linked with Māori health inequity – proportionately more Māori live in rural areas and the age structure for Māori and non-Māori in rural areas is very different. We know that on many measures rural Māori have poorer health outcomes than their urban counterparts. However, this paper is principally focussed on the needs of rural communities.

Figure 6: Rural Māori and non-Māori age distributions, 2006
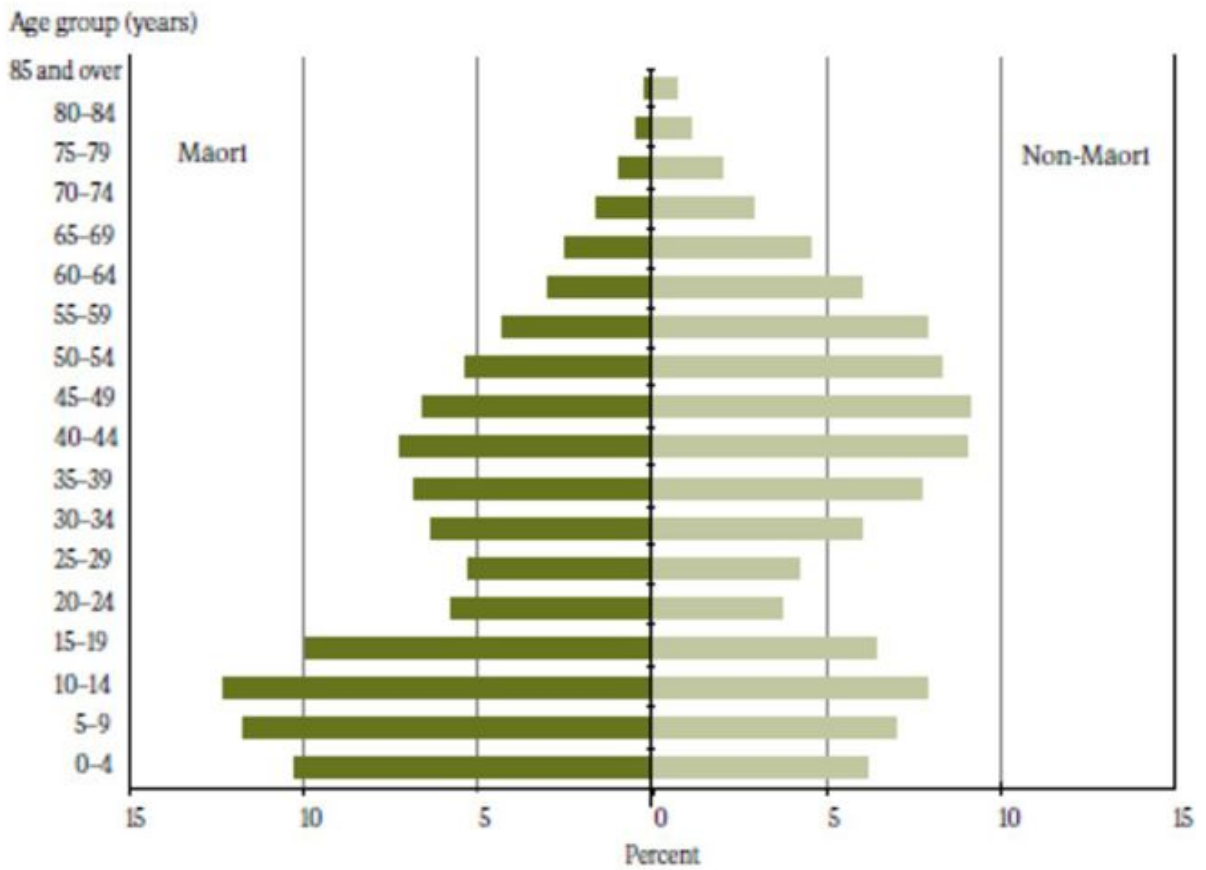
Source: Estimated resident population at 30 June 2006, Statistics New Zealand

What do we mean by rural?
The National Health Committee noted that many DHBs had challenges in co-ordinating and delivering health and disability services for rural communities. (NHC 2010) There is no agreed definition of rural - it depends on the context (Fearnley 2016). Within health, it usually refers to the locality of residence or in some situations where people access their health care. In popular understanding rurality is a locality – a place where there are few houses, narrow roads which may not be sealed, little infrastructure – rural houses do not have reticulated water or sewerage, may not have mains power or internet access. Rural people are traditionally involved in in primary industries – farming, forestry and fisheries. However today with better roading and wider access to the internet we are seeing urban workers living rurally and commuting, IT workers living and working from home in a rural environment, wealthy retirees or former urban people living on benefits, moving to rural locations for cheaper housing. Therefore to be able to understand rural health demands we need to understand not only issues around distance from residence to health care services, or issues about infrastructure but we also need to understand more about the people living rurally and their health care needs. Traditionally New Zealand defined rurality based on population density. Communities were defined on their size with rural centres being those with populations of 300-999 population. (Fraser 2006) In 2003 NZ stats changed their urban/rural definitions to 3 urban and 4 rural categories. Rural communities were defined not just on their size but also other influences e.g. rural communities close to urban conurbations were defined as "rural with high urban influence" e.g. Tamahere or Ngahinapouri. (NZ Stats) Urban communities were defined as either main urban communities (greater than 30,000 people) or satellite urban communities e.g. Huntly, which were classified differently to independent urban communities e.g. Te Kuiti or Matamata based on populations of 1000 to 29,999. The health status of these different definitions of urban or rural communities have been compared. Generally those living in rural communities with high urban influence generally have the best health status, while independent urban communities often have the worst health status. (Matatuhi Tuawhenua 2012)

Table 11: Disability prevalence, Māori and non-Māori, by age and urban/rural area, 2006

| Age group (years) | Percentage of population group with a disability | | | | | |
| | Māori | | | Non-Māori | | |
	Main and satellite urban	Independent urban	Rural	Main and satellite urban	Independent urban	Rural
0–14	14.0 (12.4–15.6)	16.6 (13.0–20.2)	12.4 (9.2–15.7)	9.0 (8.1–9.9)	12.4 (9.5–15.4)	8.8 (6.9–10.7)
15–24	7.7 (6.0–9.3)	15.4 (10.1–20.8)		4.9 (4.1–5.7)	17.4 (13.1–21.6)	5.5 (3.4–7.6)
25–44	15.3 (13.5–17.1)	19.0 (14.1–23.9)	16.5 (11.8–21.2)	8.0 (7.3–8.7)	15.8 (13.0–18.6)	10.7 (8.8–12.6)
45–64	26.6 (23.2–29.9)	35.6 (27.5–43.6)	26.2 (19.6–32.8)	17.7 (16.6–18.8)	27.2 (23.8–30.6)	21.2 (18.7–23.7)
65 and over	43.0 (34.1–51.8)	58.5 (39.7–77.4)	48.9 (32.8–65.0)	39.9 (37.5–42.3)	43.2 (38.0–48.5)	43.6 (37.5–49.7)
All ages	16.1 (15.1–17.1)	22.3 (19.7–24.8)	16.9 (14.6–19.2)	14.4 (13.9–14.9)	24.2 (22.4–26.1)	16.7 (15.4–18.0)

Source: 2006 New Zealand Household Disability Survey, Statistics New Zealand

Notes: Percentages are crude, not adjusted for age.

Where data are not presented, the data were suppressed due to low numbers.

However there are differences also based on socio-economic status or ethnicity. So understanding the health status of communities needs to take into accounts not only rural location, but importantly other factors such as occupation, socio-economic status and ethnicity. Currently the University of Waikato is developing new methodologies for measuring the health needs of Waikato communities based on spatial equity (Whitehead J. 2018) Of course another difference between rural and urban communities is the health care they receive. Traditionally general practitioners have been defined as urban or rural by a ranking score based on a distance from hospital services, size of the practice, the delivery of out of hours care etc. In 2016 the Ministry rural ranking measures were re-defined by agreement at a local level meaning there is variation between DHBs and even between PHOs. Within the Waikato we have been working on defining health localities based around health service provision and community. In four of these localities the focus is a DHB rural hospital.

Are rural patients disadvantaged?
Access
Much of the discourse on rurality is based on the concern that rural communities are disadvantaged. The principal concern is access to services. Those living at a distance from health services are expected to be disadvantaged. For instance the understanding of the "golden hour" in emergency care is well recognised. (Trauma guidelines 2012) However the sort of emergency that requires action within 60 minutes is rare and the proportion of the population in New Zealand who live more than an hour from health care is very small. Within the Waikato the DHB have ensured that communities in Ruapehu, Waitomo, South Waikato and the Coromandel have access by providing 24/7 emergency departments. These provide free access to care and ensure there is out of hours cover for these communities. These hospitals also provide a number of other services. They support the retrieval service (air and road ambulance) to Waikato Hospital for high acuity patients requiring complex/secondary/tertiary care, they offer a range of speciality clinics for outpatients with visiting senior doctors and they have general laboratory and radiology diagnostics. They also provide for the repatriation of rural patients from Waikato Hospital to a hospital closer to their own community for further care before discharge. However north of Hamilton there is no out of hours provision between Hamilton and our northern boundary with Counties Manukau.

There is also variation in services that are available to rural communities. For instance some diagnostic services are only available in Hamilton, or in selected communities. Thus CT is available in Hamilton and Thames, access to ultrasound has been variable especially in the south, patients in Te Kuiti and Te Awamutu can access X-rays locally but not patients in in Raglan or Huntly.

Deprivation
While rural location plays a major role in determining the nature and level of access to and provision of health services rurality per se does not necessarily lead to rural-urban disparities. Rather it may exacerbate the effects of socio-economic disadvantage, ethnicity, poorer service availability, higher levels of personal risk and more hazardous environmental, occupational and transportation conditions (Smith KB. 2008). Programs to improve rural health will be most effective when based on policies which target all risk determinants collectively contributing to poor rural health outcomes. The Waikato ranks 11th out of 16 regions as regards social deprivation. Within the Waikato it is some of our rural communities that are the most deprived. Indeed South Waikato is the 4th most deprived community in the North Island of New Zealand. On the other hand rural communities with high urban influence such as Waipa is our least disadvantaged community although many residents would consider themselves as rural.
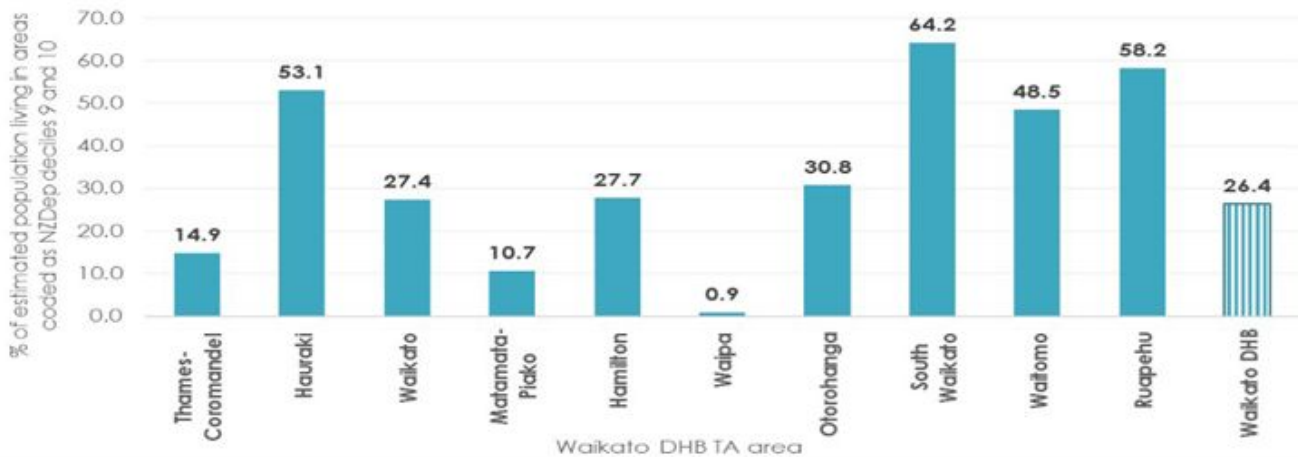
The NHC report noted that rural communities were less likely to have safe drinking water supplies than urban communities. This is not just an issue for households – many rural schools and rural Marae rely on unsafe water sources. The NHC report noted that over all fourteen per cent of the NZ population were being supplied with water that failed to comply with microbiological standards. Dust, agricultural spray-drift, bird droppings and other risks were cited as widespread in areas relying on rooftop supply for potable water; other risks to rural health included faecal contamination due to poor sewage systems (reported as common in areas of substandard rural housing) and contamination of waterways by agricultural nutrients (NHC 2006).

Transport

Transport is an ongoing problem for rural patients. There is very limited public transport available in rural areas. Those who have transport have the costs of accessing services. These can be considerable – Fearnley noted that an outpatient appointment in base hospital cost a patient an average of $732 while a local consultation at the rural hospital only cost $182. (Fearnley 2018) It can be expected that our far distant rural patients experience similar costs. We note that the DHB do spend a considerable amount on supporting transport options for patients needing hospital outpatient services. However in many situations the funding is a re-imbursement requiring up front costs that may not be affordable especially for the socio-economically disadvantaged.

Use of technology

There has been a paradigm shift in the way many communities access goods and services (internet banking, on-line shopping for example), which has been very disruptive to many businesses. This has also opened up opportunities for rural communities and the disruption to health care by the digital environment will be no different. We need to be mindful however that there is the potential for increasing inequity in digital healthcare delivery secondary to issues of difficulty of access (either due to socio-economic disadvantage, digital literacy, or physical access to an internet connection). This has been defined as the "digital divide". In order to fully utilise the increasing opportunities that Digital Healthcare will bring it will be important to recognise and address this divide. Waikato DHB has invested in a number of health technology

interventions to improve access to health care for rural and high needs populations. It is suggested that this remains a focus. Projects such as remote support for hospice patients, a virtual geriatric ward round at Thames Hospital, or rural health education sessions provided for rural general practices through video conferencing have all proved successful. We do believe that to ensure such initiatives are sustained that they need to be properly evaluated.

Workforce
Rural GPs
In the Midland region the number of GPs per patient in rural communities is half that of Hamilton. From the National GP survey it is estimated that 93/346 Waikato GPs intend to retire in the next 5 years. 65% of GPs registered in the last 3 years in our region have been international graduates as we are not training sufficient numbers locally (MCNZ 2018).
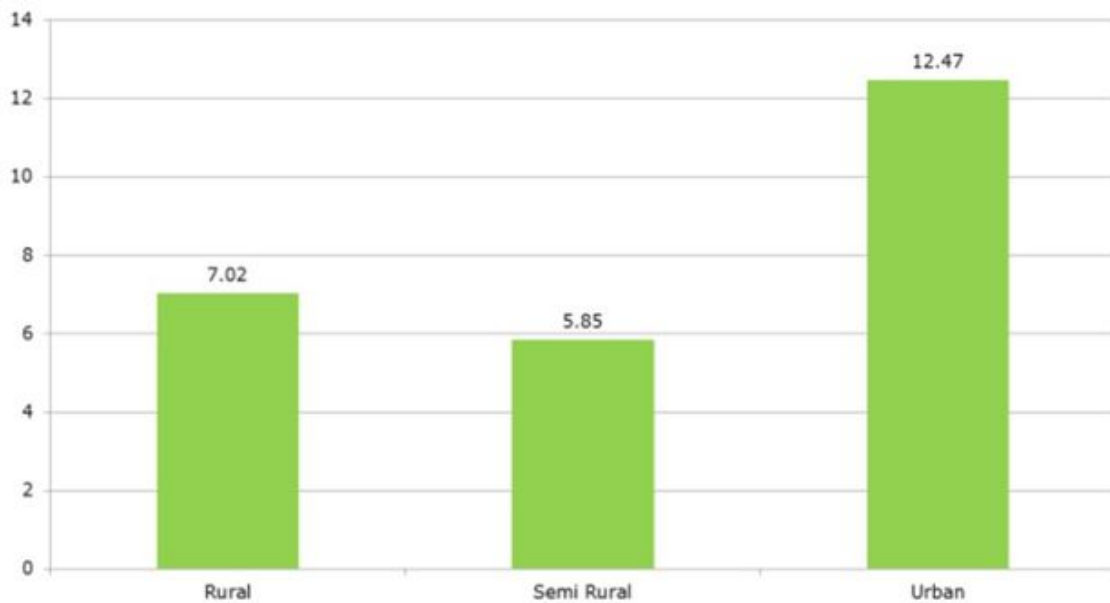
This shortage of doctors leads to reduced access to care – for instance rural patients are less likely to be prescribed mental health medications (Waikato Mental Health needs assessment) and rural men are half as likely to be tested for prostate cancer (Obertova).

In the NatMedCa survey, Raymont et al found that rural GPs recorded the highest volume of patients per day and the highest number of weekends on call (Raymont)
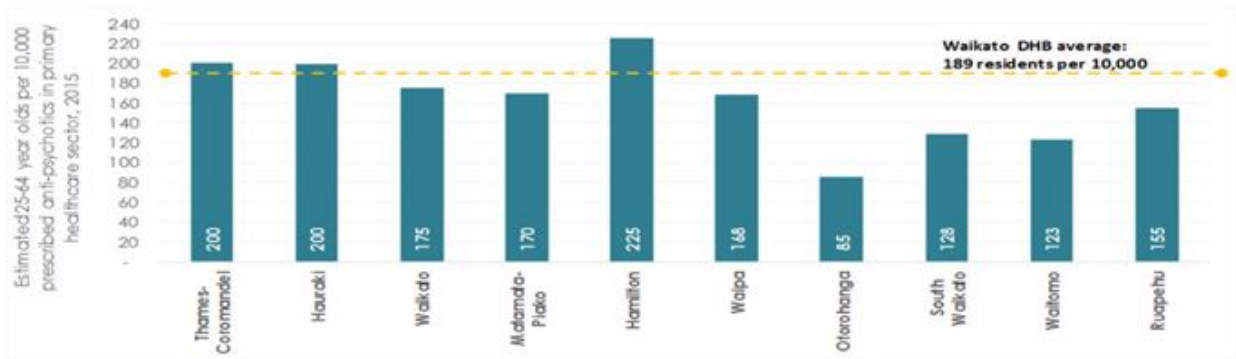
Prescription of antipsychotic medications by GP by TLA

Rural Hospital doctors

The Waikato DHB has four rural hospitals. Staffing of these hospitals has always been a challenge. The new scope of practice and training program –" Rural Hospital Medicine " has been specifically designed to address the workforce needs of our rural hospitals. Despite the success of the program only 30% of hospital mangers indicated that there is an adequate supply of rural hospital doctors, and a quarter indicated there is still a serious or critical shortage. (Lawrenson 2016). Waikato DHB is one of the few DHBs with a large rural population that does not have a formal rural hospital medicine training program.

Rural Nursing
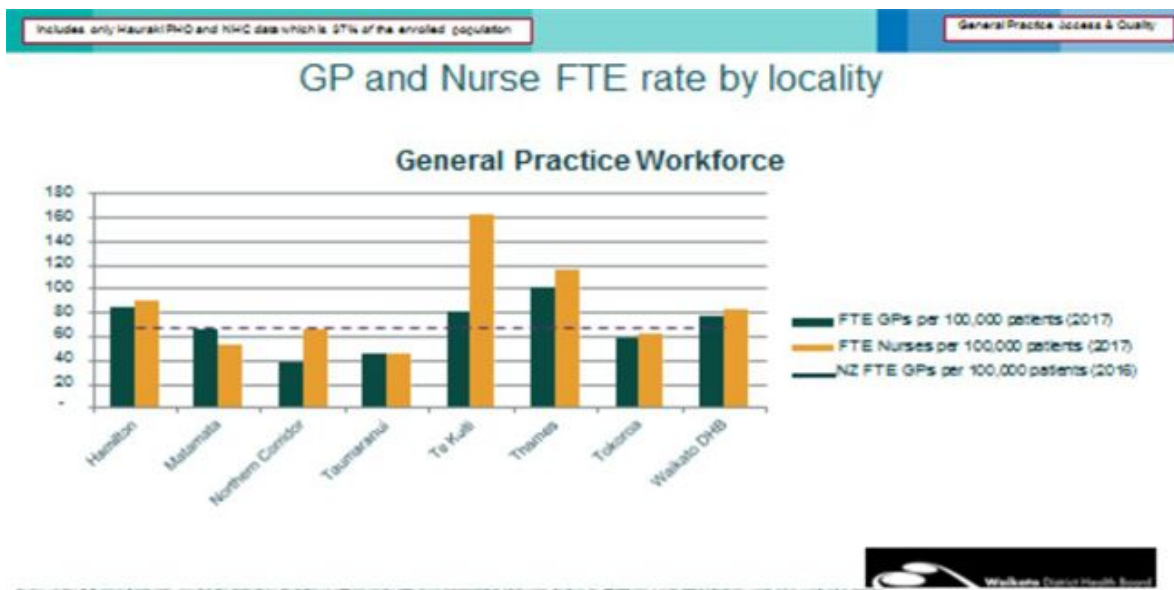
While there has been much interest in expanding the nursing workforce to meet the demand for primary care in many of our rural communities not only do we have a shortage of doctors but there are also fewer nurses per population than in Hamilton. Hauraki practices in Te Kuiti and Thames are an exception to this. Of especial concern is that the number of nurses in our rural areas is actually falling.

Rural Midwifery

The Board has had a comprehensive review of rural midwifery services and this has highlighted the shortages in many rural communities. We note the changes to maternity services in Te Kuiti and Morrinsville in particular in response to changing demand from women. In a study of rural women in the region many rural women described the lack of choice being of concern. Safety for themselves and their unborn child was a major underpinning theme in women's expectations. There is evidence both in this study and in the Ministry of Health report that local primary birthing units in rural areas are bypassed (not always on midwives' recommendation) to attend secondary and tertiary units. (Gibbons 2016). We should note that 40% of births in the Waikato are Māori, and this proportion is growing. In many rural communities the proportion of Māori births exceeds 50% - and yet there are few Māori midwives available and in some circumstances Māori women have experienced culturally in-sensitive care. Any rural maternity plan should also address the needs of Māori mothers.

Mobile services

A number of services are provided for rural communities by mean of mobile services. The mobile breast-screening services are provided throughout the region, helping women to access mammography screening. There are mobile oral health clinics and the mobile surgical services provide elective day surgeries to Taumarunui. For those patients that do need to travel as noted above the National Travel Assistance scheme provides financial help towards the expenses for rural patients travelling to get specialist care.

Rural Health Outcomes.

Very brief life expectancy data were provided in a 2002 Ministry of Health Rural Health Survey. In addition to echoing widely reported findings of poor longevity for Maori as compared with non-Maori, these data showed that whereas rural non-Maori had a slightly longer life expectancy at both birth and age 65 than urban non-Maori, rural Maori had a shorter life expectancy than urban Maori (Ministry of Health 2002b p33).

Life expectancy at birth

Figure 10: Life expectancy at birth, Māori and non-Māori, by sex and urban/rural area, 2005–07
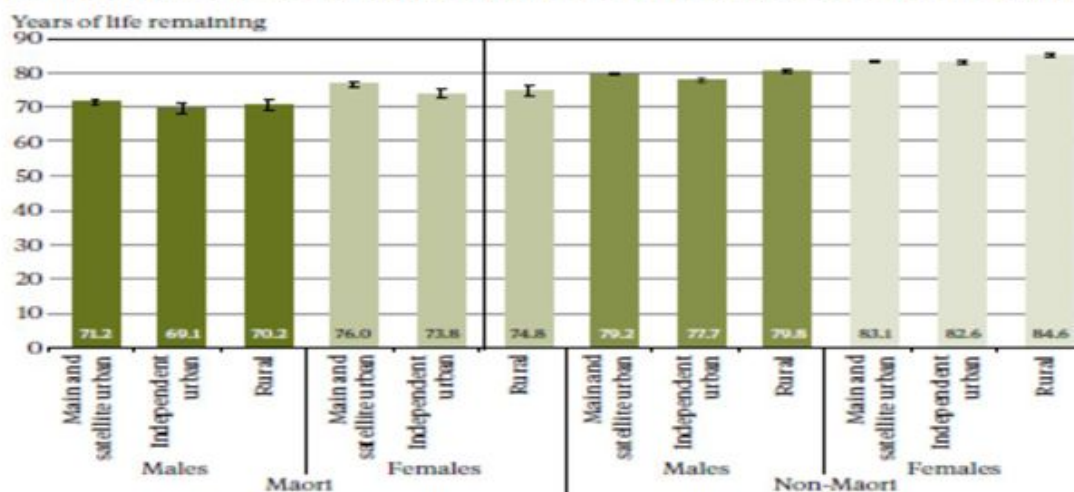
Source: Abridged life tables produced by Statistics New Zealand according to assumptions agreed to by University of Otago, 2005–07

Serious difficulties were encountered during this review in identifying comprehensive national data on the health and independence of rural versus non-rural populations. This highlights serious gaps in the analytical base for health and disability planning for services to rural communities in particular the lack of recent comprehensive analysis of morbidity and mortality in New Zealand, stratified into rural versus urban population groups. This is still a concern today although Strategy and Funding are now beginning to analyse DHB health data by locality. The New Zealand Health Survey data 2004 showed little evidence that in New Zealand rural (based on distance) have poorer outcomes than those living in an urban communities living close to a major hospital. Urban dwellers were significantly more likely to have been diagnosed with heart disease than rural dwellers, for both males and females. There were no significant differences in the prevalence of diabetes between urban and rural dwellers. However, in urban areas the prevalence of diabetes was significantly higher in areas of high socioeconomic deprivation than in areas of low or medium deprivation, for both males and females. For females aged 45 or less, the prevalence of asthma was significantly higher in urban dwellers than in rural dwellers. For males, the prevalence of spinal disorders was significantly higher in rural areas than in urban areas. This difference was particularly marked between true rural areas and main urban areas. More recent studies of cancer have shown similar patterns. Generally rural patients have the same outcomes from cancer as urban patients. The difference is that rural Maori have poorer outcomes than urban Māori as well as the generally recognised disparity for Māori compared to non-Māori. (Sharples, Obertova, Lawrenson, Bennett). Patterns of hospital utilisation can also be used as a proxy of health status. This we can see in our review of hospital admissions by locality while there are only moderate differences between Māori and Pakeha, there are wide variations by locality.
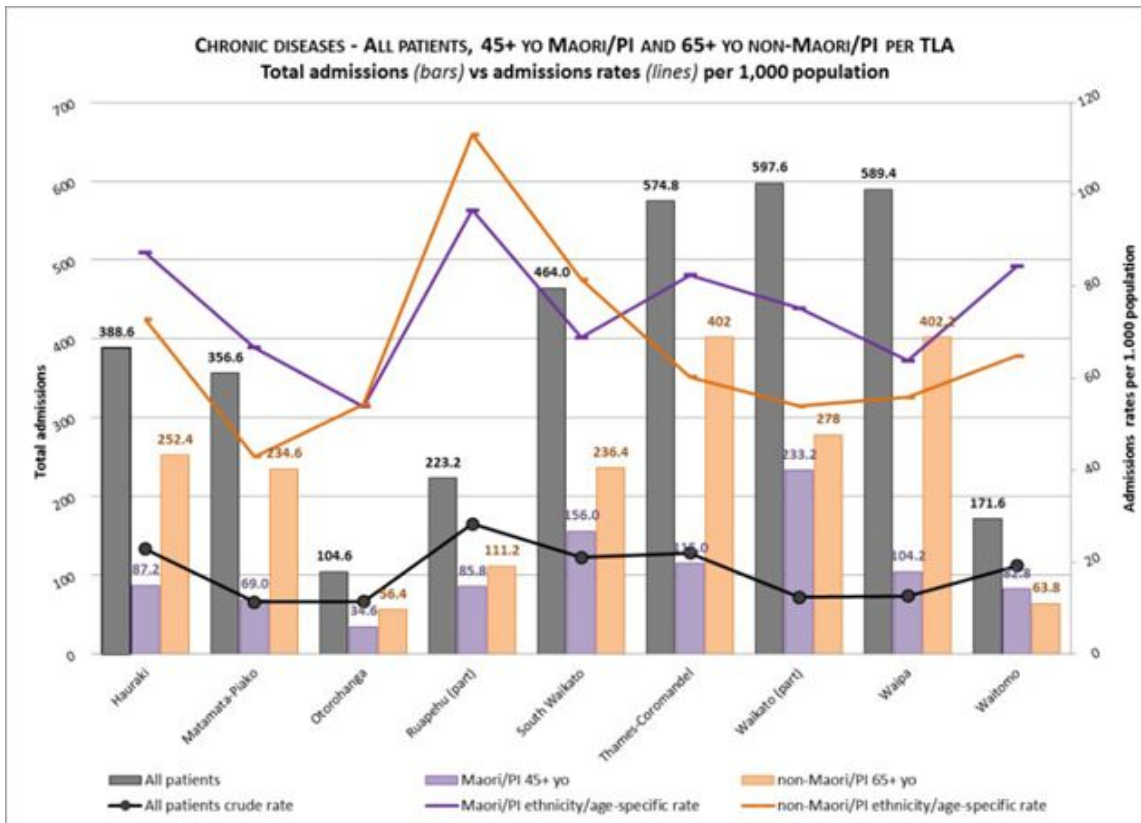
Hospital admissions for chronic conditions by TLA, comparing all patients, to Maori/Pacific Island over 45 years of age, and to Non-Maori/PI over 65 years of age.

Admission rates for Maori/PI 45+ are higher than Non-Maori/PI 65+ in Hauraki, Matamata-Piako, Thames-Coromandel, Waikato, Waipa, and Waitomo.

Mental Health and Addictions

There are few studies on the mental health of rural communities (Gibb 2018). The latest review of mental health services by the Ministry, He Ara Oranga (2018) noted the prevalence of mental health conditions is similar in urban and rural settings, but people in rural settings are less likely to access mental health care. In addition, while numbers are relatively small, data suggest that suicide rates are slightly higher for people in rural areas than in urban areas. Young farm labourers are at highest risk of suicide among the rural population, with isolation, alcohol use and availability of firearms considered to be contributing factors. There were concerns about the challenges for people in rural areas or smaller centres trying to access specialist services such as detox centres, respite care or treatment for eating disorders. Although people acknowledged that such services could not be available everywhere, they were concerned that DHBs do not appear to collaborate well on a regional or national basis to provide consistent coverage. They also mentioned that rural patients with mental health problems were concerned about anonymity when accessing services. The Waikato DHB funds a number of providers to ensure access for mental health and addiction services. There are two Rural Community Mental Health & Addictions Services – one in the North and another based at Tokoroa Hospital and Te Awamutu with services also delivered at satellite clinics in Te Kuiti and Taumarunui. Mental health is one field where rural communities have been active in self help. WorkSafe's GoodYarn programme aims to help rural people recognise and respond to stress and mental illness. This programme has been expanded into an award-winning national initiative for dairy farmers led by DairyNZ, with workshops conducted across the country. Another rural initiative is Farmstrong, a web-based, prevention-focused initiative founded by FMG Insurance and the Mental Health Foundation. Farmstrong's emphasis is on building resilience and healthy thinking skills to handle stress. Its website (www.farmstrong.co.nz) contains practical tips and evidence based strategies to improve mental health and wellbeing.

Palliative Care

The New Zealand Palliative Care Strategy noted the importance of access for people in rural areas, the need for greater recognition of the role of the general practitioner (GP) and the need for sufficient community care and social support to allow people to die at home. In our survey of rural palliative care services we found 98% of GP practices provided palliative care and 98% had access to district nursing although in 30% of cases this was not available out of hours. Most of the time GPs were able to access equipment for their patients, usually acquired from the District Health Board with the help and cooperation of the district nurses. The hardest to obtain was domiciliary oxygen and specialist beds, (Smyth 2010)

What voice do rural communities have?

The World Health Organization's definition of primary health care includes recognition of the 'full participation' of communities. The first key direction of the New Zealand Primary Health Care Strategy was to work with local communities and enrolled populations. It is believed engaging local rural communities in their own health and disability services improves health

outcomes and local service viability as well as reducing costs. The DHB have recently established a Consumer Council and are reviewing the purpose of their Community Health Forums and Rural Health Advisory Group. It is generally believed that a strong primary health care system means community involvement so that local people can have their voice heard in the planning and delivery of services. We also need to have processes for identifying need and allowing community members and those who use services to influence the DHB's decisions. It would seem that this should include a locality input as well as involving key stakeholders and decision makers within the DHB and local PHOs. It is also important that rural Māori have a voice in the way services are provided. We would look to Iwi Māori Council for advice on consultation with the rural Māori stakeholders.

Summary

The Waikato DHB district has a 23 percent Māori population and over 60 percent of the population is rural. Yet rural people and particularly rural Māori have poor access to services. It is our socially deprived rural communities with a high proportion of Māori that have the worst health outcomes. (Huntly, Tokoroa, Kawhia, Te Kuiti etc) The population in our rural communities are older, with a higher proportion in the retirement age and with increasing health needs as they age. Much of the poor outcomes for rural patients are due to social and economic factors – the housing stock in rural areas is old and substandard, there are limited employment opportunities especially for young people and there is a lack of public transport. In addition access to quality health care is variable. There are almost half the number of general practitioners per 10,000 population in rural areas compared to the ratio in Hamilton. Many rural practices have vacancies for doctors and are dependent on locums. The majority of Waikato rural practices are low cost access practices, with high demand from patients and some will have difficulty in remaining financially viable. Investment in facilities/buildings is problematic as the capital return on investment is poor compared with investing in facilities in growth areas such as Hamilton or Cambridge. This is true not only for general practices, but also when looking at pharmacies, aged care facilities or maternity facilities. Also due to the population density investment in technology can be less attractive as it may only be used infrequently and patients may not be able to afford additional charges e.g.; X-rays, ultrasound, point of care testing. While the public health services have divested themselves of many rural facilities over the years the Waikato DHB is unusual in that it still has 4 fully owned general hospitals providing services to high needs communities (Thames, Tokoroa, Te Kuiti and Taumarunui). The DHB also still runs 2 elderly care facilities one in Morrinsville and another in Te Awamutu and a maternity centre in Thames. Where the DHB does not own facilities, it provides funding for similar services through private providers e.g. it funds GP beds, respite care and palliative care on a per patient basis. Other key needs for rural communities are access to out of hours urgent care. For many rural communities this is provided through rural hospitals or through specific contracts with rural GP practices. However to the north and west of Hamilton rural patients will have to travel to Waikato hospital ED department or a Hamilton A&M Centre. Discussing the aetiology of barriers to health, Rameka observed: "The importance of having access to shops and services

cannot be overestimated. Accessing services of any nature, whether health, social or economic, is costly. Having to pay for petrol and car maintenance, as well as having money to attend the medical services and pay for prescriptions and other referral services, begins to add up for the whanau of Ngāti Pāhauwera." (NHC report 2010)

Recommendation
THAT

The Committee note:
1) Having an equity focus for our rural populations requires an information strategy which Strategy and Funding has put in place using its locality approach.
2) The rural populations in the Waikato are ageing rapidly providing challenges as to how we plan future services
3) While we need to provide excellent access to services the role and function of our T hospitals will need to be reviewed
4) A rural focus is needed as part of our response to the development of our mental health services following He Ara Oranga .
5) A focus on the benefits of health technologies will continue to be important if we are to find innovative approaches to addressing the health equity needs of our high needs rural populations.

ROSS LAWRENSON
POPULATION ADVISOR

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MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
13 FEBRUARY 2019

AGENDA ITEM 6.2

WAIKATO DHB ANNUAL PLAN 2019-2020

Purpose	To provide the most up to date information (as at 30 January 2019) on the 2019/20 Annual Planning process, expectations and priorities

Background

The 2019/20 planning package was received on the 20 December 2018. This paper outlines the planning process, timelines and guidance from the Ministry.

- The Annual Plan Planning Package was released on the 20 December 2018, along with the Minister's Letter of Expectations 2019/20 (attached). Please note that the Planning Package is incomplete. Further direction from the Ministry of Health will not be received until a later date (February – March 2019) impacting on our ability to provide a full draft to the Board in March 2019.
- The first draft 2019/20 Annual Plan is due with the Ministry of Health on 5 April 2019
- The draft Statement of Performance Expectations is due by 1 May 2019 with the final draft being due on 1 July 2019
- Any potential service changes are to be indicated to the Ministry by 8 March 2019.

Minister's Letter of Expectation

The main expectations are:

- Achieving equity within the health system, underpins all priorities
- The Ministers' prioritised business cases are delivered in a timely manner
- Support the National Asset Management Plan programme of work
- If devolution of a service is required the DHB is to work with the Ministry of Health to ensure a seamless transition of responsibilities
- DHBs are to develop bargaining strategies that are consistent with the Government Expectations on Employment Relations in the State Sector, and to act collaboratively
- DHBs are to support training opportunities for the range of workforce groups
- develop a sustainable endoscopy workforce
- 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 to deliver more planned care

- Work towards implementing or implement the Convention on the Rights of Persons with Disabilities
- Continue to co-design and deliver initiatives to achieve progress on System Level Measures
- When making decisions regarding health services consider rural health needs and the factors affecting health outcomes for this population
- Prioritise strengthening and improving mental health and addiction service areas
- Actively work to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes
- Stronger DHB leadership and collaboration between health and social services to improve equity and wellbeing outcomes
- Refresh the Statement of Intent to identify each DHB's intended strategic direction over the next 3 years

Government Planning Priorities

The Annual Plan guidance and Minister's Letter of Expectation also outlines the following priorities:

- 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.

Annual Planning Process for 2019/20

The Strategy & Funding planning team are meeting with each of the executives during February to discuss the Annual Plan requirements and capture agreed activities in each area. Performance measure reporting requirements and milestones will also be detailed.

The Annual Plan and Statement of Intent will incorporate the work to date on the Health System Plan where possible to ensure alignment.

A more detailed process timeline can be found in Appendix 1.

Recommendation
THAT

The Committee notes the content of the report.

TANYA MALONEY
EXECUTIVE DIRECTOR STRATEGY, FUNDING AND PUBLIC HEALTH

Appendix 1 - Draft Planning Process Timeline

Activity	Date
Planning Package Guidance received from the Ministry (Awaiting further guidance on some matters)	20 December 2018
Annual Planning and Statement of Intent workshops with each Executive member	18 February 2019
Drafting of Annual Plan, Regional Services Plan, Public Health Unit Annual Plan and Statement of Intent	January-June 2019
DHB advises Relationship Manger of service changes	8 March, 2019
Report Draft Annual Plan to the Board	23 March 2019
DHB submit draft Annual Plan, including budgets, with Statements of Intent, SLM improvement plans, Regional Service Plan, and Public Health Unit Annual Plan to the Ministry	5 April, 2019
Report Draft Annual Plan to the Community and Pubic Health Advisory Committee	10 April 2019
Ministry expects to facilitate formal feedback on DHB draft Annual Plan, Regional Service Plans and, Public Health Unit Annual Plan.	17 May 2019
To provide the draft Statement of Performance Expectations and Statement of Intent to the Ministry	1 May 2019
Report final draft Annual Plan (including Public Health Unit Annual Plan) to the Board	23 June 2019
To provide the final Statement of Performance Expectations and Statement of Intent to the Ministry	30 June 2019
Submit final draft System Level Measure Improvement Plan to Ministry	1 July 2019
System Level Measure Plan approved by the Ministry	31 July, 2019
Ministry expects to facilitate formal feedback on DHB draft Annual Plan, Regional Service Plan, and Public Health Unit Annual Plan	Still tba
Final DHB Annual Plan delivered	Still tba

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

MEMORANDUM TO COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
13 FEBRUARY 2019

AGENDA ITEM 6.3

TE PAE TAWHITI UPDATE

Purpose	For information

The attached draft 'Framework for Change for Waikato Mental Health, Alcohol and Other Drug Services 2018 – 2030' was released to the sector for feedback in late 2018. The document brings together the significant work undertaken under both the Te Pae Tawhiti models of care development, and the DHB Provider Arm's Creating Our Futures plan. Fourteen responses have been received and are currently being considered.

The framework attached is well aligned to the recommendations within He Ara Oranga; the Report of the Government Inquiry into Mental Health and Addictions, and with the feedback from Me Koorero Taatau (the cross-district programme of "Lets Talk" hui).

Further refinement of this framework will be undertaken following feedback from the February Community and Public Health Advisory Committee meeting.

Recommendation
THAT

The Committee receives the report and provides feedback.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

TE PAE
TAWHITI

Pursuing a new future
for Mental Health and Addictions
in the Waikato

Framework for Change for
Waikato Mental Health Services and Alcohol and Other Drug Services
2018 – 2030

A Synthesis of Waikato DHB Mental Health and Addictions Models of care

November 2018

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This Document

This document aims to weave together the work already undertaken by Waikato District Health Board (DHB) to develop models of care for mental health and addictions. It describes an overarching wellbeing approach and framework for change for the whole system of mental health services and alcohol and other drug services. It should be read in conjunction with the "Te Pae Tawhiti" and "Creating Our Futures" models of care documents that have informed its development.

The wellbeing approach and framework for change set out in this document will guide the work of Waikato DHB's Strategy and Funding division in developing its strategic directions for mental health and addictions through to 2030 and its commissioning approach and plans. In combination with the individual model of care documents, it will also guide the work of the mental health services and alcohol and other drug services funded by Waikato DHB to support the wellbeing of people and whānau.

Many other organisations have an impact on people's health and wellbeing. This document does not have a role in guiding the activities of organisations and services other than those funded by Waikato DHB, but it does describe the way in which the DHB and the services it funds can support communities, whānau, hapu, iwi, other sectors and government to play their part in enhancing the wellbeing of the people of the Waikato.

Waikato DHB also pays other DHBs to deliver services to Waikato residents referred by local specialists. These include child and youth inpatient and general hospital liaison services (ADHB) and alcohol and drug residential services (Lakes DHB and Canterbury DHB). This document does not have a role to play in directly guiding the delivery of those services, or of the regional forensic mental health services delivered by the DHB. Nonetheless, transitions between all these services and local Waikato DHB-funded services will be critical to the experience of care for people and whānau. Therefore, this document will be shared with the other service providers with the intent that it will inform the interface between their services and local Waikato services to ensure well-coordinated delivery and seamlessness during transitions.

How We Developed the Document

Preliminary work to develop this document involved summarising the key common elements from all of the previous models of care and then holding a workshop in order to agree the outcomes, principles and key challenges that would shape this Framework for Change.

The Waikato DHB source documents included in the mapping exercise were:
- Creating our Futures: Mental Health and Addictions Service Proposed Model of Care (2017)
- Te Pae Tawhiti Model of Care - Adult Mental Health (2018)
- Te Pae Tawhiti Child and Youth Mental Health Model of Care (2018)
- Te Pae Tawhiti Older Persons Mental Health and Addictions Services Proposed Model of Care (2017)
- Waikato Adult Addictions Model of Care (2013)
- Waikato Youth Alcohol and Other Drug Model of Care (2015)
- Health Needs Assessment Mental Health and Addiction Service Utilisation (2017)
- Te Rōpū Tautoku ki Waikato Wānanga Outcomes Summary Report (2017).

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The information from the workshop and the content of the above documents formed the basis for the development of this Framework for Change.

This document was also shaped by the key themes emerging from a series of public meetings, the "Let's Talk" hui, held by Waikato DHB to ask the Waikato community to share experiences, views and ideas to guide the new direction of mental health and alcohol and other drug services in the Waikato.

Acknowledgements

Waikato DHB acknowledges the huge commitment of time and energy spent in preparing the six models of care and other key documents upon which this Framework for Change was based. Without this prior work, and the generous contribution of participants in the workshop to distil the common features of the wellbeing approach and framework for change, this document could not have been written. In weaving together the existing models of care, every effort has been made to reflect their collective richness and depth. Some of the words in this Framework have been drawn directly from one or more of the source documents, while some are new, written to ensure the relevance of this document to all services and to draw the component parts into a whole of system view. We acknowledge that this document has therefore effectively been collectively written with contributions from all of the authors of the source documents.

Vision and Mission

The Waikato DHB vision and mission set out in its strategy *Healthy People, Excellent Care* provided the context for the development of *Te Pae Tawhiti Framework for Change for Waikato mental health services and alcohol and other drug services 2018 – 2030*:

Our Vision:
Healthy people, excellent care

Our Mission:
Enable us all to manage our health and wellbeing.
Provide excellent care through smarter, innovative delivery.

Three of the six strategic imperatives for Waikato DHB form the core of the wellbeing approach and framework for change. They are:

1. *Oranga:*   Health equity for high needs populations
2. *Manaaki:*   People-centred services
3. *Whanaketanga:*   Productive partnerships

Services funded through Waikato DHB also reflect the other three strategic imperatives, which are:

4. *Haumaru:*   Safe, quality health services for all
5. *Ratonga a iwi:*   Effective and efficient care and services
6. *Pae taumata:*   A centre of excellence in learning, training, research and innovation

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Population Overview

Waikato DHB is New Zealand's largest DHB by geographical area and has a broad mix of large urban, small urban, rural and significantly isolated communities and a high proportion of rurality. It covers 10 territorial authority areas and had an estimated total population of 390,700 people in 2015. At that time, 36% of the population were aged 24 or under, 49% were aged between 25 and 64 and 15% were aged 65 or over.

Waikato DHB has one of New Zealand's largest proportional Māori populations with Māori constituting 23% of the total population and 37% of children under 15 years. The Waikato population is projected to grow by 13% in the next 15 years and more than two-thirds of the Waikato District's projected growth will be at 65+ years. Over this time period, the Māori population is predicted to rise by 30%.

There are significant health inequalities for Māori in the Waikato. Māori experience social conditions that are likely to adversely impact on health at significantly greater rates than non-Māori (for example living in the most deprived decile areas, experiencing unemployment, living in crowded homes, and living in low income households). Life expectancy is lower for Māori than for non-Māori (by 7.5 years for females and 8.1 years for males). Potentially avoidable mortality rates are 2.6 times as high for Māori as for non-Māori.

The high proportion of rurality is also associated with health inequalities. People who live in rural areas have the highest incidence of cardiovascular disease, malignancy, renal and respiratory disease as well as the highest levels of potentially avoidable mortalities.

Waikato DHB's Health Needs Assessment Mental Health and Addiction Service Utilisation (2017) identified significant health inequalities for people with mental illness who have high levels of comorbid physical conditions and shorter lives. Additionally, the impact of mental illness on physical health disproportionately impacts Māori and Pacific people and people who face greater socioeconomic deprivation.

While suicide rates in the Waikato are comparable with national rates, New Zealand's youth suicide rate is one of the highest among OECD countries. Within the Waikato, the rate for Māori is significantly greater than that for non-Māori and the rate for males is significantly higher than for females.

There is an over-representation of males (66%) and Māori (44%) in utilisation of services, and this is seen particularly in alcohol and other drug services.

Key Themes Emerging from Let's Talk hui

While this Framework was under development, Waikato DHB held a series of public meetings to ask the Waikato community to share experiences, views and ideas that will help guide the new direction of mental health and alcohol and other drug services in the Waikato and to improve the services. Although at the time of writing this Framework, a formal summary of the key themes from these "Let's Talk" hui had not yet been prepared, the key themes noted by Waikato DHB hui participants included the need for:

- More support, education and involvement for whānau and more rapid response to whānau in need
- Whānau ora as a model for mental health services

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- Alternative treatments to medication and alongside medication (eg talking therapies, rongoa for Māori)
- People who listen, show respect and treat those using services with care
- Improved access to crisis care/local solutions for people in crisis while they are waiting for the community assessment and treatment team
- More local services including local respite, local points of entry to services and local follow up
- Better Integrated care
- Addressing transport issues in rural communities
- Providing support for rural GPs.

Outcomes Sought

The two key outcomes the Framework for Change seeks to achieve are:

- Equity of health outcome for Māori and
- Improved wellbeing/oranga for all

Both of these two outcomes reflect the strategic imperative from Waikato DHB's strategy: *Oranga: health equity for high needs populations.* The first outcome *Equity of health outcome for Māori* is aligned with Waikato DHB's first priority for implementing this strategic imperative, which is *radical improvement in Māori health outcomes by eliminating health inequities for Māori*.

Our focus for achieving the second outcome *Improved wellbeing/oranga for all* will also be on addressing health inequity, and specifically the needs of those who currently experience inequity in access or outcome e.g. those in rural communities, people living with socio-economic disadvantage, people with poor physical health outcomes as a result of serious mental health or addiction challenges, and people with mild to moderate mental health and/or alcohol and other drug issues currently unable to access services.

This Framework for Change describes the collective effort that will enable the achievement of both of these outcomes.

Delivering Equity of Health Outcome for Māori

To deliver equity of outcome for Māori, te Tiriti o Waitangi principles of Partnership, Participation and Protection will underpin engagement with Māori to develop Māori responsiveness. This will involve:
- Taking a community development approach, working with whānau, hapu and iwi to develop effective responses for Māori
- Commissioning services for the achievement of outcomes that are measured (e.g. health literacy, health determinants, access rates)
- Commitment to engage with the Iwi Māori Council to achieve the outcomes.

A great deal has been written in the various model of care documents and the Wānanga Outcomes Summary Report about the central concepts that will be essential to delivering radical improvement in health status for Māori.

To summarise, in order to deliver equity of health outcome for Māori, the Framework for Change aims to:

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- Be whānau-driven and led, supporting whānau to be their own experts equipped with the tools to achieve whānau oranga
- Promote health and wellbeing and the prevention of illness
- Take a holistic view of wellbeing that incorporates relationships, life purpose and wairua)
- Encompass the wellbeing of individual, whānau and environment
- Take into account social, economic, and cultural determinants of health
- Ensure staff demonstrate competency in tikanga Māori and that service environments reflect tikanga
- Increase access to Māori staff across the service spectrum including primary care
- Deliver a seamless continuum of support through primary and secondary health services, where any door is the right door through which to access help
- Provide Māori pathways and choice, particularly early on, including access to kaupapa Māori services and to Māori practices e.g. rongoa, tohunga, mirimiri.

Figure 1: Māori health gain
(from the Wānanga Outcomes Summary Report)

The Concept of Oranga/Wellbeing

Waikato DHB's models of care for mental health services and for alcohol and other drug services all emphasise the concept of wellbeing. Wellbeing is more than simply the absence of symptoms of illness, problematic substance use or addiction. People can experience wellbeing in the presence of mental illness or addiction.

Wellbeing has been defined in many ways, but perhaps the simplest and most useful definition is "feeling good and functioning well" (Keyes and Annas, 2009).
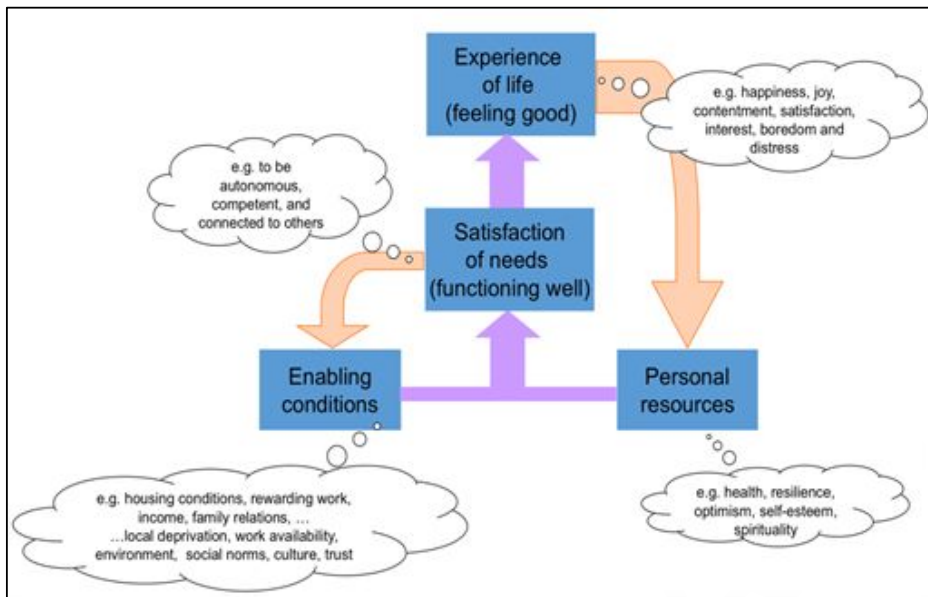
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Figure 2: A dynamic model of wellbeing

Figure 2 above is derived from the work of Thompson and Marks (2008) which draws on the increasing body of evidence regarding the factors that play the greatest role in relation to wellbeing. Wellbeing is represented as a dynamic process in which a person's external circumstances ("enabling conditions") interact with their personal resources to satisfy (to a greater or lesser extent) their needs, giving rise to feelings of happiness and satisfaction. The process also highlights that a person's wellbeing in turn impacts on their personal resources and their circumstances.

Figure 3. Source: Ministry of Health (2016)
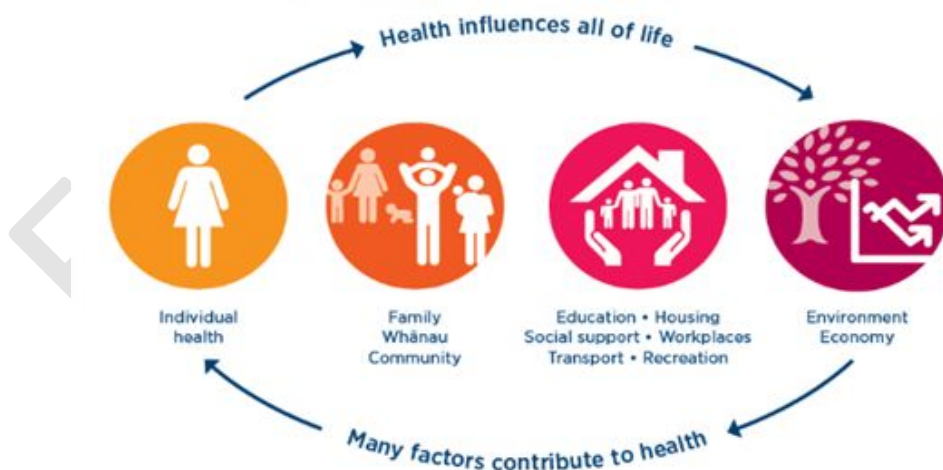
This recognition of wellbeing as a dynamic process is also reflected in the Ministry of Health (2016) representation of health in the wider context (figure 3) which illustrates the various factors that contribute to health and the way in which health influences on people's lives.

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Wellbeing Approach

Figure 4: Te Pae Tawhiti Wellbeing Approach

Waikato DHB's wellbeing approach, illustrated in figure 4 above, depicts the outcomes this Framework seeks to achieve (at the heart of the model), the personal resources, life circumstances and wider community context that will impact on the achievement of those outcomes and the integrated spectrum of health and social services that will need to work together to support people and communities to achieve those outcomes.

This illustration has been adapted from Waikato DHB's Youth alcohol and other drug model of care (2015), incorporating concepts from the dynamic model of wellbeing previously described.

There is a growing evidence base about the factors that most strongly influence wellbeing (Hämäläinen and Michaelson, 2014) and these factors are included in the more detailed description of the components of Waikato DHB's wellbeing approach below.

Outcomes

The centre of the diagram depicts the two key outcomes
the Framework for Change seeks to achieve, as previously described:

- Equity of health outcome for Māori *and*
- Improved wellbeing/oranga for all.

Figure 5: Ora – Equity for Maori

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Personal and whānau resources

People's personal and whānau resources form the foundation through which they can achieve and maintain wellbeing. Personal and whānau resources include:

- self-esteem, optimism and resilience, which in turn are shaped by early life experiences
- whānau supportiveness
- relationship status
- social networks
- physical and psychological health
- lifestyle, especially physical activity and sleep
- engagement in spiritual/religious activities and altruistic activities
- a sense of purpose and meaning.

Figure 6: Personal and Whanāu Resources

If services are to achieve equity of health outcome for Māori and improve wellbeing for all they will need to recognise that people and whānau play the central role in managing their own health and wellbeing, and therefore support and strengthen people's personal resources, including whānau support.

Life circumstances

Life circumstances have a direct impact on wellbeing, and particularly:
- Income
- Employment
- Housing circumstances (quality, overcrowding).

Recognising the role that social determinants play in people's wellbeing, services will need to enable people and whānau to access supports and resources to address their life circumstances in order to improve equity of health outcome for Māori and wellbeing for all.

Figure 7: Life Circumstances

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Community context

Factors within the wider community have been shown to have a direct impact on wellbeing, for example:

Figure 8: Community Context

- Social trust (trust in other people and trust in public institutions e.g. police, government, legal system)
- Community cohesion, cultural connectedness
- Availability of jobs
- Local neighbourhood characteristics (local deprivation, population density, walkability, pollution, crime)
- Access to natural landscapes
- Accessibility of recreational opportunities and arts
- The supply and accessibility of factors that adversely impact wellbeing such as alcohol, drugs and gambling
- Participation and contribution within the community.

To achieve equity of health outcome for Māori and wellbeing for all will require Waikato DHB and the services it funds to work with Māori, iwi, local communities and community leaders to create the conditions most likely to support wellbeing.

Working with communities

To achieve equity of health outcome for Māori and improve wellbeing for all, integrated services and Waikato DHB as funder will work closely with the communities they serve to plan and design services, build community capability to support wellbeing and advocate to government (both local and national) for changes that will promote wellbeing and tackle stigma.

A "community" can be any group of people who identify with one another and feel a sense of belonging. For the purposes of this Framework, priority communities are those experiencing inequity of health outcome and include Māori and rural communities. It may also include people living with addictions or people experiencing severe mental illness where they define themselves as a community.

The DHB will adopt a community development approach to planning and designing integrated services and building community capacity. The community development approach will involve having a good knowledge and understanding of the communities served, connecting with and supporting those communities to design their own community-relevant approaches to enhance wellbeing and address mental health and alcohol and other drug needs, and developing health services that build on community strengths and respond to the unique qualities and constraints of the community. This approach will also underpin co-design work with tangata whaiora[1]. He Korowai Oranga: Māori Health

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[1] tangata whaiora in this document refers to people who use health services to address mental health or alcohol and other drug needs.

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Strategy (Minister of Health and Associate Minister of Health, 2002) provides guidance for Māori providers working towards collective impact with Māori communities and its key messages will also inform the way in which all integrated services work with Māori communities for whom this Framework for Change strives to achieve equity of health outcome.

In addition to adopting a community development approach, Waikato DHB will ensure community members can access training and support that will help them to recognise distress or problematic use of substances in themselves and others, provide useful responses, know what other help is available from the health system and support help-seeking when appropriate. Particularly important will be building this capability among people whose work brings them into contact with people in distress, such as ambulance staff, police, school teachers, MSD staff, primary care providers.

Integrated services

Services will need to work together if they are to have an impact on all of the above factors that have been demonstrated to affect wellbeing, both at a community level and when working with people and whānau. The services that will work in an integrated fashion include Waikato DHB-funded health services: primary healthcare[2], secondary[3] alcohol and other drug services and secondary mental health services. Other services not funded by Waikato DHB also have a significant role to play in wellbeing, for example those provided by local iwi, the Health Promotion Agency, Education, Housing, Social Development, Oranga Tamariki, Police, and Justice. All of these services will work closely together to support people's wellbeing across their lifespan.

Figure 9: Integrated Services (a)

For the purposes of this Framework, integration between services encompasses integration to enable people to have co-existing difficulties addressed in a coordinated way, for example co-existing mental health issues, problematic alcohol and other drug use and/or physical illness. It also includes integration along the pathway of care for different intensity of

Need and integration between services for different age groups, so that people moving between services experience a seamless response without having to re-tell their story multiple times. Integration is also essential between health and social services, where people's life circumstances adversely affect (or are adversely affected by) their mental health or addiction issues.

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[2] In this document, primary healthcare refers to community based healthcare that is not solely focused on alcohol and other drugs or mental health, including general practice, well child and maternity providers, pharmacists, district nursing and school-based health services

[3] secondary services are those with a specialised focus on alcohol and other drugs and/or mental health, and include DHB and NGO services and services in community, residential and inpatient settings

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Working with people in need and their whānau

As in Figure 9(a), the four koru represent integrated services. They are shown extending inwards towards the two outcomes sought to illustrate their role in supporting people and whānau to make changes that improve their life circumstances and their health and that build their personal resources and strengths so that they are themselves able to improve and maintain their own wellbeing and that of their whānau.

Supporting personal and whānau wellbeing is the primary focus of health services and through these actions the services contribute to achieving both outcomes for this Framework.

Figure 9: Integrated Services (b)

The Spectrum of Services (the Koru)

This section has been drawn from the models of care documents and sets out the principles that will underpin service delivery along with some of the key changes to services that have been described in the model of care documents. It also provides examples of the role that Waikato DHB and the services it funds will play in working with other sectors and health services not funded by the DHB.

Principles of service delivery

The principles set out below are based on the models of care and will guide the work of all the Waikato DHB-funded mental health services and alcohol and other drug services.

Oranga Tangata
- Wellbeing and resilience focus
- Sooner than later: a focus on education, prevention and early intervention
- Highly responsive to Māori and whānau
- Flexible and responsive (to needs, culture, age, gender, religion, etc)
- Closer to home: accessible and easy to navigate
- Holistic: addressing social, emotional, behavioural, physical, cultural and spiritual health
- Actively engage communities to support wellbeing

Oranga Whānau
- Focus on, and involvement of, whānau
- Provide support/education for whānau

Whaka Mana
- Whakamana: mana-enhancing, enabling self-efficacy, self-determination and self-advocacy
- Eliminate stigma
- Provide choice and voice for tangata whaiora in service planning, delivery and improvement

Integrated Care
- Joined up and well-coordinated across health and social services and between providers

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The services

The four koru in the wellbeing approach illustrated in figure 4 represent the services that contribute to achieving the outcomes for this Framework for Change. These include the services that are funded by Waikato DHB (primary care, secondary alcohol and other drug services, secondary mental health services) and other services not funded by Waikato DHB. The services funded by Waikato DHB are delivered in a range of settings including community, residential and inpatient settings. They are delivered by a range of providers including the DHB, Primary Health Organisations and Non-Governmental Organisations. There is a mix of kaupapa Māori providers and mainstream providers. The other services include the Health Promotion Agency, Education, Social Development, Housing, Oranga Tamariki, Police, and Justice. The integrated way in which the services will work together is illustrated by the woven background in figure 10 below.

Figure 10: The spectrum of services (the koru)

Key changes planned for the three DHB-funded koru are summarised briefly below, however for more detail refer to the individual model of care documents.

Primary Care
Key changes in primary care include enhanced primary care capability to intervene early and effectively to address mental health need, alcohol and other drug issues, addictions and comorbidities with physical illness, enhanced general practice capability to work with children and young people, more proactive screening and assessment (including early identification of isolation and neglect for older people in primary care) and expanded primary care team membership to include, for example, behavioural health consultants, kai awhina, health coaches and navigation/social support.

Alcohol and other drug services
Key changes in alcohol and other drug services include increased community-based services for

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example home based detox services and non-clinical positions such as peer services and whānau support, increased access to navigation/social support, provision of liaison/advice to other health services including primary care and increased residential treatment and support.

Mental health services

Key changes in mental health services include increased community service provision including crisis responsiveness and non-clinical positions such as peer services and whānau support, increased access to navigation/social support, provision of liaison/advice to other health services including primary care, expanded residential respite and alternatives to admission and residential rehabilitation and a sufficient level of fit for purpose acute inpatient care.

Other Services

This koru is a reminder that there are many other players contributing to wellbeing that are not funded by Waikato DHB. The Framework for Change does not provide guidance for those other services, rather it sets out some ways in which Waikato DHB and the services it funds will work with them to achieve the outcomes sought. Examples of collaborative working are:

- Joint advocacy: together influencing local and national government to create the conditions that will improve wellbeing
- Co-commissioning: where services from multiple agencies are delivered to the same people/whānau, combining funding streams and jointly commissioning those services
- Shared workforce development: where staff from different services are working to address wellbeing for the same people/whānau, providing shared workforce development to build relationships and create shared ways of working
- Integrated delivery: this covers both coordinated delivery across multiple agencies and services, for example in campaigns such as suicide prevention or challenging stigma and discrimination and creating teams across agencies to deliver seamless services e.g. for homeless people or use with multi-sector involvement.

Services span all age groups

Waikato DHB-funded primary and secondary services will seamlessly deliver end to end care across the lifespan. Some secondary services have a focus on a people in a particular age group and where this is the case will demonstrate flexibility of access criteria so that age is not a barrier to accessing needed services. When people who need ongoing care move between age-based services as they grow older, services will facilitate a seamless transition.

Key changes planned for the age-based secondary services are summarised briefly below, however for more detail refer to the individual model of care documents.

Children and young people:

Key changes in services for children and young people include integrated delivery with schools and with other agencies in youth one stop shops, more early intervention e.g. parenting programmes, programmes for children of parents with mental health or addiction issues, provision of infant mental health services, programmes for parents of youth with alcohol and other drug issues and increased community services e.g. youth alcohol and other drug services, child and adolescent mental health services, assertive outreach and crisis responsiveness and paediatric consultation liaison.

Adults:

Key changes in services include increased access to psychological interventions within primary care and

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better physical healthcare for people with the most high and complex needs, increased community based alcohol and other drug services with focused services for people with complex/chronic difficulties, increased co-existing problem capability across mental health and alcohol and other drug services and more community based mental health services for people acutely unwell and for people with high needs and whānau.

Older people

Key changes include interdisciplinary work between mental health and health of older people, expanded community services e.g. acute responsiveness, dementia behaviour support teams and older adult-focused residential services.

Framework for Change

Waikato DHB is committed to achieving the outcomes set out in this Framework. Central to achieving these outcomes will be working with communities, tangata whaiora and staff to co-design services, identifying ways to measure outcome achievement and creating the processes that will enable continuous learning and improvement. Delivering equity of outcome for Māori will be an ongoing focus for all mental health services and alcohol and other drug services funded by Waikato DHB. This Framework for Change will be used as the basis for prioritising any planned changes and developments.

Co-design

When planning developments, making changes and reviewing impacts, Waikato DHB and the services it funds will actively involve the range of people likely to be affected by the changes. This co-design approach will involve tangata whaiora and whānau and other community members, alongside staff involved in service delivery. Together they will consider local information about strengths, needs and services alongside evidence from the work of others where this is available.

Continuous learning and improvement

Waikato DHB and the services it funds will adopt a continuous learning approach to implementing changes and achieving the outcomes sought. The DHB will work with the services it funds, tangata whaiora and whānau to establish measures of the two outcomes (using both quantitative and qualitative information) and to develop processes for continuous learning and improvement, which will involve sharing outcome information and working collaboratively to adapt and improve the services.

Delivering of equity of outcome for Māori

To deliver on equity of health outcome for Māori, Waikato DHB will agree a set of health equity outcome measures that will be used to track progress and will collect the information necessary to develop reports of progress against these measures. All service change or development will involve co-design with Māori, with a focus on achieving equity of health outcome for Māori.

Prioritising change

It will not be possible to progress changes on all fronts, and so Waikato DHB and the services it funds will need to prioritise. The key criteria listed below, drawn from the system-wide outcomes and principles, will be used when prioritising change and development in Waikato DHB-funded alcohol and other drug services and mental health services.

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Equity of health outcome for Māori

To what degree is the proposed change likely to have a positive impact on equity of health outcome for Māori?

Responsive to Māori

Is the proposed service change that it is responsive to the unique needs of Māori and is likely to be effective for Māori?

Improved wellbeing/oranga for all: focus on priority populations

Is the proposed change likely to address inequities in outcomes by improving wellbeing for a prioritised population, i.e. Māori, rural populations, people with severe mental health or alcohol and other drug issues, groups at high risk of suicide?

Needs based

Does the proposed change better align service delivery with need, as established through demographic data such as population size, growth and composition, research about the prevalence of health needs, information about the social determinants of health and the perspectives and views of the community?

Sooner than later

Does the proposed change result in earlier intervention: earlier in life, in the course of the development of mental health or alcohol and other drug problems or in preventing relapse?

Closer to home

Will the proposed change bring the services closer to people's homes (in primary and community settings) and therefore enable them to stay engaged and involved with whānau and community?

Accessible and easy to navigate

Does the proposed change make it easier to access services, for example by making every door the right door, providing virtual accessibility via text, phone or video-calling and delivering in hubs where multiple providers can be accessed in the same location?

Integrated

Will the proposed change enhance seamlessness of experience for people and whānau across health services, between health and social services and/or between providers?

Self-management and resilience

Does the proposed change strengthen the ability of people and whānau to manage their own difficulties and that build their resilience, thereby decreasing the likelihood of future difficulties?

Enablers

To implement this Framework for Change, Waikato DHB will put in place the infrastructure, resources and systems that will be essential to its success. This section describes those enablers:

- A confident and capable workforce
- Strong partnerships with tangata whaiora and their whānau
- Positive, collaborative relationships with key stakeholders within communities
- Leadership and governance

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- Accountability framework
- Strong and effective strategy and commissioning mechanisms
- Outcomes and evaluation
- Support for innovation, learning and improvement
- A single wellbeing plan
- Fit for purpose information technology and systems.

A confident and capable workforce

Successful implementation of the Framework for Change will rely on the efforts of a sufficient number of skilled, knowledgeable, motivated and competent workforce with the right attitudes to work alongside services users and their whānau and support them to address their own needs.

Achieving the Framework's outcomes will only be possible if staff have the appropriate training and supervision to deliver against the Framework for Change and are valued and supported, and if the jobs that people do are sufficiently rewarding to be attractive to both the current and future workforce.

A core capability for the entire workforce will be its cultural responsiveness.

To address workforce challenges such as the aging workforce, the limited workforce availability and the lack of diversity within the workforce, there is an opportunity to develop new roles in order to bring new perspectives and to better reflect the local community diversity. Examples of such roles include well trained and supported non-registered staff for example:
- Peer workforce (including whānau peers)
- Kai awhina/health coaching roles
- Cultural support roles
- Navigation/social supports
- Kaumatua and kuia.

Specific attention will also be given to ensuring:
- More Māori staff working within Māori settings and services – "Māori faces for Māori cases in Māori places"
- A highly skilled multi-disciplinary clinical workforce that is culturally competent and working to the top of their scope
- Shared workforce opportunities between alcohol and other drug services and mental health services around co-existing problem capabilities.

We will recognise the vital role played by tangata whaiora and their whānau in maintaining wellbeing, and invest in education and support for them to strengthen their ability to play this role.

Strong partnerships with tangata whaiora and their whānau

This Framework for Change is based upon the assumption that there will be strong partnerships with services users and their whānau at all levels of the system. This will require consultation mechanisms to ensure ready access to the voice of tangata whaiora and whānau and increased involvement of tangata whaiora and whānau in all decision-making forums guiding the Framework for Change and its implementation including those relating to strategy, commissioning, service delivery, monitoring and service improvement.

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Positive, collaborative relationships with key stakeholders within communities

Establishing and maintaining positive collaborative relationships with key stakeholders and strategic partners within communities will be key to successfully achieving the outcomes of this Framework for Change. Collaborative work with these key stakeholders will be strengthened by interagency agreements, referral pathways, combined capability development and joint planning.

Of fundamental importance will be working in partnership with Kaupapa Māori organisations, tangata whaiora and communities to agree the ways in which to collectively achieve equity of health outcomes for Māori.

Achieving improved wellbeing/oranga for all will require a collaborative integrated approach with strong partnerships across health, social services and community agencies. It will require new ways of working together including actively seeking opportunities to jointly plan, fund, deliver and evaluate innovative approaches aimed at improving wellbeing of individuals, whānau and communities.

A single wellbeing plan

For all people requiring support the long term aspiration is that there will be one shared, common, integrated wellbeing plan that describes the issues the person/whānau is seeking to address, their aspirations, planned actions to achieve these and who is responsible for the actions. Achievement of this aspiration will be dependent on an information technology infrastructure that would support sharing of a single wellbeing plan across the system of DHB-funded health services. People should expect to be involved in decision-making and wellbeing planning throughout their journey. The plan would include mental health and alcohol and other drug use, and span community, primary, secondary and tertiary services. While a record may be kept by the DHB, it would remain the property of the person, go with them and be used at any point on their care pathway.

Fit for purpose information technology and systems

Use of technology to support efficient and effective commissioning and service delivery is a key element of the planned future model of service delivery. This will include technology and systems that are fit for purpose within an ever-changing digital environment and that support:
- Ideally, use of a single plan that goes with people throughout their journey and can be used by any trained mental health worker in partnership with tangata whaiora and whānau
- Other infrastructure to support the flow of information and more integrated delivery within the Framework for Change
- Access to on-line electronic based interventions and resources
- Options for virtual service delivery – including tele-health for rural communities
- Collection and reporting of information to inform and evaluate commissioning, service delivery and progress toward the intended outcomes.

Leadership and governance

Implementing this Framework for Change will require strong leadership, commitment across many organisations and communities to implementing the changes envisaged, change management capability, and partnerships with the health, justice and social services.

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Joined up, system-wide governance arrangements will be essential in order to support a collaborative, whole of system approach, to track progress toward the outcomes sought and to enable rapid implementation of corrective change based on the impact of changes implemented.

System-wide governance will include primary care, NGOs and DHB services with meaningful tangata whaiora and whānau involvement and invitations to other sectors to participate.

Accountability framework

The DHB and the services it funds are jointly accountable for the implementation of this Framework for Change. It will develop an accountability framework for the purpose of tracking progress in implementing the Framework and achieving its intended outcomes and will use that Framework to report on progress to the DHB Board of Directors, its services and tangata whaiora and whānau.

Strong and effective strategy and commissioning

Currently the range of services available within the Waikato differs for different communities and does not align well with population size and need. Different populations are growing at different rates, and services will need to keep pace with this change. There is an opportunity now to undertake data-informed planning for future services in order to ensure service delivery is well matched to population size and need, there is a comprehensive range of services in place for each community, with choices including virtual delivery, where every door is the right door and people rapidly receive the level of support they need for as long as it is helpful. This work will be integrated with work on Health Services Planning and Care in the Community.

This Framework for Change will inform WDHB's future commissioning approach, which will include:
- Genuine partnership with tangata whaiora, communities, clinicians and providers to ensure services achieve the intended outcomes of this Framework for Change
- Shared leadership: all of the actors in the DHB-funded services share leadership and accountability in achieving the outcomes
- 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 and the end-to-end health experience of tangata whaiora
- A greater emphasis on outcome focused agreements and agreements that foster collaboration or integrated ways of working
- Integrated funding arrangements that support co-commissioning, for example across health and social services.
- Use of prioritisation criteria when considering change or developments
- More individualised funding approaches whereby tangata whaiora have greater choice and control over the services they access
- Greater use of information about the current use of funding and distribution of services to inform planning.

Outcomes and evaluation

An outcomes and evaluation methodology for the Framework for Change will be developed. This will guide the collection and analysis of meaningful information about the way the Framework for Change is being implemented, its impact and whether it is achieving its intended outcomes. This methodology will describe the outcome measures, data capture, reporting, forums to review the reports and the way in

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which these will support accountability and inform quality improvement, service change and adaptation of this Framework for Change.

Support for innovation, learning and improvement

Waikato DHB intends to ensure that learning and improvement become embedded in the way the DHB funds services and the way that services are delivered. To achieve this, it will set up processes and infrastructure to support people to think outside the square, to continuously evaluate what is being done for whom and to what effect, and to adapt based on what is learned. It will facilitate sharing what is learned and embed a culture of innovation, learning and improvement across strategy, funding and delivery.

Next Steps

This Framework for Change has woven together the work already undertaken by Waikato DHB to develop models of care for mental health and addictions and described the overarching Framework for Change for the whole system of mental health services and alcohol and other drug services. It will be used to guide the future work of Waikato DHB's Strategy and Funding division through to 2030 and its approach to commissioning and will be adapted over time as new information about what works well comes to light.

The Framework for Change will form the basis for future commissioning of services. The next steps for Strategy and Funding will be to build the infrastructure necessary to implement this Framework and develop strong and effective commissioning approaches. This will involve:

Infrastructure development:

- Developing outcome measures in terms of equity of outcome for Māori and for other prioritised populations
- Developing an Accountability Framework for implementation of this plan
- Establishing a mechanism to support ongoing innovation, learning and development.

Commissioning

- Establishing the baseline status in relation to the outcome measures
- Identifying the current map of services and their fit with population need and the wellbeing approach described in this Framework
- Based on this Framework for Change, working with communities, tangata whaiora, whānau and providers to develop future strategic directions for commissioning mental health and alcohol and other drug services to better meet the needs of key priority communities experiencing inequity of outcome
- Developing the commissioning plan for the preliminary changes needed to better align services with the future strategic directions.

Service development and commissioning

Phase 1

Indicative timeframe – February to April 2019

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- Identifying the current map of services and their fit with population need and the wellbeing approach described in this Framework
- Establishing the baseline status in relation to the outcome measures
- Developing outcome measures in terms of equity of outcome for Māori and for other prioritised populations
- Developing an Accountability Framework for implementation of this plan
- Establishing a mechanism to support ongoing innovation, learning and development.

Phase 2

Indicative timeframe – May to July 2019

- Based on this Framework for Change, working with communities, tangata whaiora, whānau and providers to develop future strategic directions for commissioning mental health and alcohol and other drug services to better meet the needs of key priority communities experiencing inequity of outcome
- Developing the commissioning plan for the preliminary changes needed to better align services with the future strategic directions.

Phase 3

Indicative timeframe – beginning August 2019

Service re-configuration/new services commissioned

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https://b.3cdn.net/nefoundation/10b8aabd90c5771ff9_a0m6bvv5a.pdf

Waikato DHB source documents:

- Creating our Futures: Mental Health and Addictions Service Proposed Model of Care (2017)

- Health Needs Assessment Mental Health and Addiction Service Utilisation (2017)

- Te Pae Tawhiti Model of Care - Adult Mental Health (2018)

- Te Pae Tawhiti Child and Youth Mental Health Model of Care (2018)

- Te Pae Tawhiti Older Persons Mental Health and Addictions Services Proposed Model of Care (2017)

- Te Rōpū Tautoku ki Waikato Wānanga Outcomes Summary Report (2017)

- Waikato Adult Addictions Model of Care (2013)

- Waikato Youth Alcohol and Other Drug Model of Care (2015)

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Presentations

MEMORANDUM TO COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
13 FEBRUARY 2019

AGENDA ITEM 7.1

MENTAL HEALTH AND ADDICTIONS SYSTEM

Purpose	For information

Background

Two separate but related planning processes have been progressing over the last two years; both aim to refocus and develop the Mental Health and Addictions sector in Waikato DHB. Strategy and Funding have led the process of system wide planning which has been done under the *Te Pae Tawhiti* programme. The *Creating our Futures* model of care has been led by the Provider Arm Mental Health and Addictions service, and was precipitated by the urgent need to redevelop the Henry Rongomau Bennett Centre and address the significant demands on the provider arm mental health services. The *Creating our Futures* indicative business case was presented and endorsed by the Board in November 2018.

Draft System Map for Mental Health and Addictions Care and Wellbeing

This presentation focuses on mental health and addictions treatment and support *services* but also acknowledges the protective factors (determinants of wellbeing) that enhance mental health and wellbeing and the role the healthcare system has in influencing those factors. The focus on *services* is intentional in that the primary purpose of the system map is to depict the services that will be provided or funded by the DHB. The system map, once finalised, will provide the first step in developing an investment roadmap for the future.

This system map has not had wide input and should be considered a draft.

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

The system map that will be presented has a specific focus on eliminating Māori health inequities and improving health outcomes for Māori. There is also a clear commitment to supporting kaupapa Māori providers and improving the responsiveness of all ('mainstream") providers to Māori.

Recommendation
THAT

The Committee provides feedback on the draft Mental Health and Addictions draft system of care.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

Work Schedule

MEMORANDUM TO THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
13 FEBRUARY 2019

AGENDA ITEM 8.1

COMMITTEE SCHEDULE FOR 2019/20

Purpose	For information and discussion

The update committee schedule for the 2019/20 year is attached for the committee's information.

Recommendation
THAT

The Committee receive the schedule for 2019/20.

TANYA MALONEY
EXECUTIVE DIRECTOR, STRATEGY, FUNDING AND PUBLIC HEALTH

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
- Creating our Futures
- Drinking Water Compliance
- REACH

June

- Understanding the Determinants of Health
- Final Disability Responsiveness Plan
- Dental Health Services Overview
- 2019/20 Annual Plan
- Our approach to Community Engagement and Partnering with Māori
- Draft Disability Responsiveness Plan

August

- Immunisation – Performance and Service Overview
- Older Peoples Services – Comprehensive Model of Care
- Disability Support Services – Overview
- Addressing Acute Demand
- Prevention and Management of Long Term Conditions

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)
- Other

General Business

Date of Next Meeting
10 April 2019