Hospitals Advisory Committee Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	23 October 2019	**Time:**	10:30am

Committee Members:	Mr A Connolly, Deputy Commissioner (Chair) Dr K Poutasi, Commissioner Mr C Paraone, Deputy Commissioner Professor M Wilson, Deputy Commissioner Ms TP Thompson-Evans, Chair Iwi Māori Council Ms R Karalus Dr P Malpass Mr J McIntosh Mr F Mhlanga Ms G Pomeroy Mr D Slone Ms J Small Mr Tupuhi
In Attendance:	Mr K Whelan, Crown Monitor Dr K Snee, Chief Executive Mr R Dunham, Interim Chief Operating Officer and other Executives as necessary

Next Meeting Date:	February 2020	
Contact Details:	Phone: 07 834 3646	Facsimile: 07 839 8680

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Hospitals Advisory Committee Agenda

Item	
1.	Apologies
2.	**INTERESTS** 2.1 Schedule of Interests 2.2 Conflicts Related to Items on the Agenda
3.	**DECISIONS** 3.1 No Papers
4.	**DISCUSSION** 4.1 Views on Matters Coming within Scope of the Committee 4.2 Locality Development Approach 4.3 Mental Health Overview Including Waikeria Prison
5.	**INFORMATION** 5.1 No Papers
6.	**GENERAL BUSINESS** 6.1 No Papers
7.	**DATE OF NEXT MEETING** 7.1 February 2020

Apologies

Interests

SCHEDULE OF INTERESTS AS UPDATED BY HOSPITALS ADVISORY COMMITTEE MEMBERS TO OCTOBER 2019

Dr Karen Poutasi

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Commissioner, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Finance Risk and Audit Committee, Waikato DHB	Non-Pecuniary	None	
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Chief Executive Officer, NZ Qualifications Authority	Non-Pecuniary	None	
Deputy Chair, Network for Learning			

Mr Andrew Connolly

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Deputy Commissioner, Waikato DHB			Refer Notes 1 and 2
Member, Finance Risk and Audit Committee, Waikato DHB			
Chair, Hospitals Advisory Committee, Waikato DHB			
Member, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB			
Board member, Health Quality and Safety Commission			
Southern Partnership Group			
Employee, Counties Manukau DHB			
Member, Health Workforce Advisory Board			

Mr Chad Paraone

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

Note 1: Interests listed in every agenda.

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

Member, Iwi Maori Council, Waikato DHB			
Independent Chair, Bay of Plenty Alliance Leadership Team			
Independent Chair, Team Rotorua Alliance Leadership Team			
Independent Chair, Integrated Community Pharmacy Services Agreement National Review			
Strategic Advisor (Maori) to CEO, Accident Compensation Corporation			
Maori Health Director, Precision Driven Health			
Board member, Sport Auckland			
Committee of Management Member and Chair, Parengarenga A Incorporation			
Director/Shareholder, Finora Management Services Ltd			

Professor Margaret Wilson

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Deputy Commissioner, Waikato DHB			Refer Notes 1 and 2
Member, Finance Risk and Audit Committee, Waikato DHB			
Member, Hospitals Advisory Committee, Waikato DHB			
Chair, Community and Public Health and Disability and Support Advisory Committee, Waikato DHB			
Member, Waikato Health Trust			
Law Professor, University of Waikato			

Ms 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, Commissioners Group, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Finance Risk and Audit Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Chair, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Chair, Iwi Maori Council, Waikato DHB			
Iwi Maori Council Representative for Waikato-Tainui, Waikato DHB			
Iwi: Ngāti Hauā			
Member, Te Whakakitenga o Waikato			
Director, Whai Manawa Limited			
Director/Shareholder, 7 Eight 12 Limited			
Co-Chair, Midlands Iwi Relationship Board, Midlands			
Deputy Chair, River Plan Taskforce, Hamilton City Council			
Maangai Maaori, Community Services & Environment Committee,			

Note 1: Interests listed in every agenda.

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

Hamilton City Council **Director/Shareholder, Haua Innovation Group Holdings Limited**			

Ms Rachel Karalus

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospital Advisory Committee, Waikato DHB	Non-Pecuniary	None	
CEO K'aute Pasifika			
Trustee, Pacific Business Trust			
Trustee, Child Matters			
Trustee, Hamilton Christian Night Shelter			
Trustee, St Joseph's Primary School Fairfield			

Dr Paul Malpass

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospital Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Fellow, Australasian College of Surgeons			
Fellow, New Zealand College of Public Health Medicine			
Trustee, CP and DB Malpass Family Trust			
Eldest son employed by Bayer Pharmaceuticals			
Eldest daughter: registered nurse employed by Tuwharetoa Health			
Youngest daughter employed by Access Community Health			
Member, Grey Power			
Member, Taumarunui Healthcare Governance Group			
Attendance, Nga Kaumatua o te Mauri Atawhai hui			

Note 1: Interests listed in every agenda.

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

Mr 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
Member, Hospital Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Community Liaison, LIFE Unlimited Charitable Trust			
Co-ordinator, SPAN Trust			
Trustee, Waikato Health and Disability Expo Trust			

Mr Fungai Mhlanga

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Community ad Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospital Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Employee, Department of Internal Affairs (DIA)- Office of Ethnic Communities			
Trustee, Indigo Festival Trust			
Trustee, Waikato District Health Board			
Member, Waikato Sunrise rotary Club			
Trustee, Grandview Community Garden			
Volunteer, Waikato Disaster Welfare Support Team(DWST) - NZ Red Cross			
Volunteer, Ethnic Football Festival			

Ms Gerri Pomeroy

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospital Advisory Committee, Waikato DHB	Non-Pecuniary	None	
CO-Chair, Waikato DHB Consumer Council			
Waikato Branch President, Disabled Person's Assembly			
National Executive Committee Member, Disabled Person's Assembly			
National President, Disabled Person's Assembly			
Member Enabling Good Lives Waikato Leadership Group			
Member, Machinery of Government Review Working Group			
Co-Chair Disability Support Service System Transformation Governance Group			
DPO coalition representative, Enabling Good Lives National Leadership Group			

Note 1: Interests listed in every agenda.

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

Mr 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
Member, Hospital Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Director and Shareholder, The optimistic Cynic Ltd			
Trustee, NZ Williams Syndrome Association			
Trustee, Impact Hub Waikato Trust			
Employee, CSC Buying Group Ltd			
Advisor, Christian Supply Chain Charitable Trust			

Ms Judy Small

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

Mr Glen Tupuhi

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	
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	
Board member, Hauraki PHO			
Trustee, Te Korowai Hauora o Hauraki			

Note 1: Interests listed in every agenda.

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

Decisions

Discussion

REPORT TO HOSPITALS ADVISORY COMMITTEE
23 OCTOBER 2019

AGENDA ITEM 4.1

VIEWS ON MATTERS COMING WITHIN SCOPE OF THE COMMITTEE

Purpose

The purpose of this report is to facilitate a discussion involving the external appointees on what they consider to be the primary areas of focus for the Committee.

Recommendations
THAT

1) A discussion on priorities with representatives of the wider Waikato community on the committee is held to inform the work plan for 2020.

RON DUNHAM
CHIEF OPERATING OFFICER

REPORT DETAIL

Background

The chairs of the Community and Public Health Advisory Committee (incorporating the Disability Support Advisory Committee) and the Hospitals Advisory Committee have agreed the first meeting of their committee should include a session enabling the external appointees to express their views on the priorities for the committee.

With this in mind the terms of reference for Hospitals Advisory Committee are attached in Appendix 1.

Equity

Determining the priorities of the committee will determine the extent to which equity is addressed.

Efficiency

Determining the priorities of the committee will determine the extent to which efficiency is addressed.

Quality and Risk

Determining the priorities of the committee will determine the extent to which quality and risk are addressed.

Strategy

Determining the priorities of the committee will determine the extent to which the Strategy will be advanced.

APPENDICES

Appendix 1:
Hospitals Advisory Committee Terms of Reference

Waikato District Health Board

HOSPITALS ADVISORY COMMITTEE TERMS OF REFERENCE

1) In accordance with the NZ Public Health and Disability Act, the Commissioner shall establish a Hospital Advisory Committee, whose members and chairperson shall be as determined by the Commissioner from time to time.

2) The Committee does not have delegated authority. Its advisory role will normally be discharged by way of the Commissioner adopting the Committee's minutes but other forms of reporting/advising may occur from time to time.

3) The function of the Hospitals Advisory Committee shall be to consider and advise the Commissioner on:

   a) How equity may be achieved and work prioritised to best achieve it;

   b) How radical improvement in Maori health outcomes may be achieved and work prioritised to best achieve it;

   c) How institutional racism and unconscious bias may be addressed in the delivery of services by Waikato DHB;

   d) Strategic issues relating to the provision of hospital services and other services directly delivered by Waikato DHB;

   e) Other issues arising from oversight of hospital and other services as presented in executive reports;

   f) Its findings on detailed investigation of particular problems, challenges, or issues coming within the Committee's scope;

   g) Issues that the Committee is directed by the Commissioner to examine, including mitigation of particular risks;

   h) Progress in implementing specific programmes and projects; and

   i) When opportunities to advocate and make submissions on matters coming within the scope of the Committee should be taken up, and on the content of such advocacy/submissions.

4) The Committee's advice may not be inconsistent with He Korowai Oranga, Te Korowai Waiora and Ki te Taumata o Pae Ora.

5) The Hospitals Advisory Committee shall hold meetings as frequently as the Commissioner considers necessary. Six meetings are normally held annually.

REPORT TO HOSPITALS ADVISORY COMMITTEE
23 OCTOBER 2019

AGENDA ITEM 4.2

LOCALITY DEVELOPMENT APPROACH

Purpose
The purpose of this report is to provide the Committee with an overview of the Locality Development approach being adopted by the DHB. The substantive content was provided in a report to the Commissioners from Tanya Maloney, Executive Director Transformation in September 2019 for their approval.

Recommendations
It is recommended that the committee:

1) Note the content of the report
2) Provide feedback on the approach outlined

PHILIP GRADY
INTERIM EXECUTIVE DIRECTOR – STRATEGY, FUNDING AND PUBLIC HEALTH

REPORT DETAIL

Background

The Waikato District is a large geographical area comprising a number of distinct communities. In 2017, the Strategy and Funding team began work to identify how the district could be viewed as a mix of discrete localities, allowing place-based planning and development to occur around logical geographical settings. The seven localities agreed by the Executive Leadership Team at the time are Greater Hamilton, North Waikato, South Waikato, North Ruapehu, Thames-Hauraki-Coromandel, Matamata-Piako, Waitomo-Otorohanga. These localities map reasonably well with Iwi boundaries enabling us to recognise our Iwi partnership responsibilities as the first step in locality development.

Through the engagement process to develop the Waikato Health System Plan (HSP), local Iwi, communities and stakeholders expressed a clear desire to be actively involved in the planning and design of health services for their communities. This aspiration was reflected in the HSP, together with the adoption of a stronger focus on addressing determinants of health in local communities. Improving the health and well-being of the population through upstream measures is critical to addressing inequity of health outcomes for Māori and other disadvantaged communities.

The Waikato DHB Resource Review (RR) also highlighted a mix of service coverage and sustainability issues facing communities and the DHB. The future use of DHB facilities in the smaller towns is of particular importance, and their future configuration

will depend on the models of care adopted across the Waikato Health System over coming years.

Locality development is being led within the Transformation Programme to address the commitments made in the HSP, and the issues raised in the RR. It will be managed in a staged approach, to ensure local communities and stakeholders are engaged in the future-proofing of services in their local communities, whilst also ensuring the DHB can make well-informed decisions in respect to future investments and models of care to eliminate inequities.

Discussion

Locality development has 4 key objectives:

1. To optimise people's access to health and well-being services, ensuring people receive high quality health and well-being services locally, and only travel when they need to
2. To scope and implement an appropriate service mix for the population of each locality in respect to what is provided locally, and what can be accessed through district-wide services
3. To ensure appropriate health-system enablers are adopted to ensure the provision of health services into local communities is sustainable. These include rural workforce development, digital health capability and transport
4. To support communities in the development of their own capacity with respect to community activity that supports good health and well-being

The approach to locality development will incorporate previous work where relevant, and will integrate existing service improvement activity (for example, the Rural Service Improvement Framework, focussed on the 'T' hospitals, presented at the August meeting). This will ensure that all service development and improvement activity is aligned with the directions set out in the HSP.

Whilst the Waikato has one of the largest rural populations in the country, it is not the only DHB to face the mix of sustainability and service coverage challenges that comes with servicing rural communities. The focus of other regions has been on much stronger integration of DHB, Primary Care and other community services, together with the adoption of rural generalist workforces. We can learn from such successful models that have been implemented in many parts of the South Island.

Our approach to locality development will ensure there is appropriate coverage of services to meet the needs of rural communities over the next decade, and ensure that services are well integrated. The process for locality development is described in the diagram in Appendix 1.

Significant work is underway to develop population and service profiles for each of the localities. It is proposed that the first localities for development will be South Waikato and North Ruapehu. The rationale for prioritising these two localities is:

- These localities constitute some of our highest need populations
- They have significant unmet need and service gaps
- They have significant local stakeholder and community networks, providing a strong platform for locality development
- There are existing hospitals in those localities.

Development work across the other localities will begin in 2020.

Local stakeholder leadership groups will be critical to support and drive this work. The DHB will work with these groups to undertake a systematic process of analysis, design and change implementation. It is envisaged that these locality based health networks will be active in on-going transformation over time.

The service areas within scope of the locality development approach are as follows:

Primary Care and DHB Community Services
There is value in planning and developing Primary Care in our localities as a broader conglomerate of community based care than simply General Practice (GP).

The sustainability of future rural and small town health services is likely to be built on alternative models of care and workforce approaches. These will include: Rural Generalists (where doctors operate in smaller communities as both General and Hospital Practitioners), nurse-led primary care teams, designated nurse prescribers, nurse practitioners, and stronger integration of district nursing and allied health with local primary care teams.

Work is underway to define Waikato's *Enhanced Primary Care* approach for the future. This is likely to consistent with the proposed PSAAP strategic framework (Appendix 2), which in itself is consistent with the DHB's HSP.

DHB Community Hospitals
The DHB operates five hospitals of differing configurations across the Waikato. Aside from the secondary/tertiary hospital site in Hamilton, there are hospitals in Thames, Tokoroa, Te Kuiti and Taumarunui all operating with different service models. The DHB also operates two continuing care hospital facilities in Morrinsville and Te Awamutu.

Each of the southern rural facilities will require substantial capital investment over the next decade, therefore developing facilities that are right-sized and right-purposed is critical. The future for the Tokoroa, Te Kuiti and Taumarunui facilities will need to take this into account.

With respect to the Morrinsville and Te Awamutu continuing care hospitals, these services are also out-dated both in terms of facilities and model of care. Future models operated out of those facilities will need to take account of this.

Mental Health Services
The "Lets Talk" engagement process undertaken during 2018 identified many gaps in mental health services across the DHB's rural communities. The issues ranged from the lack of whanau support and advice, through to the absence of local crisis management teams, and inadequate community care facilities. These service gaps will be addressed as part of the locality development approach, in conjunction with Strategy and Funding and Mental Health Service colleagues.

Other Community Health Services
The DHB funds a range of other community based health and well-being services across the district. These are critical to supporting our population's health and wellbeing. These services include Aged Residential Care, Home Based Support Services, Maternity Services, Oral Health, Child Health Services and Community Transport.

Next Steps

November
A report providing population and service profiles for two of our priority locations.

A paper discussing early changes that can be made to transport, to and from priority localities.

December
An implementation plan for transport to and from rural hubs/hospitals and Waikato hospital.

February
An implementation plan for Rural Health Hubs.

Equity

Locality development is primarily focussed on increasing access and improving health outcomes for Māori and other priority groups within each locality. The inequities associated with rurality impact Māori significantly; thus, this work is critical in ensuring we achieve equity of access and outcomes for Maori. By its nature locality planning is about engaging and partnering with the communities and providers at the centre of these communities – it builds on their knowledge and experiences to ensure future service delivery is appropriate and effective in each locality. We will work with local Māori and Iwi to ensure there is a partnership approach to local delivery in the future.

Efficiency

Health services across rural Waikato communities are currently siloed, disconnected, and inconsistent and thus are inherently inefficient. Locality based service development will ensure that service provision is optimised for each of those communities resulting in better access for patients, and better utilisation of health resources in rural communities.

Quality and Risk

Locality development will be predicated on new models of care that focus on ensuring patients get access to effective and safe care wherever they live.

Strategy

Locality development is a key commitment of the HSP and a key mechanism to achieve health equity and improved access for our communities, irrespective of where they live.

Future Reporting

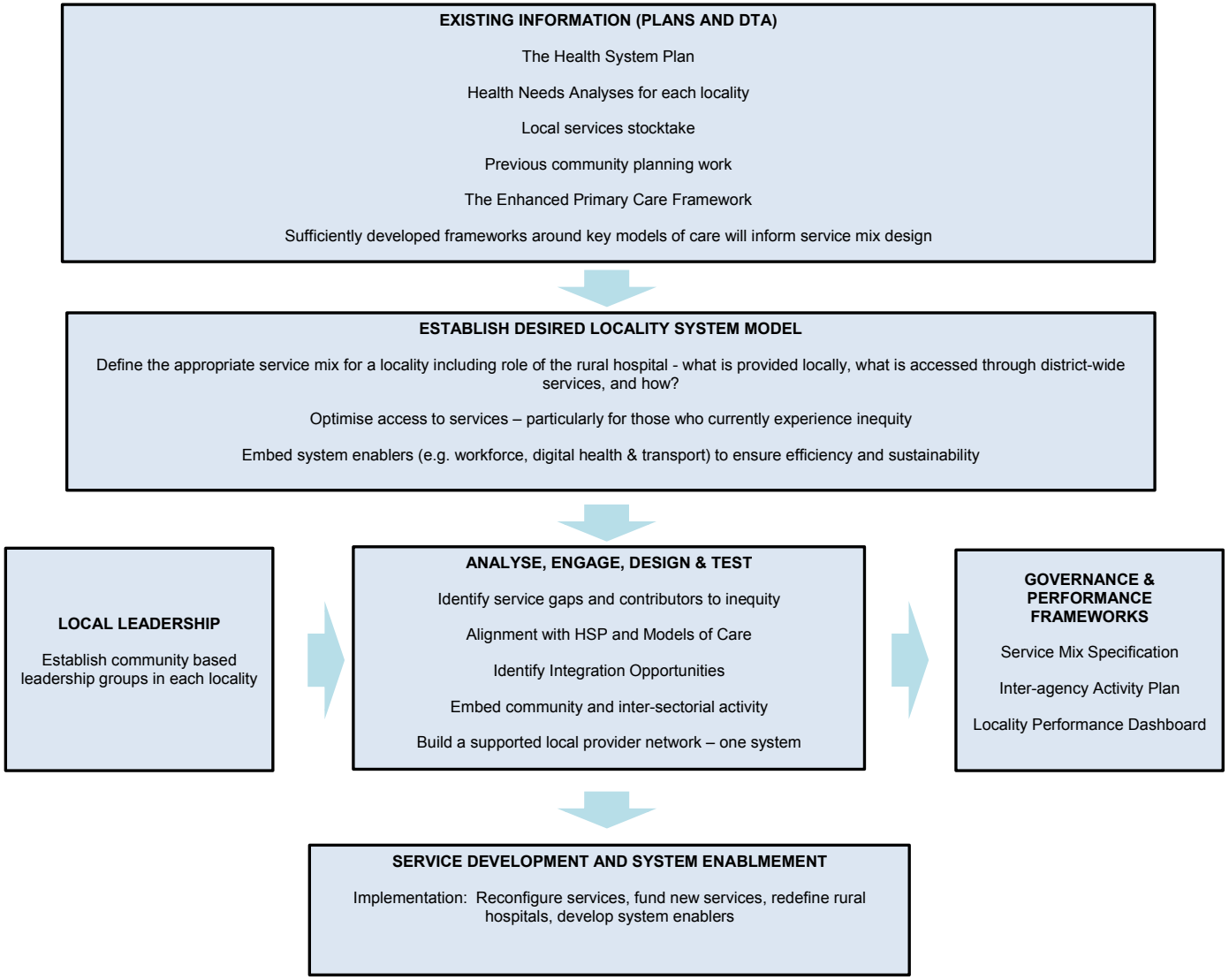
As the DHB progresses the locality approach there will be future reporting in progress under the Transformation Programme.

APPENDICES

Appendix 1:
Locality Development Approach

Appendix 2:
Proposed PSAAP Strategic Framework

APPENDIX 1: LOCALITY PLANNING APPROACH



APPENDIX 2 – PROPOSED PSAAP STRATEGIC FRAMEWORK

Vision for Primary Health Care in New Zealand

We want a primary health care sector that delivers good quality and accessible health services, reducing inequalities and securing better health outcomes for every New Zealander. Primary health care is a central part of an effective system helping all New Zealanders to live well, stay well and get well. This requires greater collaboration and integration across the health system (Ministry, DHBs, PHOs, NGOs, practitioners, communities, people), and changes to service and business models. High-performing primary health care relies on general practice, community providers and iwi providers delivering high quality care in their local communities.

FINAL WORKING DRAFT – NOT GOVT POLICY

Government priorities underpinned by equity

- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention
- Improving population outcomes through a strong and equitable public health system
- Improving population outcomes though primary health care

Primary Health Care Strategy

The principles of the **Primary Health Care Strategy (2001)** remain central to the system we want.

The principles guide us to:

- Work with local communities and enrolled populations
- Identify and remove health inequalities
- Offer access to comprehensive services to improve, maintain and restore people's health
- Co-ordinate care across areas
- Develop the primary health care workforce
- Continuously improve quality using good information.

He Korowai Oranga

High-performing primary health care is:

- Person-centred and inclusive of family/whānau
- Team-based with effective interdisciplinary care that delivers the right people, in the right place, with the right skills to provide the best care and equitable outcomes
- Organised around individual, community and population needs and the needs of subgroups of the population
- Comprehensive, coordinated and provides continuity of care
- Concerned with reducing inequalities, improving access, and facilitating participation and engagement
- Informed by data, evidence and client insights, using analytics to drive improvement
- Focused on addressing the broader social determinants of health through intersectoral collaboration
- Integrated with the wider system
- Future-oriented

What we want from the system:

1. **Responsive models of care**
2. **Inter-professional collaboration and integration**
3. **Reduced inequalities and better health outcomes for those with most need**
4. **High quality information and data that supports decision making at all levels**
5. **Strong commissioning and governance**

Primary Health Care (PHC) is usually the first point of contact for people seeking support for their health needs. PHC services, events or information are provided to a) promote or improve health and support people to live well, b) support people to manage long-term conditions or other life events so they can stay well, and c) treat people (including involving other community and specialist health services where needed) to get well.

APPENDIX 2 – PROPOSED PSAAP STRATEGIC FRAMEWORK

Health & Social Care Coordination
(Offer access to comprehensive services to improve, maintain and restore people's health)
(Co-ordinate care across areas)
(Work with local communities and enrolled population)

Embed improved models of care
2019/20
- Evaluate models of care (interim report due August 2019), and use the recommendations to support policy development for a more responsive primary health care setting
- Identify key components of responsive, high quality models of care, aided by bringing together an informal sector group to provide advice to the Ministry
- Use the Primary Mental Health investment to drive changes, to test new ideas and then embed improved models of care
- Provide leadership and an enabling environment to support the use of new technology, including virtual health, to improve experience and create capacity
- Remove clawbacks for after hours care

Utilise multi-disciplinary primary health care teams
2019/20
- Develop System Outcome Performance indicators for interdisciplinary collaboration in the delivery of health services
- Support extended team based workforce in primary healthcare with a focus on mental health workforce through the Primary Health Mental investment
- Clarify business models and rules that enhances interprofessional collaboration, including allowing for employer-agnostic teams
- Identify localities (with populations of 20-50,000) to support community aspirations and collaborative networks of General Practices and providers that are employer agnostic, and utilise a central point of referral

2020/21
- Develop locality teams that include GPs, practice nurses, social workers, health coaches, allied health assistants, health improvement practitioners, community and public health nurses, pharmacists, paramedics/ambulance services, physiotherapists, occupational therapists, nurse practitioners, kaiāwhina, and other professionals from the social services

Eliminate Treatment, Access and Outcome Inequities
(Identify and remove health inequalities)

Enhance the ability of the system to demonstrate population health gain
2019/20
- Enhance the ability of the system to demonstrate improved outcomes at a population level
- Improve accountability and decision making at a national level for Māori and high needs populations
- Implement the first stage of the Equity 2040 project with Maori pepe
- Strengthen the primary, secondary and community alliances at an operational level to support integration across health and social services for Māori and high needs population
- Introduce provider-level initiatives that will eliminate inequities in access to services and improved health outcomes for individuals
- Strengthen iwi, Māori and Pacific Provider participation on Alliance Leadership Teams
- Use the $3 million appropriated through the Health Workforce Development Fund to support equity focused primary and community care workforce initiatives

Introduce provider-level initiatives that will eliminate inequities in access and outcomes
2019/20
- Review current DHB Maori/Pacific Provider spending using co-design (Mana Motuhake pinciples) and identify reinvestment and increased investment opportunities using co-design processes
- Develop Budget Bids for Budget 20 to address fairness, targeting and accountability within the PHO Capitation Funding Formula to enhance its impact on achieving equity. This may include:
  1. Individual targeting – reviewing income thresholds for the Community Services Card
  2. Practice targeting – High Need practices only
  3. Load formula to allocate more funding for those aged over 75, and Māori and Pacific
  4. Develop practice and equity plans, monitor these, and support practice interventions
  5. Review and publicise approved interventions and outcomes for Māori and priority populations for SIA/Care Plus (Flexible Funding Pool)
- Following a review of evidence of impact on medicines compliance, consider reducing the prescription fee to $2.50 (either CSC targeted or for whole population).

Develop a Sustainable Primary Healthcare Multidisciplinary Team / Workforce
(Develop the Primary Healthcare workforce)

Increase the size of the workforce
2019/20
- Develop pathway to increase Nurse Practitioner employment and demonstrate business model
- Increase Māori and Pacific workforce in Primary Care (match local population), and review the Māori and Pacific health workforce pipeline and funding streams (with a focus on the mental health workforce)
- Develop and grow the regulated and unregulated workforce (including kaiāwhina, health coaches, allied health and practice/health care assistants).
- Focus urgently on the Mental Health workforce through the primary mental health investment
- Enhance opportunities to support nurse prescribing
- Develop Budget Bids for Budget 20 to increase the number of GP trainees

Develop the workforce capability
2019/20
- Develop and support Rural Health Training Hubs
- Scope an annual free health check and/or free eye check for SuperGold cardholders
- Implement the second stage of the workforce development policy for the allied health care workforce including health improvement practitioners, coaches, kaiāwhina
- Build on amendments to the HPCA Act 2003 to support responsible authorities to promote and facilitate inter-professional collaboration.
- Include Disability Awareness in training for the Primary Care workforce

High Quality Information & Data to Drive Culture and Inform Policy Improvement
(Continuously improve quality using good information)

Improve quality at a systems level to support population health gain
2019/20
- Use appropriate System Outcome Measures to drive accountability for equity and service/primary care health outcomes
- Improve understanding and collection of primary care information that supports better understanding of the health needs of their population
- Develop a business case for a National Primary Care Data Service
- Align new research priorities for Health Research Council with health policy research needs through a strategic setting relationship between MOH, HRC and MBIE
- Develop Budget bids for Budget 20 to implement and fund Primary Care Data Service

Support improvements at a provider level to improve quality *2019/20*
- Support the continued use of CQI programmes as a core part of primary health care services
- Provide full support for SNOMED CT implementation
- Provide analytics to improve ability to provide high consistent, high quality care and also predict system capacity
- Develop standards-based view of GP Patient Management System and/or other community provider patient software options to ensure functionality and interoperability
- Improve interoperability of data and systems with a focus on access to patient information for a broad range of health practitioners
- Require all primary care services to offer patient portals and continue to promote their uptake.
- Support practices to implement improvements based on patient experience of care (through the national Patient Experience of Care survey)

Strengthen Primary Healthcare, Governance & Commissioning
(Set the national direction for primary health care and strengthen governance and commissioning locally)

Set the strategic direction for District Alliances
2019/20
- Set national expectations for District Alliances through MoH Annual Planning Guidance and the Minister's Letter of Expectations.

Strengthen local level decision-making
2019/20
- Invest in District Alliances to enable high trust relationships; clinical leadership; a strong focus on equity; broad membership; and robust data management and analytics; including:
  - membership that has Māori and Pacific providers, iwi, pharmacy etc.;
  - an integrated approach across health and social services with a focus on serving high needs populations;
  - joint commissioning of all primary healthcare services, informed by local plans and quality data.

- Develop a range of commissioning options for District Alliances that allow flexibility of funding based on a range of factors (eg, composition and competence of governance; relationships and trust between DHBs and PHOs; capacity and capability of support teams / SLATs) and give the opportunity to either demonstrate achievement of equity in a targeted area or a fully integrated system.

REPORT HOSPITALS ADVISORY COMMITTEE
23 OCTOBER 2019

AGENDA ITEM 3.3

MENTAL HEALTH OVERVIEW INCLUDING WAIKERIA PRISON

Purpose

The purpose of this report is to provide an overview of Mental Health and Addictions Services (MH&AS) for the Waikato DHB to inform a future committee discussion. In addition, the report highlights the Waikeria Prison mental health beds and some of the opportunities and risks associated with this initiative.

Recommendations
It is recommended that the Committee:

1) Note the content of this report.
2) Note that there will be a focussed discussion on Mental Health and Addictions with the committee meeting.

PHILIP GRADY
INTERIM EXECUTIVE DIRECTOR STRATEGY, FUNDING AND PUBLIC HEALTH

VICKI AITKEN
EXECUTIVE DIRECTOR MENTAL HEALTH AND ADDICTIONS

Report

Mental Health and Addictions is a priority area for Waikato DHB. The context is that over the past few years that there has been significant pressures across various parts of the system, including high occupancy of our inpatient services, a high level of referrals to our infant, child and adolescent services teams and alcohol and other drug treatment services being stretched to respond to the people using methamphetamine.

An attempt to reflect the Healthcare System is reflected in Appendix 1. This map enables an ability look at our mental health and addictions system as a whole and map current service provision and identify the areas that require more focus. Two areas of note are the focus on communities supporting wellbeing and Kaupapa Māori service provision.

Context

About one in five of us experience mental illness or significant mental distress. Over 50-80% of New Zealanders will experience mental distress or addiction challenges or both in our lifetime. A range of social determinants are risk factors for poor mental health: poverty, lack of affordable housing, unemployment and low paid work, abuse and neglect, family violence and other trauma, loneliness and social isolation (especially in the elderly and rural populations) and for Māori, deprivation and cultural isolation (He Ara Oranga: report of the Government Inquiry into Mental Health and Addiction, 2018).

The Blueprint for Mental Health Services (1998) provided a framework for mental health and addictions services to be delivered to 3% of the population. Over the 20 or so years there has been a significant increase in funding for services which has seen a large amount of growth. Sadly, He Ara Oranga: report of the Government Inquiry into Mental Health and Addiction (2018) highlighted that despite all of the growth in services there is much work required to build a new system that has mental health and wellbeing at its heart.

Population overview

Waikato DHB is one of New Zealand's largest DHB by geographical area covering ten territorial authority areas and services an estimated resident population of 423,320 people. Within the DHB there is a broad mix of large urban, small urban, rural and significantly isolated communities and a high proportion of rurality with 40% of the population living outside the Greater Hamilton area. 35% of the population are aged 24 or under, 49% are aged between 25 and 64 and 16% are 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 28%.

The table below shows the access rates for by age group to Waikato DHBs MH&AS.

Age	Access Rates Total	Mental Health	AOD
0 - 11	**2.57%**	**2.51%**	**0.06%**
12 - 19	**8.50%**	**6.58%**	**2.05%**
20 - 64	**4.98%**	**3.46%**	**1.72%**
65-plus	**2.31%**	**2.16%**	**0.15%**
Total	**4.52%**	**3.29%**	**1.23%**

Overall the access rates appear to be at a good level, however the story behind the access rates are that Māori are over-represented in access to services, present late to service and are more likely to be treated under compulsion than non-Māori. In our approach moving forward we must grow services which address the equity gap and respond earlier to Māori.

Investment and future provision

In order to plan for future service provision, we need to understand the spread of current services across the system map (Appendix 1) and the gaps in service provision. The work has progressed to map current service provision across the map; this is based on Vote Health funded services and does not include services that are funded through other means.

To date this work is focussed on the investment (services/initiatives) in the healthcare segment (the 'cheese segment') part of the system map, although many support services work with whānau and communities to enable and strengthen natural supports. Over the coming months we will complete the assessment of current service state and an assessment of gaps in service provision across the following domains:

- Service delivery setting – community vs residential/inpatient
- Type of service
- Māori and Non Māori providers
- Age Specific Services
- Service location

Overall the DHB spends approximately $118m on MH&AS (excluding Forensic services). The types of services are grouped into a number of areas, the detail of which are included in Appendix 2.

What is the direction we are going in?

There have been two significant pieces of work which are guiding the future shape of our MH&AS.

The first is Me Korero Tatou (Let's Talk) which through 29 community hui and workshops allowed people to talk, tell their stories and be heard. The Lets Talk hui process has been a critical guide to the new direction for MH&A services. It will be difficult to find another DHB that has gone to such efforts to hear their communities voice on MH&AS. The second is Te Pae Tawhiti, the Framework for Change for Waikato MH&A services 2018-2030. Te Pae Tawhiti outlines four koru for a wellbeing approach for services, including services both funded and not funded by the DHB.

In addition, the provider arm has been working on a transformational change programme called Creating Our Futures. The programme is aimed at establishing a whole system pathway, with appropriate fit-for-purpose facilities, and the provision of community services closer to home.

Recently all of this work has brought together through the establishment of a MH&AS Development and Oversight Group. The new group will oversee the MH&AS with a particular focus on;

- Equity for Māori
- Making recommendations in respect of the DHB's MH&AS change and investment plans
- Making recommendations regarding the change programme implementation to ensure the new system significantly improves health outcomes for service users

Overall the direction is to provide a strong focus on wellness and communities with services that are closer to where people live. There is an important direction to ensure

that our rural communities are able to access services and that these services are provided in a way that supports people to stay well and respond earlier.

System level pressures

In order to address the number of issues that are impacting on people, we need to ensure that our services are provided in a way that is inclusive of whāānau and supports people to stay well and respond earlier. There are a number of challenges that are facing our services which are briefly summarised below.

Secondary Mental Health – there is a high level of pressure on the inpatient service beds. This has been a flow on from there not being the right range of services and support to maintain people in the community. Generally, there is a sense that adult mental health services have not moved quickly enough or become whānau focussed soon enough. The responsiveness of our crisis services is also an area than requires focus. The agility of services and ability to respond to need has in part been impacted by a 70% increase in demand over the previous ten-year period.

For Mental Health Services for Older People there have been challenges in the timeliness of responding to referrers (particularly aged care providers) across the Waikato to assess and avert acute crisis leading to admissions. Development for MHSOP moving forward will focus on an acute response team within the wider community team for older adults. With an aging population, this approach would support and enhance people to remain in their own home or with a provider. Further work is also required to look at the continuum of services required in the areas of highest need, in particular the eastern part of Waikato – Cambridge and the Coromandel Peninsula.

In 2009, Infant, Child and Adolescent Mental Health Services were configured in into a cluster model. Services are dispersed across providers and each geographical area across the region – Hauraki, South and Hamilton operates a governance model. While there has been some significant focus and investment over recent times, referrals have grown by 100% since 2010. The service mix is geographically located and has a strong kaupapa focus. The workforce in this area is relatively scarce. There is still some work required to refine the service following a recent review of the cluster model.

Secondary Alcohol and Drug Treatment Services – there are some real concerns that the model of care is not being able to respond to the substance abuse challenges our communities face. There is also only a small number of local residential treatment beds available. There is a need for an increase in community-based services including home detox and access to non-clinical positions such as peer services and whanau support.

Primary Care -whilst there has been investment in this area there is an opportunity to do much more in focussing on wellness and responding earlier to Māori. The new Ministry of Health RFP for Primary Mental Health Services creates real opportunity to make a difference in this area. A focus must include enhanced primary care capability to intervene early and effectively address mental health need, alcohol and drug issues, addictions and comorbidities with physical illness and general practice capability to work with children and young people.

There is a limited MH&A workforce. There has been a move to establish non-clinical or support roles in the community, however more work needs to be done to establish

new roles such as Peer Support. This workforce will be particularly important in the area of wellness and primary care.

Waikeria Prison Mental Health Unit -In addition to all of these areas, there will be 100 mental health beds opening at the Waikeria Prison in April 2022. Whilst there is a need to address the mental health needs of men in prison, many of who are Māori, there are impacts for Waikato DHB once prisoners are released.

The Waikeria Mental Health Service development is a partnership between the Department of Corrections, Waikato DHB and Mana Whenua. Both Ministers of Health and Corrections have agreed the following should occur:

- The 100 beds will be for prisoners within this region
- The model will see a health led approach based on Māori models of MH and evidence-based practice
- The environment will be therapeutic, culturally appropriate and be part of a model that is focused on recovery, rehabilitation and reintegration.

A detailed summary is included in Appendix 3.

What work is underway?

The way in which we have commissioned services in the past has not enabled service delivery or service provision to adapt as needs change or as communities grow. This is particularly apparent provision to Māori and our rural communities. The new Commissioning approach from Strategy and Funding aligned with the Health Systems Plan will do a lot to achieve equity for Māori and overall wellbeing for all.

There are a number of activities that are underway in order to respond to the challenges our system is facing. Some of these are outlined below;

Secondary Mental Health - A phased reconfiguration of the provider arm secondary mental health services is underway to align with the overall locality approach, within the Health Systems Plan. These services will be delivered in an integrated way within each locality alongside primary and community care and other partners including NGOs. The approach will include a responsive crisis wrap approach tailored to each community. In building to this the following work is happening.

As a step to achieving a more community focus, a new 10 beds Community Based Acute Alternative to admission is in the process of being established. This new service will have a strong whanau focus and incorporates much of the feedback from Lets Talk. In addition, Strategy and Funding are in the process of reconfiguring the Residential Coordination Service to establish a new mobile community housing and support team (NGO delivered) collocated with current configuration of community mental health team. This new service begins to shift the focus of control from the provider arm to NGOs and will support the transition to locality services. There has also been a significant focus on moving people with high and complex needs from the Henry Rongomau Bennett Centre (HRBC) to more appropriate community settings.

There is a plan to pilot a Peer Support approach for the Waikato District.

Creating our Futures and Better Business Case Facility Redesign

The provider arm MH&AS has been working development of service change and new model of care. This includes a detailed business case for a new acute inpatient facility, replacing the aging HRBC.

There is a Creating Our Futures programme underway to transform the whole system pathway, with appropriate fit-for-purpose facilities, and the provision of community services closer to home, as more of the same will not deliver the wellbeing and recovery-oriented system that is required. Again, this work will be aligned with the locality approach.

The focus of the Creating Our Futures programme is to achieve equity for Māori and overall wellbeing improvement for all. We will do this through the implementation of the Wai Ora Model of Care that will inform what the service delivers; the acute environment/s and capital infrastructure needed; and, the resources required to support this model.

New Acute Inpatient Facility

The HRBC based at Waiora Waikato Hospital campus is no longer meeting the increasing demand for our very unwell people with mental health and addiction challenges who need to be cared for as an inpatient.

Work is well underway on the Better Business case with the indicative case currently before the Capital Investment Committee. The indicative case defines our vision which has been developed through extensive feedback with the help of the Waikato community, iwi, health professionals, and those with lived experience.

The proposal covers:

- A new fit-for-purpose acute and sub-specialty facility located at Waiora Waikato Hospital campus.
- Refurbishment of the existing HRBC to extend our Puawai services once the new building is complete.

Integral to this work is the development of a Māori Cultural Inpatient Pathway and framework. Mana whenua, Iwi Māori Council representatives, Te Puna Oranga and the MH&AS leadership team are working together to ensure a cultural narrative is clear and provides direction for the architects to be incorporated into the facility design.

Closer to Home

During community Hui we heard that communities wanted services closer to home and easier access to care and support. We are trialling initiatives in rural communities focusing on providing care closer to home.

The MH&AS has established a local point of access trial at Waharoa in association with Te Hauora Ngati Haua Trust. This involves a Mental Health social worker, Alcohol and other Drug Clinician and Kaitakawaenga working alongside the Hauora team to improve the range of services available to tangata whaiora and their whanau closer to home.

In Thames the community mental health and addictions team and Thames Hospital are working to establish a local service to provide a level of acute community based care closer to home. This service will be an option for people from Hauraki and the Coromandel region to receive a level of care locally as an alternative to travelling to Hamilton. The service will be supported by local tangata whaiora and whānau services, primary care and iwi services.

A Closer to Home Mental Health and Addiction Service is being developed in North Waikato that will aim to provide a range of mental health and wellbeing services to people in the North Waikato region. We envisage that working in partnership with many of the local services already available in the north Waikato we will be able to provide a continuum of services to ensure that people's mental health and wellbeing care is provided. Our goal will be for services that will want to work together to ensure that all or most of people's needs are met locally and without having to travel in to Hamilton.

We will be working with the local services in these trials to identify how we make the services sustainable, learn from these trials and look to support similar initiatives in other rural communities.

Secondary Alcohol and Drug Treatment Services
We are working with local agencies to establish a coordinated approach to supporting people using methamphetamine. The vision of the Waikato Methamphetamine Prevention Strategy is 'A cross agency approach to reducing methamphetamine and other drug related harm in Waikato communities'.

The DHB has contributed to the development of a funding proposal to expand alcohol and drug interventions and access to treatment as part of the Proceeds of Crime Fund. As a new initiative in the Waikato Police District, it presents an opportunity for a cross agency approach that addresses crime-related harm to communities and aims to improve community wellbeing in multiple ways.

There is also intent to repatriate out of district residential alcohol and other drug and establish local residential treatment services aligned with a new alcohol and drug model of care.

Primary Care
As outlined earlier in this report we are in the process of responding to the Ministry of Health's RFP for Primary Mental Health Services and when successful begin rollout across general practices.

Other services

Waikato Plan – Wellness
DHB representatives are involved with a local leadership group across local government, iwi, business and public sector organisations. One of the work streams is mental health and wellbeing. The MHAS and S&F have presented to the Waikato Plan group to explore options for joint working. The leadership group have decided to focus on community responsiveness, community resilience and community capability building in the area of prevention and early intervention.

There is scope to look at local point of access initiatives as a possibility in selected communities subject to an evaluation of the Waharoa trial.

People's project
MH&AS has taken a lead role in the development of The People's Project – a multi-agency collaborative to end homelessness alongside the Wise Group and other providers and organisations. Our involvement with The Peoples Project continues to go from strength to strength. We have staff seconded into the initiative and sit on the governance board. Since its inception in late 2014, well over 600 people have been assisted into housing – with 94% of people retained in housing.

Integrated Safety Response
The Integrated Safety Response (ISR) to Family Violence is a police-led multi-agency project, which includes the Mental Health and Addiction Service as one of the key agencies. The development and implementation of the model has involved Police, Oranga Tamariki, MSD, Justice, ACC, WDHB MH&AS, Iwi, Education, and a large number of regional NGOs and victim advocacy services. The Executive Director MH&AS sits on the Leadership Group and previously chaired the operations group for Waikato. ISR represents a truly multi-agency and community response to family violence. ISR is the multi-agency response and safety planning system to respond to violence within families

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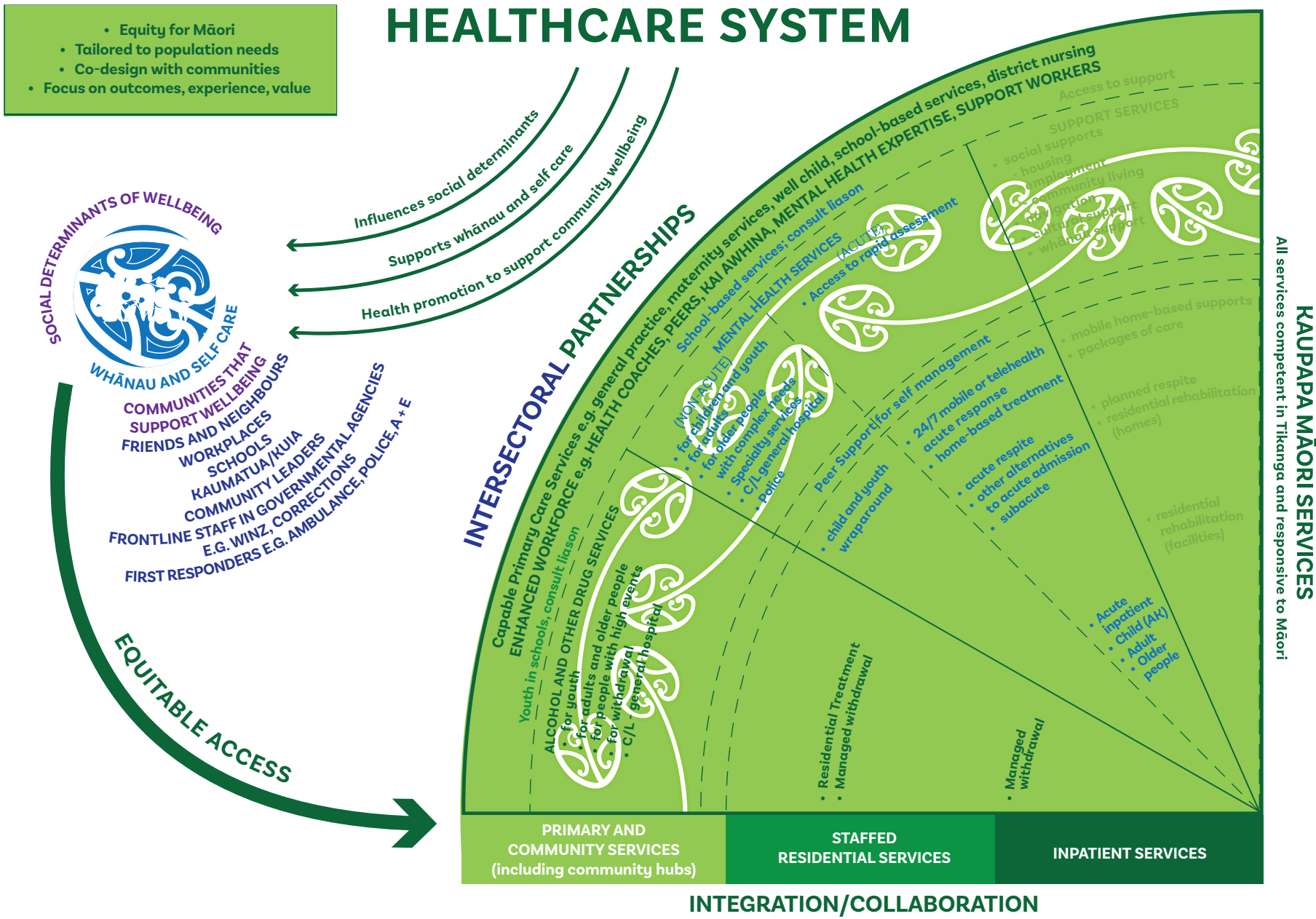
APPENDICES

Appendix 1:
Healthcare System

Appendix 2:
Overview of Investment on MH&A Services

Appendix 3:
Waikeria Prison

Appendix 1


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

Appendix 2:

Overview of Investment on MH&A Services

Service Planning

In order to plan for future service provision, we need to understand the spread of current services across the system map, and the gaps in service provision. The work has progressed to map current service provision across the map; this is based on Vote Health funded services and does not include services that are funded through other means.

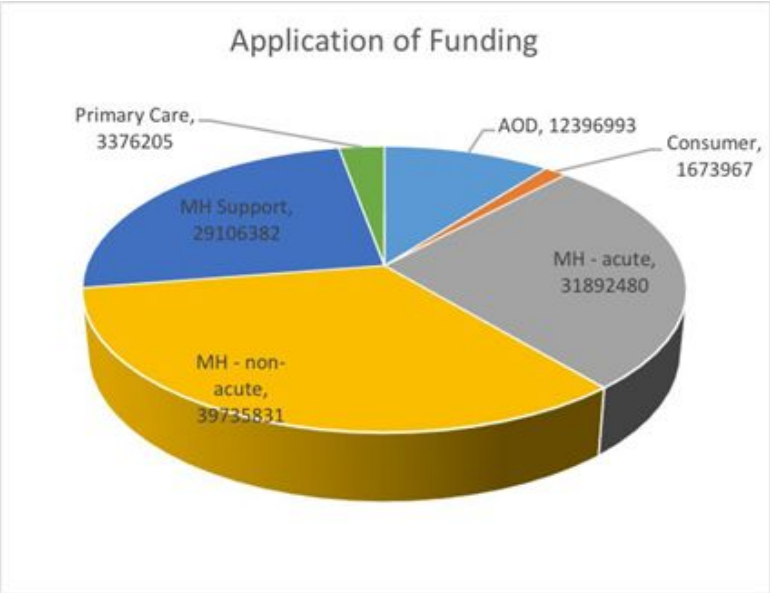
To date this work is focused on the investment (services/initiatives) in the healthcare segment (the 'cheese segment') part of the system map, although many support services work with whānau and communities to enable and strengthen natural supports. Over the next two months we will complete the assessment of current service state and an assessment of gaps in service provision across the following domains:

- Service delivery setting – community vs residential/inpatient
- Type of service
- Māori and Non Māori providers
- Age Specific Services
- Service location

A high level summary of the investment mapping completed to date is shown below. Please note that the figures are indicative only and yet to be fully verified.

Expenditure on Different Services and Settings

The application of funding across the different categories of service set out in the service map is shown below. "Primary Care" is funding for specific primary mental health and addictions initiatives. The total expenditure on Mental Health and Addiction Services is approximately $118M (excluding Forensic Services).



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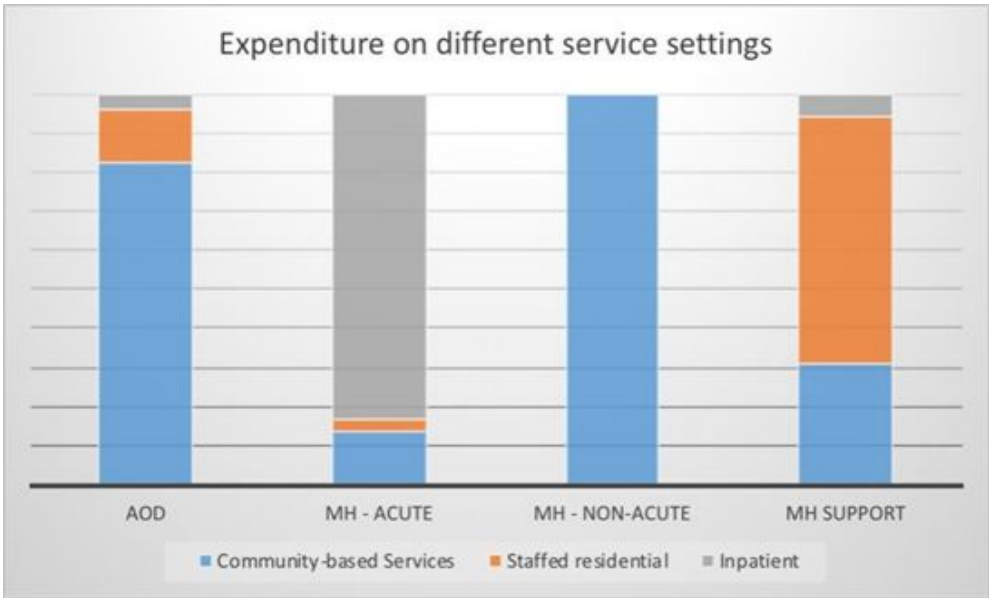
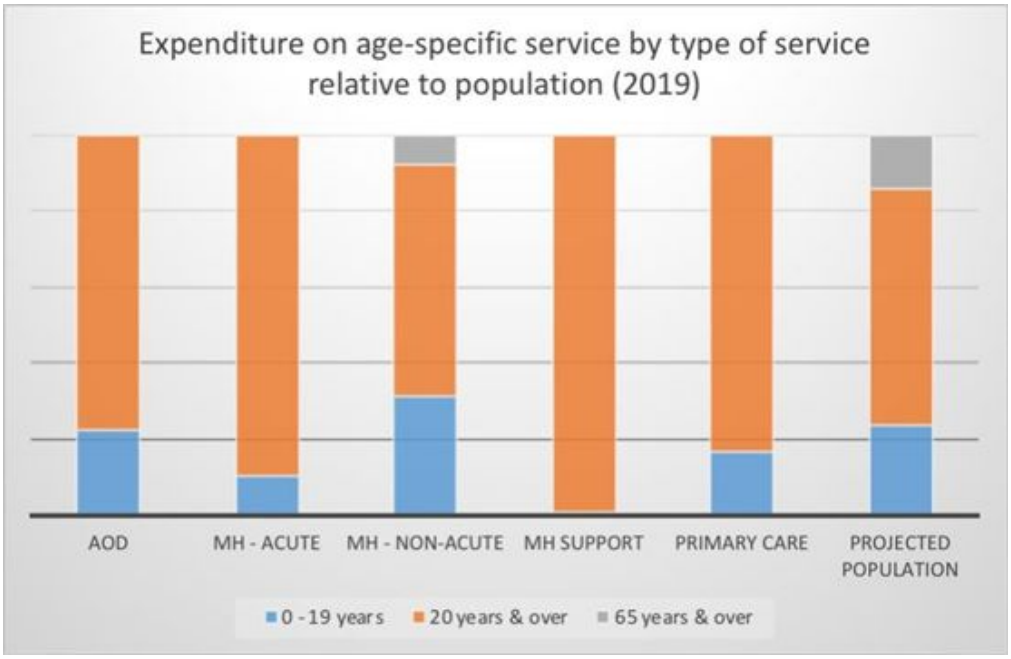


Note the different relative spending on inpatient, residential and community settings across the different service groupings. Of note is the relatively low investment in residential acute care and high investment in residential mental health support relative to community support. Benchmarking against key other DHBs may be helpful in interpreting these patterns.

Whole of Population Services

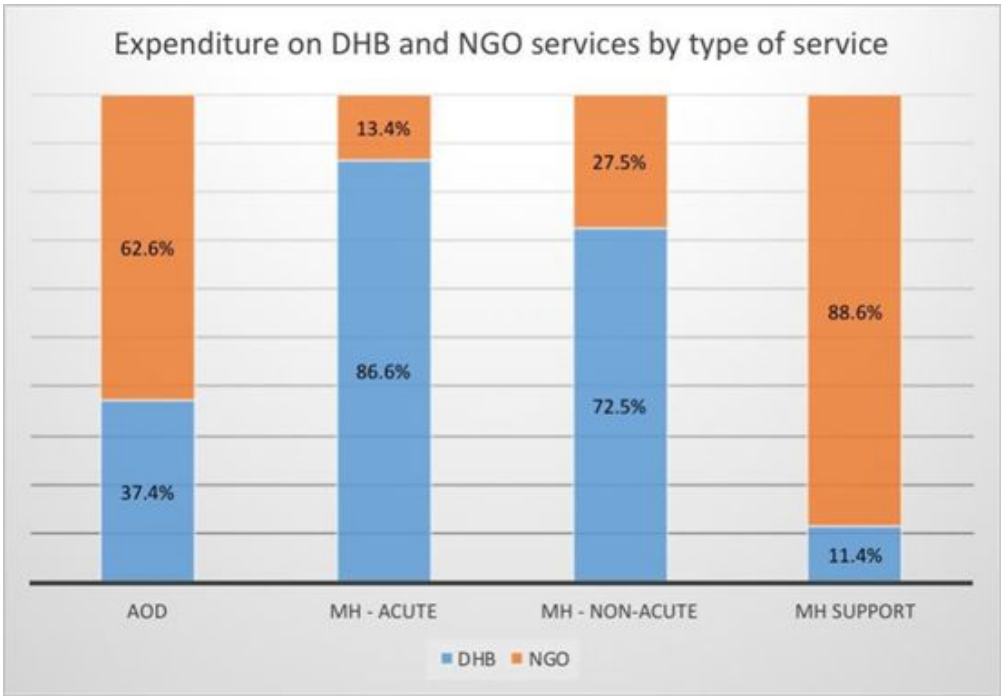
Approximately half of Mental Health and Addiction investment is allocated to services for people with an ongoing high level of need (disability), or to low volume and/or highly specialised services. It would not be possible to have these services dispersed geographically, (e.g. Eating disorders, Maternal Mental Health, Dual Disability, Acute Inpatient). The remaining community and residential services are available to people in need across the whole Waikato population. This subset of services can be tailored to the characteristics of the Waikato population: their age, ethnicity and the locations within which they live, based on their expected level of need. This "whole of population" subset of services has a value of approximately $60M and has been analysed against population characteristics below. *Note that adult mental health services also serve many of the older adults with mental illness.*



The level of expenditure on older people is low relative to their proportion of the population, however they are also served by adult-focused services and it is difficult to assess whether there is under-investment without knowing more about the number of older people accessing adult services.

The lack of investment in under twenty-year olds in the mental health support category reflects the fact that the conditions leading to high support needs commonly begin in adolescence and early adulthood, but their impact on functioning arises over time, and not in the early years.

71% of the adult mental health acute service is the crisis intervention service which covers all ages.



A significant proportion of the delivery of these services is by the NGO sector and this figure is highest for AOD services and mental health support services.

Expenditure on these services provided by Māori is variable across the different types of service. Based on the last census, projections are that 22.9% of the population in 2019 are Māori.

Looking at expenditure on services provided by Māori organisations analysed by age group served, there are no services provided by Māori organisations for older people. For adults, the proportion of expenditure on services that are provided by Māori organisations is lower than the percentage of Māori within population; however studies have shown that the level of need is higher among Māori than non-Māori. For children and young people a greater proportion of the overall expenditure is on Māori-provided services than the proportion of Māori within the population. Again the level of need has been shown to be higher among Māori than non-Māori.

Appendix 3:

Waikeria Prison

In 2018 the Minister Davis announced that Waikeria prison would see the development of a 100 bed mental health facility as part of an overall increase of 600 beds on that site. The beds are scheduled to open in April 2022 and the 100 mental health beds to be a 'one of a kind' development in New Zealand.

The design for this facility started immediately and the building works are well underway on site. The Mental Health and Addictions Service are engaged in the model of care development work and the governance oversight of this development.
The Executive Director and Clinical Services Director Mental Health and Addictions, participate in the Programme Board and have had significant involvement in the planning since the commencement of the governance structure.

Waikeria Prison is one the largest prisons across NZ. The prison has a large remand population receiving men from Rotorua, Bay of Plenty and the Waikato. Of note, while Māori are over represented in the general prison population, in Waikeria 73% of prisoners are Māori. In addition we know that the prison population has the highest mental health and addiction needs of any population group. Nine out of ten people in prison (91%) have a lifetime diagnosis of a mental health or substance use disorder. The 12-month prevalence (62%) is three times that found in the general population. Substance use disorders are 13 times that of the general population, and one in five people in prison had both a mental disorder and a substance use disorder within the last 12 months.

The Waikeria Mental Health Service development is a partnership between the Department of Corrections, Waikato DHB and Mana Whenua. Both Ministers of Health and Corrections have agreed the following should occur:
- The 100 beds will be for prisoners within this region
- The model will see a health led approach based on Māori models of MH and evidence based practice
- The environment will be therapeutic, culturally appropriate and be part of a model that is focused on recovery, rehabilitation and reintegration.

Partnership and engagement with mana whenua is a core component of governance and development of the model. Kataraina Hodge sits on the Programme Board and Hui have occurred with both Raukawa and Maniapoto to ensure involvement in developing shared principles and values to inform the model of care.

Charles Joe has also been asked to help guide the model of care development. Charles was a key person in the establishment of Tane Whakapiripiri at the Mason Clinic. Charles has a mental health background and is also from Tainui.

The funding so far is only for the capital and programme requirements to set the development up. A budget bid will be going in from Corrections in November to ensure operational funding is identified for the following year. Given the intention to have the DHB staffing the service, the funding will need to come down via the Ministry of Health or a contract established with the Department of Corrections. If the budget bid and associated funding do not recognise the flow on impact on community mental health services, this initiative will possibly place further pressure on Waikato DHB services.

The focus for this development is currently across two main areas.

1*. *Model of Care

A project team has been established that is based in the Correction Regional Office in Hamilton. The team includes a very experienced Forensic Mental Health nurse specialist, who has previously worked for our service as the Nurse Director. The project team members have been spending time in the Forensic service and have details of both our model of care and staffing arrangements.

Work is also occurring looking at the IDI data set. There is interest in utilising cross government data that can help paint the picture of the trajectories for people who end up in prison with significant mental health need. This data will also help to define what improved pathways need to look like.

Key individuals will be contributing to the development of this model as and when required. An agreement is being drawn up with the Project Director to provide reimbursement for the investment of time currently being provided across the mental health service. While collaboration is expected between government departments, there is clear understanding that the level of involvement is significant and requires recognition. This will enable the service to back fill some of the impact being felt at the leadership level to ensure this initiative is successful.

In order to ensure there is effective flow and utilisation of the full suite of forensic beds, we will be seeing the 100 MH beds as an option for flow, particularly for Section 45 prisoners who will transition from our medium secure forensic beds back to prison earlier than currently occurs.

2. Workforce Stream

One of the project team is specifically working on the workforce requirements for this development. The potential for our workforce situation to be significantly impacted is very high, therefore our contribution to ensuring this is well planned and thought through is critical. We want to ensure that the development is seen as an extension of our current workforce. The approach will see rotation as a key strategy. Any staff involved in the new development will gain experience prior to the service opening from within the MH&AS and a rotation policy will be in place.
Corrections are also working with training institutions to look at options for training the workforce required and they have identified sponsoring people from within their department to retrain in a health qualification. The overall workforce will be a mix of clinical and non-clinical staff.

Impact on Waikato DHB:

While the programme of work is progressing well, there are a number of aspects that will require monitoring:

- This initiative will require a multi-site culture change. Not only a change in culture within the wider Waikeria Prison environment, but across the two other prison sites in this region. Springhill Prison (at Meremere) and Tongariro Prison will also have prisoners who will transfer to this unit.
- Workforce is an area that is currently an area of risk for Waikato DHB across all of the MH&AS. There will be increased demand on training institutions to prepare enough health professionals to meet the increasing MH and prison mental health need. If well managed, this area will create opportunities for us. Of note, to date the workforce pipeline has not been able to keep up with demand.

- Muster pressure. This could result in pressure on the 100 bed mental health unit. Good governance arrangements will be key to mitigating this risk.
- Lack of high and complex need rehabilitation options for people leaving prison or acute mental health care. There are no agreed pathways for non-Waikato DHB prisoners being repatriated to their local areas (predominately Lakes and Bay of Plenty DHB). Waikato DHB may become the default service provider on release. This will put pressure on existing services and will have financial impact.

While acknowledging there are risks with this development, there is a real opportunity for us to build on this partnership which has a strong foundation and focus on innovation and realising better outcomes for people who we are jointly working with.

Information

General Business

Date of next meeting
February 2020