Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**AGENDA** Held on Thursday 19 March 2020 Lecture room, CSSB, Wairarapa DHB 9.00 am
COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE	**PUBLIC SESSION**

	Item	Action	Presenter	Min	Time	Pg
1. PROCEDURAL BUSINESS						
1.1	Apologies	ACCEPT		10 mins	9:00am	
1.2	Continuous Disclosure 1.2.1 Interest Register 1.2.2 Conflict of Interest	CONFIRM / ACCEPT		"		
1.3	Minutes of Previous meeting	APPROVE		"		
1.4	Schedule of Action Points			"		
1.4.1	Work programme					
2. DECISION						
2.1	Youth Health Service Development	APPROVE	Lisa Burch	30mins	9.10am	
3. DISCUSSION						
3.1	Draft Annual Plan 2020/21 incorporating the Statement of Performance Expectations 2020/21 (SPE) and System Level Measures Improvement Plan 2020/21 (SLM)	DISCUSS	Sandra Williams	30mins	9.40am	
3.2	Wairarapa Palliative Care Service update	DISCUSS	Joanne Edwards	20mins	10.10am	
3.3	Pharmacy Investment	DISCUSS	Sandra Williams	20mins	10.30am	
3.4	Maori Health Plan update (verbal)	DISCUSS	Jason Kerehi	10mins	10.50am	
4. OTHER						
4.1	General Business					
CLOSE						

Wairarapa Community and Public Health Advisory Committee (CPHAC) INTEREST REGISTER

AS AT 12 MARCH 2020

INTEREST REGISTER	
Name	**Interest**
Dr Tony Becker *Deputy Board Chair*	• Shareholder and Director (Clinical) Masterton Medical Limited • Shareholder and Director Wairarapa Skin Clinic • Wife contracts to Wairarapa District Health Board • Trustee, Hau Kainga • Member Alliance Leadership Team
Helen Pocknall *Board Member*	• Contractor with Ministry of Health
Joy Cooper *Board Member*	• Chairperson Wharekaka Trust Board Incorporated
Jill Stringer *Board Member*	• Director, Touchwood Services Limited • Husband employed by Rigg-Zschokke Ltd
Yvette Grace *Board Member*	• General Manager, Rangitāne Tu Mai Rā Treaty Settlement Trust • Member, Hutt Valley District Health Board • Husband is a Family Violence Intervention Coordinator at Wairarapa District Health Board • Sister-in-law is a Nurse at Hutt Hospital • Sister-in-law is a Private Physiotherapist in Upper Hutt
Diana Sotiri *Member of Consumer Council*	• Member of Wairarapa DHB's Consumer Council • Husband Chair of Learning Disabilities Association of the Wairarapa District Health Board • Daughter is a member of Wellbeing Working Group, Masterton Trust Lands Trust
Limone Kelly *Pacific representative*	• Works at Lyndale Rest Home
Justine Thorpe *Compass Health Wairarapa representative*	• Tū Ora Compass Health is Deputy CEO, General Manager for Equity, Population Health and Wairarapa • Member of Primary Care Alliance Trust • Member of Papakanui Iwi Land Trust • Member of South Waiarapa District Council Water Race Management Committee)
Annie Lincoln *Primary Care Clinician*	• Director Carterton Medical Centre

Wairarapa DHB Executive Leadership Team - Interest Register

Name	Interest
Dale Oliff *Chief Executive Wairarapa DHB*	• No interests declared
Sandra Williams *Executive Leader Planning & Performance*	• No interests declared
Jason Kerehi *Director Maori Health*	• Negotiator – Rangitane Settlement Negotiations Trust • Trustees – Rangitane Tu Mai Ra – Post Settlement Governance Entity • Partner is employed as a school nurse by Compass

Updated: 2020-03-11

Updated: 2020-03-11

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE **PUBLIC**

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**MINUTES** Held on Tuesday 18 February 2020 Lecture room, CSSB Wairarapa District Health Board 9.00am
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE	**PUBLIC SECTION**

PRESENT

Dr Tony Becker	Chair
Joy Cooper	Member
Helen Pocknall	Member
Diane Sotiri	Member
Jill Stringer	Member
Limone Kelly	Member
Annie Lincoln	Member
Justine Thorpe	Member

ATTENDANCE

Dale Oliff	Chief Executive, Wairarapa District Health Board (CE)
Sandra Williams	Executive Leader Planning & Performance (ELPP)
Jason Kerehi	Executive Leader, Māori Health (ELMH)
Joanne Edwards	Service Development Manager, Planning & Performance (P&P)
Daniel Kawana	Service Development Manager, Planning & Performance (P&P)
Jen Bergantino	Minute taker, Planning & Performance

Tofa Suafole Gush, Director Pacific People's Health for Wairarapa and Hutt Valley District Health Boards, was in attendance.

1.0 PROCEDURAL BUSINESS

1.1 APOLOGIES

An Apology was received from Yvette Grace (Member).

1.2 CONTINUOUS DISCLOSURE

1.3 CONFIRMATION OF MINUTES

RESOLVED
MOVED Diane Sotiri **SECONDED** Dr Tony Becker
CARRIED

CPHAC WORK PROGRAMME

The work programme will continue to be updated in line with the new Strategic Direction work.

2.0 DECISION

2.1 TREATY POLICY

Diane Sotiri arrived 9.15am

Points noted were:

NOTED that this may have implications for future staff.

NOTED that there will be training opportunities for senior managers and Board members to improve cultural competence and cultural safety specific to their roles.

AGREED that the policy was good but will be determined by how well it is implemented across the DHB and services.

DISCUSSED how do we change the way we work in primary care by incorporating the principles of the treaty and how we contract for services?

NOTED that this is a challenge for primary care and the health system.

NOTED that the DHB's older workforce may find it more challenging to change the way they currently work and to implement the principles outlined in the policy.

NOTED that the Ministry of Health are working on a treaty framework which will be released soon.

The Executive Leader Maori Health advised the Committee that the Maori GMs Regional Group are currently looking at a regional treaty framework.

The Committee would like to see some statistical data and current services available in Wairarapa for Maori Health presented in an easy to read dashboard.

Action: The Executive Leader Planning and Performance is to prepare a dashboard of statistical data and services in Wairarapa for Maori Health which will be brought back to CPHAC in June.

RESOLVED that the Community and Public Health Advisory Committee

1. **NOTED** the draft policy and the implications of its wording on business as usual.
2. **AGREED** to endorse to the Board the Te Tiriti o Waitangi policy into the Wairarapa DHB [WrDHB] policy platform.

MOVED Helen Pocknall **SECONDED** Joy cooper
CARRIED

3.0 DISCUSSION

3.1 STRATEGIC DIRECTION

First half of the presentation was presented by Sandra Williams, Executive Leader, Planning & Performance. Points noted were:

- Series of engagement sessions were undertaken with stakeholders. The summary of what we heard was:
    - Health needs are not being met- there is a growing older populations, and a growing population of young Maori, and areas of deprivation with poor health outcomes.
    - The hospital and primary care is out of capacity and personnel are increasingly stressed- the model of care in the hospital is out of date, referral hospitals are full, discharge is inefficient.
    - There is a lack of resilience in the workforce- an over reliance on locums, overworked and tired GPs with high recruitment costs, and gaps in other workforces.
- Areas we will be looking to change: more Integrated health and social services, stronger primary care, older peoples services easy access to services, closer connection between primary &

secondary services, a fit for purpose hospital, Treaty of Waitangi relationship, sustainable workforce, and equity of outcomes,

The 2nd half of the presentation was presented by Daniel Kawana, Service Development Manager, Planning & Performance. Daniel gave an overview of the philosophy underpinning the strategic direction: hauora mō tātou (health is for all), every door is the right door (providing connected services); neighbourhoods (working where people live, work and play), serving the people of the Wairarapa (taking on a servant mentality), and manaaki tangata (recognising every person's inherent value). He also described how these values could be embedded across the work of the WrDHB.

The CE advised that the Strategy will return to CPHAC to endorse and then forwarded on to the Board for final approval. The Strategy will show the way the DHB will do things, where we go and the way forward.

3.2 OLDER PERSONS INVESTMENT PORTFOLIO

The Committee wanted clarification about the recently publicised news that Healthcare NZ were restructuring and what that would mean for Wairarapa services. Joanne Edwards advised that to date there had been no indication from the organisation that the changes would impact negatively on the service they provide and the DHB expected no change to the current service for service users.

RESOLVED that the Community and Public Health Advisory Committee

(a) **NOTED** the DHB investment into long term support services for older people
(b) **NOTED** that this paper is the first part of a two part presentation for CPHAC and has a companion document which identifies the results of this investment.
(c) **NOTED** that this report outlines the results on the DHB's investment into supporting older people in Wairarapa and is the second part of the Older Person's Investment Profile
(d) **NOTED** that this reporting gives a snapshot of service utilisation and performance of a selection of older person's services which together comprise a system level view.
(e) **ENDORSED** the dashboard as the model for measuring and monitoring of changes in investment and outcomes for older people.

RESOLVED
MOVED Joy Cooper **SECONDED** Helen Pocknall
CARRIED

3.3 DEMENTIA IN OUR COMMUNITY

NOTED that training needs to occur so that the appropriate support is available to assist patients in difficult situations.

NOTED that there is a need to raising the awareness in the community.

RESOLVED that the Community and Public Health Advisory Committee

(a) **NOTED** all funded services for the elderly have clients with cognitive impairment
(b) **NOTED** 84% of people receiving Health of the Older Person funded services in Wairarapa have some form of cognitive impairment
(c) **NOTED** of those residents in care, 83% are assessed with some degree of cognitive impairment, with 43% indicating significant cognitive impairment
(d) **NOTED** at least 20% of older people interacting with hospital services (ED or inpatient) have some degree of cognitive impairment.
(e) **NOTED** it is those people over 65 years with mild cognitive impairment rather than those with significant cognitive impairment who attend ED more frequently than others and have more admissions to hospital per person. Of those with mild cognitive impairment, the 65 to 69 age group stay longer than older people. 25% of people in this cognitive impairment group are readmitted within 28 days. This has implications for effective discharge processes.

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(f) **ENDORSED** an integrated approach that includes both health and social aspects of care to maximise wellbeing and independence

(g) **NOTED** we are working with our partners to develop dementia friendly communities – including government agencies, NGOs, councils.

RESOLVED
MOVED Joy Cooper **SECONDED** Helen Pocknall
CARRIED

4.0 INFORMATION

4.1 2020/21 ANNUAL PLAN TIMELINE AND PROCESS

NOTED that the Committee will receive the draft Annual Plan at the March meeting.

RESOLVED that the Community and Public Health Advisory Committee

(a) **NOTED** that the MOH Annual DHB Planning Package for 2020/21 was released on 19 December 2019.

(b) **NOTED** that the first draft Annual Plan 2020/21 is due to the MOH on Mon 2 March 2020. At this time, there is no date set for final draft plan submissions.

(c) **NOTED** that the Funding Envelope is expected from the MOH in May 2020 after the government budget for which no date has been set yet.

(d) **NOTED** the MOH Timeline for review of 2020/21 plans (Table 1).

(e) **NOTED** the attached Wairarapa DHB Annual Planning Timeline 2020/21 (Appendix 1).

(f) **NOTED** that the Board received a presentation on the annual planning framework, process and timeline at their workshop on Monday 27 January 2020.

RESOLVED
MOVED Helen Pocknall **SECONDED** Joy Cooper
CARRIED

MEETING CLOSED AT: 11.25AM

Date of next meeting: 19 March 2020

CONFIRMED that these minutes constitute a true and accurate record of the proceedings of the meeting.
DATED this day of 2020

Dr Tony Becker
Chair, Community & Public Health Advisory Committee (CPHAC)
Wairarapa District Health Board

WAIRARAPA DISTRICT HEALTH BOARD PUBLIC CPHAC

Schedule of Actions

Meeting Date	Action	Person Responsible	Status
18 February 2020	Prepare a dashboard of statistical data and services in Wairarapa for Maori Health which will be brought back to CPHAC in May.	Executive Leader Planning & Performance	

Community and Public Health Advisory Committee Work Programme

This programme will continue to be updated in line with the new Strategic Direction work

	February	March	April	May	June	July	August	September	October	November
System and service planning	-Annual Plan -Strategic Direction	-Maori Health Plan -Annual Plan	-Final Pacific Health Plan -Annual Plan -Clinical Services update -Planned Care Plan -Health Equity report	-Annual Plan -Maori Health Plan -Wellbeing Plan update	-Clinical services and Wellbeing Plan Updates - System Level Improvement Plan	-Equity Approach - Long term conditions	-Clinical Services and Wellbeing Plan - Maori health Plan	-Mental Health and Addictions	-Community Services Integration	-Annual Plan Process
System & provider performance	-Health of Older People	- Primary and Community-community pharmacy and youth health - Palliative Care	- Mental Health and addictions - Alliance and SLM reporting - Regional Public Health	-Primary and Community incl Child (includes oral health)	-Pacific health updates -Maori health updates -Maori Health Dashboard	- Primary and Community -Alliance and SLM reporting - Regional Public Health	-Mental Health and Addictions	-Health of Older People	- Primary and Community -Alliance & SLM reporting	- Mental Health and Addictions)
Investment and prioritisation				-Investment & Prioritisation	-Investment & Prioritisation			-Investment & prioritisation		

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Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**CPHAC DECISION PAPER** **Date: 19 March 2020**

From	Sandra Williams, Executive Leader Planning and Performance
Author	Lisa Burch, Service Development Manager, Planning and Performance
Endorsed By	Dale Oliff, Chief Executive
Subject	**Youth Health Service Development**

RECOMMENDATION

It is recommended that CPHAC:

1. **Note** the DHB and Tū Ora Compass Health have received a report: *Feasibility Study. The Effective delivery of Youth Health Services in the Wairarapa*.
2. **Notes** the report found that, while there are individuals and services providing invaluable healthcare to young people, services are not connected to each other, and for many young people there are multiple barriers to care.
3. **Notes** in 2019/20 Wairarapa DHB has invested $500k in localproviders (excludes community AOD and mental health services) of youth health services.
4. **Notes** the DHBs current investment in youth health services has not been reviewed for some years, and there are expected to be reinvestment opportunities, and a small additional investment may be needed, post 2020/21, in the next three to four years.
5. **Agrees** to recommend that the Board accept the feasibility study, and endorse the development of a youth health service development programme of work that addresses the recommendations.
6. **Agrees** to recommend to the Board that the 2006 Wairarapa Youth Health Strategy be refreshed to guide the service development programme.

APPENDICES

1. McKenzie, Feasibility Study. The Effective Delivery of Youth Health Services in the Wairarapa, December 2019.
2. Wairarapa DHB, Life 2 Go! Youth Health Strategy 2006 – 2009

1. PURPOSE

The purpose of this paper is to advise the Committee of the findings of a recent review of youth health services in Wairarapa. The paper is seeking endorsement of a proposed process for addressing the findings of the review.

2. BACKGROUND

In 2019 the DHB and Tū Ora Compass Health were approached to consider options for relocating the Youth Kinnex Clinic which operates out of premises in Masterton. Currently this clinic is funded jointly by Tū Ora (rental, via Connecting Communities) and Masterton Medical (personnel costs). The venue is no longer fit for purpose. Due to its size it is unable to support more than one clinician at a time and is unsuitable for many consults, e.g. sexual health.

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Masterton Medical Limited (MML), Tū Ora Compass Health (Tū Ora) and Wairarapa DHB (the DHB) jointly agreed that any decisions about the future of Youth Kinnex should be considered within the context of all funded youth health services. The organisations commissioned a review which was conducted by Maria McKenzie, with a final report received in December 2019.
The report, which is attached as Appendix 1, makes a variety of recommendations on ways in which services could be delivered so as to improve accessibility of services and thus health outcomes for our young people.

3. CURRENT DHB YOUTH INVESTMENT

The range of services available to youth in Wairarapa is detailed in the McKenzie report. These service arrangements have largely resulted from new Ministry of Health funding which has subsequently been absorbed into the DHB's baseline. DHB discretionary spending which is funded outside of the Service Coverage Schedule, e.g. free sexual health, and the Kuranui College Clinic, has not been reviewed for over ten years.

The DHB's current investment in youth specific services is outlined in table 1 below. This excludes capitation funding paid to each practice based on the number of young people enrolled.

Table 1: DHB funded youth services

SERVICE	PROVIDER	2019/20 FUNDING	COMMENTS
Free sexual health for under 21 year olds	Tū Ora	$75,740	This funding is allocated to practices, with low utilisation in some practices. The new MOH contraception funding rolled out in 2019 should reduce the demand for this funding
Youth primary mental health service	Tū Ora	$74,328	Counselling provided under the To Be Heard service. This service, and funding level has not been reviewed since the inception of the service.
Youth alcohol brief intervention	Tū Ora	$2,222	Funding available to practices to fund brief interventions in primary care.
School based health services	Tū Ora	$119,317	Historic MOH funding for nurse clinics in decile 1 – 3 schools (Makoura, Kura, Teen Parent Unit, Alternative Education). DHB has provided additional funding for clinic at Kuranui. DHB and Tū Ora have agreed that funding would be used for GP and nurse clinics.
School based health services	Tū Ora	$34,992	Additional funding made available 2019/20 for nurse clinics in decile 5 schools. Implementation in Chanel College underway.
Youth Multi-Systemic Therapy (MST) service	Emerge	$186,942	3DHB service based in Wellington. 1 FTE dedicated to Wairarapa. Payment through IDF to CCDHB.
Community mental health and addictions services	Pathways and Te Hauora	Pathways: 2 FTE clinical, 1 non-clinical Te Hauora: 0.5 FTE approx	FTE working with young people with mental health and addiction support needs.

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Table 2: Services provided by other funders

SERVICE	PROVIDER	COMMENT
Youth Kinnex Clinic	MML/Tū Ora	Currently 2 sessions per week. Masterton based drop in clinic. Funded by MML and Tū Ora. Service demand is exceeding current provision.
Piki	Tū Ora	MOH funded pilot mental health programme for 18-25 year olds.

Table 3: Proposed service

Access and choice primary mental health initiatives – Youth funding stream	TBC (awaiting contract)	A 3DHB response to the RFP was successful and the detail for Wairarapa is currently being agreed.
Youth Primary Mental Health	TBA	WrDHB has responded to a MOH RFP closing 9 March 2020. If successful Te Hauora Runanga will employ 2FTE Youth Kairarahi / navigators who will be attached to the school and youth clinics.

4. PROPOSED SERVICE DEVELOPMENT APPROACH

As described above and in the McKenzie report, the current investment in youth health services reflects historic decisions rather than a strategic approach. We consider that the recommendations contained in the attached report provide a feasible pathway towards providing an accessible and appropriate range of services for young people. We propose that a detailed implementation plan is developed that enables rapid action where needed to address service gaps, alongside more detailed needs analysis, stakeholder consultation, and collaboration with other Government agencies and social service providers.

The key immediate actions we propose include:

4.1 Establish Youth Service Implementation Group

This group will be responsible for addressing the recommendations of the McKenzie report as they pertain to community based health services provided to the young people of Wairarapa. The group will include youth representation.

4.2 Develop process for youth participation

In conjunction with the youth representative/s on the Implementation Group, a process for meaningful youth participation in health service development will be developed, Options might include youth ambassadors, a DHB Youth Reference Group, or tapping into the Youth Council.

4.3 Procure appropriate premises for the Youth Kinnex Clinic

The youth mental health proposal submitted to the Ministry this month requires that the new youth workers are co-located with youth services to enable "warm-handover' from other clinicians. This is not possible in the current premises. All the funding partners are committed to finding premises that will enable a holistic approach to youth needs. Some DHB funding may be required to facilitate this.

4.4 Refresh the 2006 Wairarapa DHB Youth Health Strategy

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The 2006 Youth Health Strategy was based on wide consultation and youth development principles. We consider we can relatively quickly "refresh" the document to provide on-going guidelines for service development.

4.4 Identify opportunities for rapid improvement initiatives and re-prioritisation

Some opportunities for 'quick-wins' are already apparent. For example, the sexual health contract pre-dated the establishment of the Youth Kinnex Clinic, and is now supplemented by the low-cost contraception initiative.

5. CLOSING STATEMENT

It is proposed that Management will provide the Board with a progress report and detailed implementation plan in October 2020. A small investment of new funding may be required to extend access to all young people across the valley in the outyears.

Feasibility study

The effective delivery of youth health services in the Wairarapa

Maria Mckenzie

MA (Honours) Educational Psychology, PGDip Teach, PGDip RTLB

December 2019

Better Health Through Great Primary Care

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

NON-JUDGEMENTAL AND FRIENDLY ATTITUDE OF STAFF - ABOVE AND BEYOND - MANY THINGS IN ONE BUILDING - A LOT OF PEOPLE HAVE MULTIPLE NEEDS - IT'S REALLY EMPOWERING - FUN PLACE TO BE - NO BAD VIBES - IT'S DIFFERENT - FREE AND I'M SUPER BROKE - LOTS OF DIFFERENT SUPPORT IN THE SAME AREA - I CAN COME HERE FOR ALL TYPES OF HELP - FEEL AT HOME - OPEN TO ALTERNATIVE LIFESTYLES - SERVICES ARE FREE - EASY TO GET TO - KIND, FRIENDLY AND APPROACHABLE - THEY TALKED TO ME LIKE A FRIEND - IT SHOWS ME RESPECT FOR MY HEALTH - I CAN TALK ABOUT ANYTHING AND I DON'T FEEL JUDGED - I CAN BE OPEN - FRIENDLY AND SUPPORTIVE - RESPECTFUL, GENUINE, NONJUDGEMENTAL - GIVE ME HOPE - POLITE AND ASK PRONOUNS - FRIENDLY, WELCOMING, RESPECTFUL AND NOT FORMAL - TREAT US LIKE EQUALS - GIVE YOU THAT BELONGING FEELING - MORE CASUAL THAN MOST PLACES - EVERYONE IS EMPATHETIC - NO PRESSURE

How Youth One Stop Shops in New Zealand make young people feel (Gibson-Rothman, 2017).

Contents

Project outline

Tū Ora Compass Health, Masterton Medical Ltd and Wairarapa DHB are considering the relocation of the Youth Health clinic (Youth Kinex) in Masterton. The current facility which houses the service is inadequate. Before any decision is made about the location of the health specific youth service, there is an opportunity to broaden this discussion to include a wider variety of services, and delivery to young people in other Wairarapa locations. Clearly this discussion needs to take place across a number of agencies, and most importantly, with the young people of Wairarapa.

Project design process

1. Literature review of best practice on adolescent brain development, positive youth health, the importance of youth participation, youth health needs, the long term impact of youth health challenges and forgone care
2. A summary of global, New Zealand and Wairarapa youth health issues including a review of DHB strategy, documentation, statistics and data.
3. A summary of youth health services in New Zealand and the Wairarapa
4. A thematic analysis of factors impacting on the effective provision of youth health services
5. A summary of Engagement with service providers
    - The main health issues for Wairarapa youth
    - The service they currently provide for youth (client statistics, costs, access, location, referrals, opening hours, usage, funding)
    - The kaupapa (the policies, practices used to engage youth)
    - The challenges in providing effective health care for youth
    - Suggestions for improvements to the provision of effective health service for youth across the Wairarapa
6. A summary of young people's views on youth health
    - The main health issues for Wairarapa youth
    - The services they use.
    - The important aspects of a good health service?
    - The barriers they face in accessing and using a health service
    - Suggestions for an effective health service for youth
7. Recommendations for the improvement of youth health services across the Wairarapa

Disclaimer

Every care has been taken in collecting and reporting the information to date, however it is not possible to guarantee that all information is error free.

Acknowledgements

The Author wishes to acknowledge all of those people and health professionals who gave their time and expertise to examine the youth health service provision across the Wairarapa. There are many people who made themselves available, often at short notice, and whose genuine thoughtfulness and at times challenging feedback helped the review become a more robust process.

It was an honour to work alongside Wairarapa youth. The commitment from young people to participate in this kaupapa, to share their experiences and ideas openly and honestly and provide potential solutions was inspiring.

Participants

Professionals working in Youth Kinex, Makoura College Health Service, Kuranui College Health Clinic, Wairarapa College Health Clinic, Rathkeale and St Matthews Collegiate Health Clinic

Professionals working in Carterton Medical Centre, Masterton Medical Centre, Greytown Medical Centre and Featherston Medical Centre.

Professionals working in Community services: Connecting Communities Wairarapa, Carterton District Council, Wairarapa Whanau Trust, Fab Feathy Community Development, REAP and YETE (Youth Education, Training and Employment)

Youth from the Wairarapa Youth Council, YETE (Youth Education, Training and Employment) Employability Skills Programme participants, students attending secondary school across the Wairarapa and Wairarapa Whanau Trust.

Terminology

For the purposes of this report the terms 'Rangatahi', 'youth', 'young people' and 'adolescent' will be interchanged throughout. This refers loosely to people aged between 10 and 24 years old.

To ensure anonymity of those who contributed to this review, individuals are not identified in this report. They have been referenced as 'young people' or 'health professionals'.

Limitations of the study

Given the timing and short duration of the study there are inevitable gaps in the health services reported on. This report focused on those services that provide traditional medical health care for youth and do not include an in-depth study of services in the mental health or community sector.

As there was a major review of the mental health services in the Wairarapa Mental Health and Addiction Service Review Report conducted by the Wairarapa District Health Board in December 2018 it is suggested that those recommendations are included in any decisions about youth health care across the Wairarapa.

December is a difficult and busy time of the year and thus some of the core health services were unable to participate.

December is also a busy time for young people with exams and wrap up of the year end. A more formalised analysis of youth voice would provide quantitative data to the factors identified as important in the provision of health services.

Executive Summary

Adolescence

- Adolescence is a unique time of transition from childhood to adulthood
- Adolescence is a time when trajectories that influence either positive or negative outcomes may develop
- Adolescence is a time of vulnerability, change and experimentation
- Major parts of the brain are developing
- Changes in the limbic system are associated with adolescents becoming more emotional, more sensitive to the opinions and evaluations of others and being drawn to exciting and intense, sometimes risky experiences
- The frontal cortex, involved in planning, decision making, reasoning ability, problem solving, understanding consequences and controlling impulses is still developing

Positive youth development

- Adolescence is often portrayed as a time of difficult and challenging behaviours, however, there is much to celebrate regarding the adolescents in this country. Overall, most Rangatahi in Aotearoa are doing very well
- The majority of Wairarapa Rangatahi are healthy and active participants in their families, culture, educational institutions, and communities
- There have been reductions in smoking, teen pregnancy, motor vehicle crashes, high risk behaviours, drinking behaviours and an increase in celebrating diversity in adolescents across New Zealand

Youth participation

- Providing opportunities for young people to be involved in real issues in partnership with adults shows young people that their skills, ideas and views are valued
- Adults as well as young people can gain new skills and experience through youth participation
- Evidence shows that policies and programmes designed after consultation with users are more likely to be effective
- The Wairarapa Rangatahi Development Strategy 2016 – 2021 (WRDS) is an example of youth participation and aims to strengthen youth voice and support their potential
- The Wairarapa DHB published 'Life2go! Youth health in the Wairarapa' in 2005. This strategy described the many facets of health and social issues, services and points of view that impact on the wellbeing of young people in the Wairarapa
- The strategy embeds sound principles of 'youth participation' and there appear to be some informal markers of progress in the strategic priorities. A major progression has been the development of a Youth health service 'Youth Kinex'. However, no formal evidence of evaluation and monitoring has been found. It appears there is limited awareness of this strategy among health professionals working with youth across the Wairarapa.

Youth health

- Youth health issues are characterised by specific adolescent characteristics and developmental needs
- New Zealand youth have high rates of accidents, mental illness, substance abuse, suicide, obesity, and violence

- Wairarapa youth have high rates of mental illness, suicide, drug and alcohol use and teenage pregnancy

Youth health services

- Young people access health services in a range of settings, including school-based clinics, general practices, community-based health centres and through mobile and out-reach clinics. They are known to 'snack' or 'graze' on services according to their present situation and needs
- From 2008 funding has been provided for school nurses or school-based health services in the secondary schools attended by young people of highest need: decile 1 and 2 secondary schools, teen parent units and alternative education facilities. From 2013 this was extended to decile 3 schools, under the Prime Minister's youth mental health initiative
- Medical centres provide services to all enrolled patients including youth
- A number of community youth health organisations have established Youth One Stop Shops in New Zealand over the past 15 years designed specifically for youth

Wairarapa youth health services

- Each town in the Wairarapa has Medical Centre that provide services of all community members including youth
- There are school based services available to students at Makoura College and Kuranui College. The Teen Parent Unit and Kura Kaupapa are serviced through the Makoura Health Clinic
- Wairarapa College, Rathkeale and St Matthews Collegiate fund their own health clinic.
- Chanel College and Solway College do not have a school based health clinic. Some initial discussions are in place with the Tu Ora Compass health and DHB to provide a service in 2020 for Chanel College
- Youth Kinex was opened in May 2014 by Masterton Medical Centre in partnership with Tu Ora Compass Health and Connecting Communities. The idea behind this was to create a youth hub in a central location where youth specific services could be delivered. The purpose was to alleviate some of the barriers young people encounter when accessing healthcare, to provide timely, free and appropriate care in a confidential youth friendly environment
- Currently this service is still emerging and has potential to grow into a fully integrated Youth hub

Factors that impact on the effective provision of youth health services

Factors that are vital to the effective provision of youth health services include:

- Privacy and confidentiality including concerns about GP's disclosing information to parents, reception staff not protecting confidentiality, the small community and the potential impact of confidentiality on the delivery of consistent care for young people.
- Cost and funding factors include awareness of a free service, travel costs and funding models that do not support adolescent health care behaviour
- Access to health care includes opening hours, location and appointments processes
- Manaakitanga - Hospitality including attitudes and communication of health professionals, reception and waiting rooms

- Organisational kaupapa – The way of doing things including the kaupapa, theory and ideology of the service and whether it embraces youth-focused, youth-centred, culturally responsive and strengths-based practice
- Youth health literacy including help seeking behaviour, attitudes towards health care and Doctors, and the influence of family attitudes towards health care
- Kotahitanga – Cross sector Collaboration and Collective decision making among health care professionals
- Professional training including the passion, understanding and experience of youth in holistic, strengths based practices and youth specific health issues

What Wairarapa youth need

- Young people want to be involved in the planning, implementation and delivery of services that they will use. They want to be involved in designing the environment, be engaged as staff members and to be seen as positive contributing members of the community
- They need understanding of what is available to them and how they can access health care
- Young people want a free, private, confidential health service where they can drop in and receive the help they need when they need it in their own communities
- They want a service where they can access all different types of support to develop their health, wellbeing, employability skills and social connections
- Youth mental health services should be integrated with other services including physical health services, and vocational and social services
- They want timely access to sexual and reproductive health services
- Young people want to get health care in an environment that is welcoming and youth friendly
- Young people want professionals to be welcoming, use informal communication styles, and use a variety of ways to establish rapport with them

What Wairarapa health professionals need

- Health professionals want funding to provide free health care for all young people regardless of what setting they are in
- Health professionals need training in youth specific health care. They want a better understanding of adolescent brain development and behaviour, and strategies to meet their needs. They also need support to develop cultural competency
- Health professionals want opportunities to share best practice and network. They want access to specialist youth professionals to share complex cases with and assist in referrals for further intervention
- They want systems and processes that make it easy to share information with other relevant professionals in the life of the young person
- They need the time and skills to assess and intervene in a holistic manner. Opportunities for cross sector collaboration are important
- They want to provide continuous care for all young people regardless of the services youth choose to use

Strengths and gaps in the provision of youth services across the Wairarapa

- There is no cohesive youth health strategy that drives decisions, practice and policy across the Wairarapa

- Young people are not active participants in the design and delivery of the services that serve them
- Privacy and confidentiality issues are a barrier to young peoples' utilisation of local medical centres
- Cost is a major barrier for young people accessing health care in local Medical Centres across the Wairarapa
- Young people are intimidated by appointment and booking procedures
- Young people report that medical centres are not youth friendly
- There is a need to improve the cultural capability, youth specific policies, and practices of the medical centres where youth have enrolled
- Young people have limited health literacy or knowledge of services available. They have difficulty knowing how to contact, when to contact and who to contact for health care
- Medical centres work in isolation to community services
- Young people trust the health professionals in school based health services to maintain privacy and confidentiality
- Young people are deeply appreciative of the free access to health care in school based services
- Varied opening times and service availability were a concern for young people trying to access health care in schools
- Young people report that school based health services provide a holistic, youth focussed service
- School based health professionals report a strong focus on holistic health and being youth friendly in all their approaches
- Comprehensive health assessments (HEADSSS) provide important information on individual and population health and assist professionals to provide comprehensive and holistic care
- Youth Kinex provides a free, confidential, youth friendly service in a safe, friendly environment encompassing all the tenets of manaakitanga
- The current venue is woefully inadequate and hinders cross sector collaboration and ability to meet demand
- Young people who have left school need greater awareness of the service available to them
- Youth in the South Wairarapa may have difficulty accessing a youth health service.
- There is not enough time available and too many young people requiring support to take the time needed to provide comprehensive, holistic youth health care
- There is an opportunity to extend the services available at Youth Kinex to include all aspects of youth health and wellbeing. This will require coordination and cross sector collaboration

Recommendations for an effective youth health service across the Wairarapa

There is no one integrated model of youth services that will achieve optimal outcomes for all young people. Rather, it is a mixed model comprising school-based services, community-based services such as youth one-stop shops services, and general practice services.

- **Develop a District Health Board Youth Health Plan:** Develop a Youth Health Plan and incorporate it into the overall District Health Board strategy. Develop specific measurable actions that are implemented, resourced and monitored and evaluated.

- **Create a vision for youth health across the Wairarapa.** Develop a strategy that incorporates the principles of effective youth health
- **Establish a cross sector, collaborative steering group**. Create a Youth Health Steering group governed by a partnership of local organisations
- **Commit to Youth participation.** Create a Youth Health Advisory Group to provide governance over the implementation of the DHB youth health plan
- **Establish a Wairarapa Youth Health Service Specialist team**. This group would be mobile and support all school, practices and the youth clinic. These would be dedicated professionals who are trained in youth health and development
- **Train health professionals to provide best practice health care.** Develop and implement a training programme for health professionals in youth development, adolescent brain development and their behaviour, social and emotional development and health
- **Improve youth and whanau 'health literacy'** through support to school's educational health programmes and direct communication to current enrolled patients via 'youth health packs'
- **Develop a fair, flexible youth centred funding model**. Realign funding to be allocated to the young person regardless of what service they choose to access and ensure it is simple for health professionals to access
- **Implement a coordinated Patient Management System** across all services that allows youth health care to be continuous and information shared among relevant health professionals
- **Incorporate best practice for youth health care across all medical centres:** Integrate kaupapa, theory and ideology that embraces youth-focused, youth-centred and strengths-based practice into all areas and levels of the organisation, and ensure this drives all decision making and interaction with young people
- **Provide a fully resourced, equitable school based health service to every school in the Wairarapa**. This would include regular access to and support from a GP or health practitioner; Health professionals who are trained and resourced to complete a HEADSS assessment for targeted students; Regular networking and professional development opportunities for staff working across the sector and support from a social worker to work collaboratively with the Guidance counsellor and other health professionals
- **Expand Youth Kinex to become a hub for holistic youth health care across the Wairarapa** through enlarging the facility to allow for cross sector services to develop and cohabitate `and improve privacy; increasing the capacity to provide longer hours and more days; acting as a base for a Youth specialist team who are mobile and can serve satellite health clinics in schools; cohabiting with other youth services such as the Youth wellbeing café and YETE job club
- **Support the development of a Youth Health Hub in Featherston.** Work alongside South Wairarapa community development initiatives to support the establishment of a youth health service in Featherston

Adolescence

Adolescence is a unique time of transition from childhood to adulthood. Like the early years, adolescence is a time when trajectories that influence either positive or negative outcomes may develop. Lifetime problems with health and the failure to develop the skills and knowledge that are needed to succeed in employment and community life can all have their roots in adolescence (Steinberg, 2016).

Puberty, the start of adolescence now starts earlier than it has in the past, sometimes as young as seven or eight years for females. Adolescence is now thought to end in the early to mid-twenties with a transition into adult roles and responsibilities.

There are two primary brain regions where important changes take place over the period of adolescence.

The limbic system, which plays an important part in the processing of emotions, social information and reward, becomes more easily aroused around the time of puberty. Changes in this area are associated with adolescents becoming more emotional, more sensitive to the opinions and evaluations of others and being drawn to exciting and intense, sometimes risky experiences

The second part of the brain undergoing major reorganisation and growth during adolescence is the prefrontal cortex. Areas involved in planning, decision making, reasoning ability, problem solving, understanding consequences and controlling impulses are the last region in the brain to mature, somewhere around the mid-twenties. Efficient use of these functions is essential for taking on the roles and responsibilities of adulthood.

Adolescence is a time where young people make many important life choices which have long term consequences. It is a time of experimenting with different ways of appearing, behaving and sounding. Risk-taking is often seen as one of the defining features of adolescence. This has been an important rite of passage in evolutionary terms and, although it may not be so adaptive for the way we live now, it is still an inherent part of adolescent development that is 'hard-wired' in the brain.

Adolescent behaviours and attitudes are not only influenced by changes in the brain. As in all development, there are on-going and dynamic interactions between biological, social and cultural factors that contribute to development. Conditions in the family, at school and in the community will all play a part in adolescent development and trajectories.

> *"In order to provide the best opportunities for development and optimise healthy choices, it is important to provide for the specific health and social needs that adolescence brings" (Ministry of Health, 2009).*

World Adolescent Population

Around 1.2 billion people, or 1 in 6 of the world's population, are adolescents aged 10 to 19.

New Zealand Adolescent Population (Collaborative Trust, 2011)

877, 185 young people are aged between 12 and 24 years old in NZ (444,639 Males, 432546 females) 21.7% population

169,033 Young Maori Rangatahi 19% of total

80,000 Young Pacific people 9.2% of total

105,000 Asian young people 12% of total

75% live in urban areas

Wairarapa Adolescent Population (Statistics New Zealand and Profile 2016 cited in Masterton and Carterton District Council, 2016)

6, 231 Rangatahi are 12 – 24 years' old

15.2% of the Wairarapa population

8.4% of these are secondary school aged.

28% of the District's youth aged 15–24 years are Māori. (Rangahau Hauora, 2015)

Positive Youth Development

Adolescence is often portrayed as a time of difficult and challenging behaviours. Yet it's possible to view adolescence in a much more positive light. Recent research may help adults understand and appreciate the remarkable changes that are taking place.

For a long time, the teen years have been seen as a time of 'storm & stress'. We assume that Rangatahi cause problems; problems for themselves, and for those around them. Hormones are frequently attributed. Whānau and others 'need to cross their fingers and hope to make it out the other side, preferably in one piece.' This view is widespread and reinforced by media, parents, and sometimes even 'experts' on adolescents. Parents of young children sometimes dread their Tamariki becoming Rangatahi.

When we expect the worst, we are more likely to get it.

> Studies have shown that the more parents expect their teen to be rebellious and take risks, the more likely this is to actually happen (Buchanan & Hughes, cited in O'Neill, 2019).
>
> Similarly, parents who believed that their teen was likely to drink, had teens who drank more (Madon, et al., 2006, cited in Steinberg, 2016).

In other words, research suggests that not only are these negative stereotypes wrong much of the time, they can also contribute to poorer outcomes.

This view has influenced the study of adolescents since early last century. These ideas began to change as researchers started to realise that most Rangatahi actually do well during their teen years. Positive Youth Development (PYD), shifts our view of Rangatahi from 'problems to be solved' to 'resources to be developed'.

There is much to celebrate regarding the Rangatahi in this country. Overall, most young people in Aotearoa are doing very well. The majority of Rangatahi negotiate this transition in

healthy ways. They're mostly demonstrating good choices and self-management, they mostly live by strong morals and values, and generally function well in relationships with their peers, parents and other adults. Research demonstrates that the majority are healthy, happy and well adjusted. Most young people report having positive relationships in their lives and positive aspirations for their future (Denny, 2014).

> In 2012, most students (91%) reported that their general health was excellent, very good or good (Clarke, 2013).

We have seen many improvements in adolescent health and wellbeing including

> A reduction in daily smoking from 15.6% in 1999 to 4.1% in 2012 (ASH, 2012)
>
> Teen pregnancy has decreased significantly since 1971 with 7 births per 100 (15-19 years) to 2.8 births per 100 teenage women in 2011 (Families Commission, 2011)
>
> Motor vehicle crash deaths have reduced from 51 per 100,000 in the 1985-1989 period to 19 per 100,000 in the 2005-2009 period (15-24 years) (Ministry of Social Development, 2010)
>
> New Zealand research carried out by Noel (2013) found that about 80% of secondary school students were not engaging in high risk behaviours.
>
> While it may feel as though 'everyone else is drinking,' the reality is a large proportion of under-18s are not. The 2011/12 New Zealand Health Survey (Ministry of Health, 2013) reported that overall fewer 1517 year olds were drinking alcohol - significantly reduced from 75% in 2006/07 to 59% in 2011/12.
>
> Aotearoa New Zealand is becoming increasingly diverse. Young people's ethnic identities (both in traditional and contemporary form) are a common source of pride and having a positive ethnic identity is an important contributor to their wellbeing (Clark, 2014).

Positive Wairarapa Youth Development

The Wairarapa also has much to celebrate in their young people. The Wairarapa Safer Community Trust Rangatahi Health and Wellbeing Report (WSCT, 2016) asked small town, rural and semi-rural Rangatahi about their health and wellbeing experiences as young people growing up in these environments. Rangatahi are healthy and active participants in their families, culture, educational institutions, and communities. It found:

> 78% described their health as 'excellent', 'very good' or 'good'.
>
> Rangatahi who have good nutrition and engage in physical activity generally feel good about themselves.
>
> There has been a significant decrease in the proportion of Wairarapa Māori aged 15–17 years who smoke regularly (Rangahau Hauora, 2015).

Youth Participation

> *"Youth participation is a central feature of successful youth programming and effective policy-making. It is an important part of the development of citizenship and youth development. Young people bring with them new ways of thinking and acting that add value to the work of organisations" (Ministry of Youth Development, 2009).*

Adolescence brings with it an opportunity for the successful development of children into healthy and fully contributing adult members of our community.

We can contribute to the positive development of young people by creating opportunities for them to influence, inform, shape, design and contribute to an idea or activity. Learning by doing, and being involved in decision-making, is part of young people's contribution to changes in society.

Providing opportunities for young people to be involved in real issues in partnership with adults shows young people that their skills, ideas and views are valued. Adults as well as young people can gain new skills and experience through youth participation.

Evidence shows that policies and programmes designed after consultation with users are more likely to be effective.

By utilising youth participation principles an initiative is more likely to avoid wasting time and money on services young people don't want to use.

Organisations committed to effective youth participation can boost their profile and credibility with stakeholders, funders and the community. Encouraging youth participation contributes to the positive image of the organisation, making it easier to attract young people, their friends and families, and to promote the organisation to them.

Wairarapa Youth participation

There are many areas where youth play a positive part in decision making in the Wairarapa. For the purpose of this report two areas where young people can pay an important role have been highlighted.

Wairarapa District Health Board Youth Health strategy

Each District Health Board is required to have a youth health plan as part of their responsibilities for the health of their catchment population.

In July 2005 the DHB published 'Life2go! Youth health in the Wairarapa'. This document described the many facets of health and social issues, services and points of view that impact on the wellbeing of young people in the Wairarapa. It outlined the health objectives that need to be targeted and why. It described how the DHB would work with young people and agencies to make demonstrative health gains in the future. It set directions and actions that would directly impact the health of youth / Rangatahi in the long term.

Six Overarching Principles were identified.

Achieving whanau ora
Youth participation in the development and delivery of services
Information that allows them to make well informed choices about their health and wellbeing
Collaboration between service providers, families / whanau, schools and youth
Accessibility for young people to health and social services
Acceptability of services to youth / Rangatahi and their family /whanau

Five Health Priorities were also identified

Reduce motor vehicle accidents
Improve the mental wellbeing of all youth / Rangatahi
Reduce drug and alcohol related disorders and problems
Improve sexual health
Encourage healthy lifestyles.

To achieve this, three strategic priorities were advanced. These priorities required input from all corners of the community, and required a collaborative and intersectorial approach.

Youth Participation including establishing a Wairarapa DHB Youth Advisory Group who would provide governance over strategy implementation and management teams to guide the development and operation of individual services.

Communities Working Together through an increased focus on health promotion and education, joint approaches would ensure effective use of resources, underpinning all action. Use of the health concept Te Whare Tapa Wha, and holistic approaches would support long term behavioural changes in both the young person and their family/whanau.

Youth Health Services. The DHB aimed to develop a network of youth health services and programs across secondary schools and the community in order of assessed priority as resources become available over the next three to five years. These would include school based health services in secondary schools, community based clinics that target young people who are not at school and programmes targeting the needs of specific groups to complement existing ones as opportunities present.

The strategy embeds sound principles of 'youth participation' and there appear to be some informal markers of progress in the strategic priorities. A major progression has been the development of a Youth health service 'Youth Kinex'. However, no formal evidence of evaluation and monitoring has been found. It appears there is limited awareness of this strategy among health professionals working with youth across the Wairarapa.

Wairarapa Rangatahi Development Strategy 2016 – 21

The Wairarapa Rangatahi Development Strategy 2016 – 2021 (WRDS) was developed by the Wairarapa District Councils of Carterton and Masterton.

The WRDS was developed to reaffirm the Carterton and Masterton District Councils' commitment to Rangatahi and outline the ways in which the Councils will work together. In particular, the WRDS focuses on strengthening Rangatahi voice and supporting Rangatahi potential. It outlines a strategy for District Councils to work together with the Rangatahi development and services sector to maximise their community development, funding and

partnership resources for the benefit of Rangatahi. The strategy provides an excellent example of youth participation and positive youth development.

Two key goals have been identified for this strategy:

Strengthening Rangatahi Voice. This is reflected in positive participation in Council and community affairs and ensuring their participation in the democratic process.

Supporting Rangatahi. Potential to grow into vibrant, optimistic and connected adults and future citizens through support with positive environments and opportunities to reach their full potential.

Reports in November 2019 indicate progress in the implementation of the strategy across the Wairarapa

Rangatahi actively participate in Council and community affairs and the democratic process

Councils have implemented 'Best Practice' Youth development processes into relevant job descriptions and professional development meetings

Mayors and Councilors have visited secondary schools to promote the Youth Council and encourage civic engagement

Youth Council representatives attend Council meetings and/or Wellbeing Committee meetings where relevant issues are discussed

Youth Council & R2R deliver Rangatahi engagement workshops to newly elected Councils

Annual Governance training is delivered to all Youth Council members

Youth leadership and participation is celebrated in the Annual Youth Awards

Youth health challenges

Normal development entails facing challenges across the lifespan. Being able to cope with adversity, and to seek and receive help during these times is important for development. The Collaborative Trust (2011) have identified specific characteristics of youth health issues and developmental needs.

The causes of ill health in young people are characterised predominantly by psychosocial rather than biological issues.

They engage in health risk behaviours that reflect the adolescent developmental process of experimentation and exploration.

Young people often lack awareness of the harm associated with risk behaviours and the skills needed to protect themselves.

Young people lack knowledge about where and when to seek help for themselves

Developmental difficulties and conditions related to pubertal growth commonly occur during adolescence.

Adolescent health problems are often complex and frequently one health problem frequently raises risk for another health problem.

Many of the risk behaviours and lifestyles developed in adolescence establish a pattern of behaviour that continues into adulthood and contribute to long term health issues across the life span.

Young people's health status is often influenced by family social and cultural factors as well as environmental hazards to which they are exposed. Their wellness is dependent on the wellness of their whānau and communities (Deane, 2019).

Young people themselves have talked about the challenges they experience and see in their everyday lives. They identified mental health and education, economic insecurity, body image, oppression, the environment, community, role models, and a desire to contribute to positive change as significant issues in their lives (Nga Kōrero Hauora o Ngā Taiohi Action Station, 2018). New Zealand youth have higher rates of mental illness, suicide, teen pregnancy, abortion and suffer more injuries than their counterparts in other Organisation for Economic Co-operation and Development (OECD) countries.

Globally more than 1.1 million adolescents aged 10-19 years died in 2016, over 3000 every day, mostly from preventable or treatable causes. The World Health Organization (WHO 2017) identifies that almost two-thirds of premature deaths and one-third of total disease burden in adults can be accredited to the state of youth health and behaviours they choose to partake in. This includes tobacco, drug and alcohol use, decreased physical activity and poor diet, unprotected sexual intercourse, exposure to violence and abuse and untreated mental health issues. Addressing these issues when people are young is likely to lead to improved health outcomes as well as higher health literacy in adult life, and inevitably to reduced health costs in the future (cited in Helman, 2019).

Accidents

Unintentional injuries are the leading cause of death and disability among adolescents across the world.

In 2016, over 135 000 adolescents died as a result of road traffic accidents. (WHO, 2011).

Drowning is also among the top 10 causes of death among adolescents – nearly 50 000 adolescents, over two thirds of them boys, are estimated to have drowned in 2016 (WHO, 2011).

In New Zealand there were 2366 accidental deaths in 2003-2008 among15-24 year olds. The leading causes of death for young people in NZ at ages 15-24 are external factors such as accidents, poisoning and violence including car accidents, self-inflicted injuries and suicide. These are mostly due to risk behaviours where earlier intervention could have prevented these deaths (Collaborative Trust, 2011).

Mental health

Mental Health and mental distress encapsulates the main concerns facing young people today. Mental health includes an individual's self-esteem and sense of self-worth and is reflected in how they choose to treat and care for their bodies (Helman 2019).

Depression is one of the leading causes of illness and disability among adolescents, and suicide is the second leading cause of death in adolescents. Violence, poverty, humiliation and feeling devalued can increase the risk of developing mental health problems.

Mental health and mental distress is an area that is worsening and accounts for the majority of the disease burden for young people. Around three quarters of all lifetime cases of mental health disorders begin before age 24 years (Duncanson, 2019).

Between 2009 and 2017 15- 24 year olds across the Wairarapa DHB had rates of mental distress similar to New Zealand rates (Duncanson, 2019).

high psychological distress	9.4 %
diagnosed depression	9.3%
diagnosed anxiety disorder	8%

Māori were 63% more likely than non-Māori to be admitted to hospital for a mental disorder during 2011–2013. Psychotic related disorders were the most common disorders, followed by substance use disorders. The rate of admission for schizophrenia disorders was 4.2 times the non-Māori rate (Rangahau Hauora, 2015).

The number of people who have taken their own lives in New Zealand is the highest since records began, with 668 dying by suicide in 2018-2019. It was the fourth year in a row that number has increased. It was also the highest number of suspected suicide deaths since the Coroner's annual provisional suicide statistics were first recorded in 2007-08 (Chief Coroner, 2019).

The number of Māori deaths is also the highest since records began, with 142 deaths from July 2017 to June 2018 (Chief Coroner, 2019).

The highest number of suicides was within the 20-24-year-old group with 76 deaths.

Mental health service access rates in Wairarapa were consistently higher than national rates, particularly for 15–24 year olds between 2009 and 2017 (Duncanson, 2019).

Substance abuse

Drug use among 15–19 year olds is also an important global concern.

Comparisons between 2001, 2007 and 2012 in the youth 2000 survey indicate there has been a significant decline in the use of cigarettes, alcohol and marijuana reported by students.

In New Zealand 30% of males and 15% of females aged 15-17 have used drugs (MOH cited in Collaborative Trust, 2015) and out of those who have used 44.9% of males and 32.4% females are weekly users of cannabis.

Around 57% of young people under 18 years old had consumed alcohol in the past year, which was significantly lower than the rate in 2006 when three quarters of under-18 year olds had consumed alcohol in the past year. The percentage of 18–24 years who consumed alcohol in the past year was consistently higher than the rate of their younger peers at around 84-86% since 2011.

Globally, at least 1 in 10 adolescents aged 13 to 15 years uses tobacco, although there are areas where this figure is much higher. Cigarette smoking appears to be decreasing among younger adolescents in some high-income countries. (Clarke 2013).

Sexual behaviour

In New Zealand, secondary school students are delaying initiation of sexual behaviour when compared with their peers ten years ago.

In 2012, the Youth2000 survey found that

11.2% of school students aged under 16 years and one-third (32.9%) of school students aged over 15 years were sexually active. (Duncanson, 2019).

18% of women aged 16–24 years had been pregnant in the previous five years. (Duncanson, 2019).

There has also been a strong downward trend in the rate of terminations of pregnancy for women aged 15–19 years since 2007.

Contraception use among sexually-active school students has shown little change over time; in 2012, 45.5% always used a condom, and 58.2% always used contraception.

Nutrition and physical activity

Many boys and girls in developing countries enter adolescence undernourished, making them more vulnerable to disease and early death. At the other end of the spectrum, the number of adolescents who are overweight or obese is increasing in low-, middle- and high-income countries.

Globally, in 2016, over one in six adolescents aged 10–19 years was overweight. Prevalence varied across WHO regions, from lower than 10% in the WHO South-East Asia region to over 30% in the WHO Region of the Americas (WHO 2011).

Violence

Interpersonal violence is the third leading cause of death in adolescents, globally, though its prominence varies substantially by world region. It causes nearly a third of all adolescent male deaths in low- and middle-income countries of the WHO Region of the Americas. Globally, nearly one in three adolescent girls aged 15 – 19 years (84 million) has been a victim of emotional, physical and/or sexual violence perpetrated by their husband or partner (WHO, 2011).

Wairarapa Youth Health Challenges

Challenges faced by Wairarapa youth that can affect their health and wellbeing include socioeconomic factors, perceived positive school climate, access to healthcare, exposure to violence, and risky health behaviours including suicide attempts (Crengle et al, 2013). There are significant number of Wairarapa Rangatahi who drive vehicles while unlicensed, binge drink substantial volumes of alcohol, engage in earlier sexual intercourse compared to other regions nationally, have high levels cigarette and marijuana use, and have limited knowledge about how to access services when required (WSCT, 2016).

Suicide and self harm

In the Wairarapa the provisional suicide rate was 17.8 deaths per 100,000 people, year to June 2018. This is the seventh highest DHB rate in New Zealand (Chief coroner, 2019).

Among Māori aged 15–24 years there was an average of nine hospitalisations per year for injury from self-harm during 2011–2013 (Rangahau Hauora, 2015).

Drug and alcohol use

Ministry of Education data on school stand-downs and suspensions for drug and alcohol use show overall higher proportions of drug and alcohol related stand-downs and suspensions for school students in the Wairarapa compared to New Zealand as a whole. over the period 2009 to 2013 (Waldegrave 2015).

Wairarapa youth have a marginally higher percentage of young people had an alcoholic drink in the past year when compared with the national percentage. (Duncanson, 2019).

Tobacco use

There has been a significant decrease in the proportion of Wairarapa Māori aged 15–17 years who smoke regularly, but no change in smoking rates among Māori aged 20–24 years. In 2013 48% in this age group were smoking cigarettes daily, compared to 27% of non-Māori (Rangahau Hauora, 2015).

Teenage pregnancy

While teenage pregnancy termination rates have tended to fall overall, during the period 2008 to 2014, Teenage birth rates have been higher in the Wairarapa DHB area than for all DHBs over the period 2010 to 2014 (Waldegrave 2015).

Sexually Transmitted Infections (STIs)

The gonorrhoea rate for Wairarapa is lower than the rate for New Zealand while the Wairarapa chlamydia rate is higher.

When gonorrhoea and chlamydia infection rates are combined the Wairarapa combined rate is slightly higher than the New Zealand combined rate (Waldegrave 2015).

Long term health issues

28% of Wairarapa Rangatahi described themselves as having a health issue that has lasted six months or more. This health condition has either caused difficulty or stopped them from everyday activities that other Rangatahi can usually do (23%), communicating or socialising (19%), or other activities (18%) (WSCT, 2016).

The long term impact of youth health challenges

Adolescence can be considered a sensitive phase, during which the quality of the physical, nutritional and social environments may change trajectories of health and development into later life.

The developmental science of adolescence is providing new insights into windows of opportunity during which intervention can have especially strong positive impacts on trajectories of health, education, social and economic success across the lifespan.

ACE studies

Understanding of the link between adverse childhood experiences (ACES) and adult health issues has been deepened by longitudinal research from the United States. These findings indicate strong links between adverse experiences during childhood and adolescence, and medical problems and unhealthy behaviours that occur later in life.

The studies focused on key ACEs) and their lifelong impact on individuals (Felitti,1998). Adverse childhood events include psychological, physical and sexual abuse; violence against mother; and living with household members who were substance abusers, mentally ill or suicidal or who had been imprisoned; emotional and physical neglect, residential mobility and parental education.

The research found a strong relationship between the degree of exposure to ACEs and multiple risk factors for several of the leading causes of death in adults, including alcoholism, drug abuse, heart disease and suicide. Those with many ACEs were more likely to have many health risk factors later in life, however, these consequences of early adversity may not be seen for many years.

Adolescents who experienced early adversity are more likely than others their age to go on to use tobacco, alcohol and drugs and have unprotected sex, increasing the risk for pregnancy. They're less likely to have good family and community support, may have on-going conflict with family and are at greater risk for mental health problems such as depression.

> *"If we wish to prevent poor adult health, and the associated spending, policy makers would be advised to take heed of the potentially long lasting effects of early childhood experiences." (O'Neill, 2018)*

Forgone health care

New Zealand secondary school students have high rates of forgone health care. (missed opportunities for health intervention). A study by Denny (2013) indicated one in six students (17%) had not seen a doctor or nurse when needed in the last 12 months.

> In the past year 74% of Wairarapa Rangatahi have received healthcare and generally use a range of services (WSCT, 2016).
>
> Another area that has significantly worsened over the last decade as shown by the Youth Survey Series includes access to a family doctor (Clark, 2014).

It is of concern that both students with health concerns and students from populations experiencing disparities in health outcomes were most at risk of forgone health care, as these issues are generally amenable to good quality primary care.

> Female Maori and Pacific students and those living in neighbourhoods with high levels of deprivation were more likely to report forgone health care (Denny, 2013).
>
> Students with chronic health problems, those engaging in health risk behaviours or experiencing symptoms of depression were more likely to report being unable to access health care when needed (Denny, 2013).

There are a number of factors that influence health care access and utilisation among adolescents, including individual characteristics such as age, gender and socioeconomic factors, availability and adolescent perceptions of their health care provider, and level of need or illness (Denny, 2013).

The challenge for the health sector is to configure services that address youth concerns and provide youth specific healthcare for all young people across Aotearoa. Adolescents who forgo health care are a vulnerable group at risk of physical and mental health problems (Denny, 2013).

Youth Health Services

Young people access health services in a range of settings, including school-based clinics, general practices, community-based health centres and through mobile and out-reach clinics. They are known to 'snack' or 'graze' on services according to their present situation and needs.

In New Zealand, over 80% of secondary school students access health services in any given year. Of the 128 young people interviewed by Wairarapa Safer Community Council in the past year 74% of Rangatahi have received healthcare and generally use a range of services.

In New Zealand, the Ministry of Health has allocated DHBs funds to provide primary mental health services for youth (YPMHS) with the expectation that such services will deal with young people aged 12–19 years with high prevalence mental health conditions, such as mild-to-moderate anxiety, depression, alcohol and drug problems, and coexisting problems with medically unexplained symptoms. The DHBs have taken a variety of approaches to providing YPMHSs, including expanding the age range of existing primary mental health services, adapting existing primary mental health services for youth, expanding existing NGO or community-based services, and developing new services, for example psychologists in schools or NGO youth services, and funding youth specific services such as youth one stop shops.

Where youth access help for their health and wellbeing needs

	NZ school students (Denny, 2013)	Wairarapa Rangatahi (WSCT, 2016)
General practitioners (GPs) or family doctors	93%	61%
School health clinics	23%	5%
After-hours or 24-hour accident and medical centres	16%	16%
Hospital emergency departments	18%	15%
Family planning or sexual health clinics	5%	-
Youth centres	2%	7%
Drug and alcohol service	-	2%.
Kaumatua		5%
School guidance counsellor		9%
Friends		11%
Teachers		30%
Parents		77%
Other family members (e.g. grandparent, aunts, uncles, cousins)		80%

Medical centres

> *"The quality of an adolescent's initial contact with a GP influences the way they perceive the health system and their future patterns of utilising health services" (Bennett, 201 cited in Collaborative trust, 2011).*

GP's are ideally placed to respond to young people's complex health problems by providing comprehensive health care, and acting as a first 'port of call' in the identification, treatment,

follow up and referral of adolescent health problems. They are the gateway to the health system and can facilitate young people's access to other services they require.

They are the most accessible primary health care provider for young people. Young people themselves perceive Doctors as one of the most credible sources of health information (Barber et al, 2001 cited in Collaborative trust, 2011).

However young people are often reluctant to visit doctors for fear of embarrassment in discussing sensitive issues such as sexuality, drug use and psychosocial problems. They are concerned about confidentiality and privacy and believe that GP's treat only physical ailments. They also face administrative, psychological and financial barriers to accessing GP services.

Wairarapa Medical Centres

Enrolments

There are 8163 youth between 10-24 years enrolled in Medical centres across the Wairarapa (Tu Ora Compass, 2019).

The table below gives the number of enrolments across each medical centre in the Wairarapa and their ethnicity (Tu Ora Compass, 2019).

Enrolled Patients Aged 10-24	**Carterton Medical Centre**	**Featherston Medical Centre**	**Greytown Medical Centre**	**Masterton Medical centre**
Total	1111	712	590	4216
Female	537	322	291	2092
Male	573	390	299	2124
Unknown	1	12	23	90
Asian	19	1475	481	2816
European	828	210	72	1150
Maori	225	1	13	141
Pacific	1	13	1	12
Other	38	0	0	0

Enrolled Patients Aged 10-24	**Kuripuni Medical Centre**	**Martinborough Medical Centre**	**Whaiora Whanui**
Total	233	441	860
Female	115	209	434
Male	118	232	426
Unknown			
Asian	5	22	18
European	181	309	349
Maori	40	111	438
Pacific	0	1	49
Other	7	7	0

Presenting health issues

Medical centres do see a broad range of health concerns however all health professionals interviewed for this study rated mental health as the highest health concern for young people in the Wairarapa, followed closely by sexual health and injuries.

Privacy and confidentiality

Medical centres require young people to present at the clinic in the same manner as other patients. None of the medical centres have a specific space or provision to ensure youth privacy.

If the child is under 16 years old a health professional has an obligation to share information if requested by a parent. This may be in direct conflict to the child's wishes not to share information with the parent.

All medical centres have a mandatory role to maintain confidentiality from parents for a person over the age of 16 years old, although billing processes can challenge this as many young people are enrolled as a whanau and the parent/caregiver receives the bill.

Cost

Medical centres have varying charges for patient consults. Most general practices offer zero fee visits for children aged 13 and under, and most non-VLCA practices offer cheaper visits for Community Services Card holders and their dependants.

Service Access

Medical practices across the Wairarapa have the same process for making appointments for all patients.

One medical centre reported an informal policy of triaging young people immediately by a nurse if possible when they presented at the clinic. They accepted 'drop ins' from youth and tried to see them as soon as possible.

Appointments are usually 15 minutes' duration for all patients

Manaakitanga – Hospitality, Attitudes and Communication

Medical centres have the same policy and code of conduct for all patients regardless of their age. There are no specific policies around engagement or communication with young people.

One medical centre did point out they had a policy of employment diversity across their service to ensure their receptionists are reflective of the general population. This has had a distinct advantage to the practice with an increase in young people who make appointments.

Organisational kaupapa - Way of doing things

Individual practitioners have a variety of skills and approaches to treating young people. The same procedures for assessment apply to all patients. There are no youth specific approaches reported by health professionals working with youth.

No medical centres conduct health assessments specifically for youth as part of their practice. The expectation is that school based clinics or Youth Kinex manage these if required.

Kotahitanga – Cross sector Collaboration and Collective Decision making

Two Medical Centres support local school based health clinics (Masterton Medical and Featherston Medical) with nurses, GPs, equipment and resources. One medical centre supports Youth Kinex with GP, Nurse and resources. (Masterton Medical).

All medical centres have access to a variety of specialists such as physios, Maori health team, Lab, Podiatry and Counsellors. Often these are on site and provide easy access for patients.

Professional training in youth health

Many nurses and GPs have undertaken training in particular youth heath issues such as sexual health and mental health. However there is no training for nurses, GPs or reception staff across the Wairarapa in specific youth development and needs.

Funding

There are a variety of funding sources that fund youth consultations.

Capitation: An allocated amount of money per enrolled patient is paid to the enrolling medical service based on historical demographic data e.g. ethnicity, age. When someone visits a practice they are not enrolled in they will be charged a higher co-payment. If they have a CSC the co-payment will be reduced and the balance of the fee will be "clawed back" from the practice of enrolment.

Casual enrolments

Enrolment is automatically maintained at the practice of choice as long as the patient is seen within three years. Even if they are not seen, the enrolment is maintained if they complete a new enrolment form confirming they wish to be enrolled. If they fill out an enrolment form at another practice, this becomes their practice of choice and the enrolment transfers. If they are seen at another practice they will be charged a higher fee and seen as a casual patient. Unless they confirm they want to be enrolled this should not happen. If they have a CSC a clawback will apply.

Claw back: All medical practices 'claw back' funding from the enrolled centre for seeing patients who present as casual patients at their service.

Sexual health: The DHB contracts Tu Ora to provide free sexual health and contraception services to young people. This funding is then allocated to practices according to the enrolled population under 21 years old for contraception and related consumables to enable a free service to young people aged under 19 years' old

Package of care: A free consult for Maori but this currently at capacity in the Wairarapa

Guided care: A further flexible funding pool, also determined through the national capitation formula. This is available for prevention and screening of long term health conditions, but is usually for older people.

ACC claims: An accredited Provider can claim for these. There are different allocations for each clinic

Services to Increase access funding: All practices are allocated funding (the amount is determined through the nationally agreed PHO Agreement) to provide access for groups who have traditionally been less likely to access services. This includes Maori, Pacific and people living in low decile areas. Most practices allocate this as packages of care and it is used at their discretion.

Youth specific funding

The DHB has a number of contracts with Tu Ora Compass Health. Tu Ora is the service provider, but in most instances sub-contracts the service to individuals or practices. These contracts include:

Sexual health (as above)

School based Health Services in Makoura and Kuranui colleges (and from 2020, Chanel College). This is a service with a nationally agreed service specification. The spec includes nurse clinics (according to the school roll) and HEADSS assessments. Tu Ora also use some of the funding to pay for GP clinics in the schools.

Masterton Medical Centre:

Masterton Medical funds a GP twice a week, each 3 hours long, at Youth Kinex for people aged 13-23.

They also provide a nurse and a GP to two local secondary schools (Rathkeale College and St Matthews Collegiate) at the school's cost

They provide a GP to one other school health clinic (Makoura college) funded by Tu Ora Compass health.

Featherston Medical Centre

The practice provides GP support to the school based clinic at Kuranui funded by Tu Ora Compass health.

The GP also provided a whanau and students health clinic at the local primary school but now provides regular support to the school Principal as it was not widely utilised

Carterton Medical Centre:

The centre provided a youth clinic for 6 months during 2018 and supported the school based clinic at Kuranui. They no longer do this.

Integrated models of health service for youth

> *"Accessible, acceptable, appropriate, effective and equitable youth services are the key principles for integrated care stipulated in the WHO's framework for adolescent and young adult-friendly services" (WHO, 2001, 2012).*

While there is no single universal definition for 'integrated care services', it is generally accepted that integrated care is a practice unit with clinical and non-clinical personnel working collaboratively to provide comprehensive, multidisciplinary care; ideally in one location. Primary health care and social services are organised and coordinated around the individual and his/her needs (Porter & Lee, 2013; World Health Organization [WHO], 2012; Hetrick et. al., 2017).

Integrated youth services are typically school-based services, community-based services (i.e. one-stop shop services) and services provided in general practice settings.

The key principles or core features of integrated youth services in community-based settings to inform and strengthen practice are:

- an emphasis on rapid access to care and early intervention
- youth and family engagement
- youth-friendly settings and services
- evidence-informed approaches, and
- partnerships and collaboration

Evidence supports the effectiveness of community based integrated youth services, including findings that young people respond better to youth specific services; there are improved mental health outcomes and that young people who would otherwise not access services engage with a youth specific service (Hetrick et. al., 2017; Halsall et. al., 2018).

Many young people may not otherwise have sought help from the mental health services, and with symptomatic and recovery success (Hetrick et. al., 2017).

Young people report high levels of satisfaction with these services (Hetrick et. al., 2017).

There are improved mental health outcomes for young people who received integrated care compared with usual care (Hetrick et. al., 2017).

Integrated services attract the traditionally under-serviced i.e. female, ethnic (Maori, Pacific (Hetrick et. al., 2017).

School health services

From 2008 funding has been provided for school nurses or school-based health services in the secondary schools attended by young people of highest need: decile 1 and 2 secondary schools, teen parent units and alternative education facilities. From 2013 this was extended to

decile 3 schools, under the Prime Minister's 'Youth Mental Health Initiative'. There is considerable variability in the provision of health services in schools across New Zealand.

A significant proportion (12%) of secondary schools report no health services beyond the minimum requirement of first aid provision; this was more common among private schools than integrated or state-funded schools.

The other 88% of schools report some level of health service. The most common model of health service provision, in 56% of schools, was by visiting health professionals.

Other schools had on-site health professionals: 20% had a health professional (a school nurse) and 12% had a collaborative health team of health and other allied health professionals on site for most of the week.

Schools with higher levels of health service (an on-site school nurse or health team) were more likely to have more facilities, to be better integrated with the school, the community and local Primary Health Organisations, and to provide routine comprehensive health assessments (including HEEADSSS screening) and more comprehensive health services.

High quality school health services (those that have on-site staff well trained in youth health, with sufficient time to work with students and to perform tasks like routine HEEADSSS assessments) do impact positively on student health and wellbeing outcomes in areas such as depression, suicide risk, sexual health, alcohol misuse and school engagement.

There is also evidence that high quality school health services reduce the use of hospital A & E by students (Denny, 2014).

Wairarapa School health services

Schools serviced

There are school based services available to students at Makoura College, Kuranui College Wairarapa College, Rathkeale and St Matthews Collegiate. The Teen Parent Unit and Kura Kaupapa are serviced through the Makoura Health Clinic.

Chanel College and Solway College do not have a school based health clinic. Some initial discussions are in place with the Tu Ora Compass health and DHB to provide a service in 2020.

Presenting health issues

All school health professionals and students identified mental health as the most challenging health concern for youth. This includes but is not limited to, depression, anxiety, eating disorders, deliberate self-harm and abuse from others (physical, mental, sexual).

Sexual health followed closely behind as a concern for youth health.

Injuries and other general health issues such as skin issues e.g. eczema, infection, bites/stings, acne, weight loss/gain and respiratory-managing asthma and allergies (conditions associated with economic deprivation).

Drug issues are mainly managed by the School Guidance Counsellor and referred to community services across the Wairarapa.

Privacy and confidentiality

All clinics have a self-referral system and operate a 'drop in' rather than appointments procedures.

Some schools have system where students must have teacher permission to leave class prior to attending the health clinic.

One school had concerns about the confidentiality of the record keeping and management as she is using the school data management system. School nurses usually use the medical centres' patient management system which is secure. School nurses usually use a Patient Management System which is independent and secure, similar to the systems used by medical centres. However, notes can be shared with the local GP.

Cost

All schools have a free service to youth.

Funding

Funding for school clinics is based on the current Ministry of Health criteria administered by Tu Ora Compass Health and therefore is inequitable across the Wairarapa schools due to individual school decile ratings.

School based health services are funded by the Tu Ora Compass Health in 2 of 8 schools across the Wairarapa and includes the Teen Parent Unit and Kura Kaupapa. These are Makoura College and Kuranui College.
Masterton Medical Centre and Featherston Medical Centre provide a GP to the two PHO funded schools. (Wairarapa College and Kuranui College)

Three additional colleges, Wairarapa College and St Matthews and Rathkeale College, provide their own nurse during school terms employed by the Boards of Trustees and Masterton medical centre respectively.

Medical supplies are funded through school Boards of Trustees, Medical Centres and Tu Ora Compass Health.

SIA (Services to improve access) This is specific funding for projects, programmes or a new service for targeted needs**.** Scripts are funded at school clinics. The pharmacy invoices Tu Ora Compass Health.

HEADSS assessments A percentage of funding is allocated by Tu Ora Compass for HEADSSS assessments for all year nines in two schools, the alternative education facilities across the Wairarapa and the Teen Parent Unit students.

Service Access

All services are only available during school time and during the school term. One school nurse indicated she made home visits but rarely.

Most services are available part time ranging from two mornings to five days a week at a variety of times during the day.

Manaakitanga – Hospitality, Attitudes and Communication

All school health professionals demonstrated empathy and passion for young people. They talked about a positive, strengths based approach, the importance of rapport, taking time to get to know the student and caring about them. The author is deeply appreciative and in awe at their genuine commitment to the wellbeing of all Wairarapa youth.

Organisational kaupapa - way of doing things

HEADSSS assessments are a tool to understand adolescent behaviour, assess risk-taking behaviours and provide appropriate interventions. These are conducted with all year nines in two schools, the Teen Parent Unit and the Kura Kaupapa. They are long, complex and time consuming but provide important data that has the potential to assist schools and health services to understand and respond to collective needs. They also serve as a referral point for other health related services and provide the school and other services with important information about the students total wellbeing.

Consults can be as long as a young person needs and up to one hour in duration

Kotahitanga – Cross sector Collaboration and Collective decision making

All school nurses report excellent relationships with the school counsellor and school pastoral team.

Some schools have support from a GP and one has a psychiatrist available for case consults. Some schools have excellent support from the local medical practice but Wairarapa college has no support from any medical practice or GP.

Most report positive relationships with CAMHS although everyone was challenged by the long wait time for a referral.

Despite good intent there is only informal and sporadic networking or collegial support among school nurses and youth health professionals.

Professional training

Some Nurses have training in HEADSS assessments but not all

Individual health professionals have a variety of training in specific youth health issues such as sexual health, contraception, suicide prevention and management and self- harm but none are trained in holistic approaches to youth development or adolescent brain development.

Professionals are passionate, youth focussed and adopt positive strengths based approaches to youth health care.

Youth participation

One school clinic has a student reference group twice a year as part of the school clinic contractual requirement. This is made up of representatives from all year levels and school personnel gaining feedback and suggestions for improvements in the service.

Individual School based health services

The following tables give an overview of the services that are available in the school health clinics.

Makoura College Health clinic

Presenting Health challenges	Mental health Family deprivation Sexual health - contraception, STI's, information, decision making Injuries in the winter due to sports Drug and alcohol comes through the GP not through the clinic
Client base	737 consultations 243 individuals (DHB, July 2018 and June 2019) The clinic also services the Kura Kaupapa and the Teen Parent Unit.
Funding	Compass fund and provide a nurse 4 days a week during school hours and terms Compass fund a GP once a week who is employed by Masterton medical centre
Hours	20 Hours a week during school hours and terms GP 4-5 hours per week
Supporting Services	A full time Guidance Counsellor is employed by the school A Youth GP from Masterton Medical provides individual consults to students and case management support to the nurse for between 4-5 hours per week Referrals are made to Family Works, CAMHS, psychologists, counsellors, Te Hauora, 'To be heard' nurses. Whaiora for smoke free, fitness, Family Start; South Wairarapa Community Trust for benefits and youth mentors
Privacy and confidentiality	All students informed of confidentiality, unless concerns of safety then someone is informed. All other information sharing is done with consent of student. Parents are not informed. All notes are recorded in Medtech a patient management system specifically for the school. The GP has access to Masterton medical centre Medtech patient management system to ensure continuous care. The nurse maintains close contact (phone and email) with Whaiora for shared students. For students enrolled in other medical centres there is either a conversation with nurse or email to students GP if they have been given permission.
Referrals	All year nines receive a HEADSS assessment during the year Students may self-refer for any reason. The guidance counsellor, Teachers and Whanau also refer students
Location	The clinic is based in a house separate to the rest of the school, housed alongside the School Guidance Counsellor
Concerns	HEADSSS is a great way to meet with students initially as they arrive at college. The HEADSSS framework is used as the base for all consultations.

	Although very useful HEADSS assessments are time consuming and referrals to other services is limited due to their limited capacity. There is a gap in the service provision for dietary referrals for general wellbeing rather than severe illness.

Kuranui College Health clinic

Presenting Health challenges	Mental health - Students mostly present with a physical issue or Environmental causes. Pressure with exams, fear overwhelm for the future Sexual health - contraception, Sexually transmitted infections, information, decision making Injuries in the winter due to sports Drug and alcohol comes through the GC but also through the clinic No smoking referrals of late Skin issues- eczema, infection, bites/stings, acne; abuse-physical, mental, sexual; weight loss/gain; respiratory-managing asthma and allergies; (conditions associated with economic deprivation)
Client base	646 consultations 286 individuals (DHB, July 2018 and June 2019)
Funding	Compass health fund a nurse twice a week Compass Health funds a Featherston Medical centre Doctor to attend once a week A psychiatrist attends a clinicians meeting once a fortnight at his own cost
Cost	No consultation cost to young people Scripts are paid for under SIA funding Students have to pay for specialists e.g. physio
Hours	Two days a week during school hours
Supporting Services	A full time Guidance counsellor is employed by the school and the nurse works closely with them Referrals are made to GPs, Pathways, Family works, CAMHS, psychologists, counsellors, Te hauora, To be heard nurses, PIKI and Oranga Tamariki Psychiatrist Dr Hill meets Dr Harsha Dias most fortnights as required for a clinicians meeting to triage and support the health team referrals to GP practices for long term conditions
Privacy and confidentiality	There are some challenges with the waiting room mixed with the Guidance counsellor.

	Results from the student reference group survey in 2019 indicate strong confidence in the privacy and confidentiality of the service. During holidays if they need anything the nurse liaises with the medical centre or GP for a private referral. GPs at the local medical centres are constantly reminded not to send bills to student's homes to ensure confidentiality The Youth clinic GP sends patients notes to the local enrolled medical centre
Referrals	Students refer themselves to the nurse or Guidance Counsellor or GP Wherever possible the nurse triages student`s request for GP appointment as some do not need to see the GP to have their health issue addressed. Prior to school holidays of they need anything the nurse liaises with the medical centre or GP for a private referral The nurse aims to see all year 9 students for a HEADSS assessment
Location	On site in a private house separate to the rest of the school
Concerns	As the school role has increased dramatically the service allocation has not, therefore demand exceeds capacity HEADSS assessments are time consuming

The clinic has a student reference group twice a year as part of the school clinic contractual requirement. This is made up of representatives from all year levels and school personnel gaining feedback and suggestions for improvements.

Consultations and Individuals seen at Makoura and Kuranui college school based clinics (DHB, July 2018 and June 2019)

Consultations by Ethnicity		**Individuals Seen by Ethnicity**	
25	Asian,	10	Asian
550	European	232	European
564	Maori	192	Maori
67	Pacifica	30	Pacifica,
177	unknown	65	Unknown
1383	Total	529	Total

Consultations by gender		**Individuals by gender**	
1007	Female	331	Females
333	Male	182	Males

Consultations by age		**Reasons for visit**	
16	<12	137	Other
3	12	193	Sexual Health

112	13	99	Accident/Injury
102	14	75	Dermatology
101	15	60	Mental Health
84	16	39	Respiratory
62	17	19	Chronic Care
28	18	28	Musculoskeletal
13	19+	12	Ear, Nose, Throat (not injury)
		11	Gastroenterology
		11	Smoking
		5	Sore Throat NOS
		7	Opthalmological (not injury)
		5	Gynaecological (not SH)
		2	Neurology
		1	Drug and Alcohol
		1	Nutrition/weight management

Wairarapa College health clinic

Presenting Health challenges	Mainly mental health – deliberate self-harm depression, anxiety, somatic issues Sexual health – pregnancy tests and advice, contraception Injuries Family life challenges Students have poor health literacy and inconsistent help seeking behaviours
Client base	2,333 consults in 2019. Some of these are repeat clients More females than male refer but there is a mix of ethnicities that refer
Funding	The Wairarapa College Board of Trustees employs and pays for a health clinic and nurse The nurse is ACC accredited so is able to claim for accepted referrals. The ACC claims help to support the service with medical supplies There is no external funding supporting this service
Hours	5 days a week, during school terms between the hours of 8.45 – 3.15. The nurse does make home visits outside of these hours on occasion. The nurse has 40 minute appointments regularly. During holidays and weekends there is no school service.
Supporting Services	The health clinic compliments the full time Guidance Counsellor, the internal school Deans and guidance systems. There are good relationships with the guidance system The school has a contract with the local Physio who provides a clinic on Tuesday morning for a discounted fee to students. The nurse has a close relationship with a local pharmacy The nurse makes referrals to and consults with Changeability, STOP, Youth Kinex GP and 'To be heard' counsellors and CAMHs, The nurse has worked with Hutt hospital on long term chronic illness management.
Privacy and confidentiality	All patient notes are filed in the school system KAMAR. There are concerns about confidentiality of this information as KAMR is accessed by school staff. There is no exchange of patient notes with the patients local GP Students have to be released from class by a teacher to attend the clinic
Referrals	Students can drop in at any time during the school day They have to be released from class and most teachers support this to occur when requested The nurse follows up with regular check ins.
Location	The clinic is on site, not too close to classrooms, easily accessible
Challenges	Despite a strong need and various requests there is no GP service or support to the school There is sometimes some teacher reluctance to release students for a consult The nurse is isolated from other youth health expertise and professional network support

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Rathkeale College and St Matthews Collegiate

Presenting youth Health challenges	A broad range of issues are presented e.g. sexual health, boys with wounds infections, general colds, 1 mental health Most mental health issues are managed by the Guidance Counsellor
Client base	Students from both Rathkeale and St Matthews. As this is a new service no statistics have been collated on gender, ethnicity or need in 2019 The nurse indicates that there are approximately 6 students per day but comments it is "only a new service"
Funding	The Trinity Schools Board fund Masterton Medical centre to supply a nurse for nine hours per week Masterton Medical provide a GP once a week. Casual patients are funded through the 'claw back' from the enrolled Medical Centre
Hours	The service started in August 2019 Rathkeale Monday and Friday 10.30 - 1.30 St Matthews Wednesday 1030 - 1.30 3hrs
Supporting Services	There is some case management sharing with the local GP at the youth clinic and there is a visiting GP attending the clinic once a week. Referrals to local GPs are made as required.
Privacy and confidentiality	A request by one school to have names shared with the school has been refused due to patient privacy constraints The nurse is able to access the Masterton Medical Medtech system for patients enrolled there but creates separate files for those who are not.
Referrals	Appointments are made through the office where a student gets sent a permission slip with 'internal appointment' on it. They are sent from the office to the clinic. Students can refer themselves but need permission to exit the class from the teacher. School vans are available for referrals to other services The nurse is able to provide photo evidence to Masterton medical centre for prescriptions and advice Medtech system ensures information is shared with the students local GP
Location	The clinic is situated in a private space in the school with access to a toilet and water and a separate entry and exit
Challenges	This is new service. Information has been shared with community in newsletters and student assemblies about the service but it is word of mouth that works best. Some parents expressed concern about the need to know if their children were attending the clinic. They were concerned about terminations. Education on the 'Privacy Act' and processes for referrals has alleviated this somewhat.
Youth specific training	Training and implementation of HEADSS assessments are planned for 2020 Training in specific health issues such as mental health and contraception has been competed No specific training in 'youth' development The nurse receives informal mentoring form the GP at the local health clinic

Youth One Stop Shops

A number of community youth health organisations have been established in New Zealand over the past 15 years. These have been set up by passionate and motivated health professionals in response to a need for healthcare specifically targeted at New Zealand youth. Youth specific services have evolved in response to local demand as well as to opportunities for growth, supported by relationships with funders and other providers. As such each service has developed independently in its own setting although they are united by a common goal is to promote access to healthcare and social services for youth.

The population serviced by Youth One Stop Shops is aged predominantly between 10 and 25 years.

Approximately 137,000 occasions of service were provided in the previous year. (MOH, 2009)

The Youth One Stop Shops all receive significant proportions of their funding directly from the District Health Boards or through Primary Health Organisations that are themselves funded by the DHBs. Additional funding is provided through a multitude of other sources, ranging from private donors and City Councils to the Ministries of Social and Youth Development.

Youth One Stop Shops provide access to a range of services in youth-friendly settings, including health, social, education and/or employment services with the ability to refer to secondary or tertiary services as required. They employ Doctors, Nurses, Social Workers, Facilitators, Counsellors, Youth workers, Community Health Workers, Mentoring, Peer support, Clinical Psychologists, Therapeutic Group Facilitators and Youth Workers.

Some Youth One Stop Shops offer outreach, mobile and satellite services and/or evening clinics to increase access opportunities for young people.

Services are available at little or no cost to clients, are centrally located and provide a safe and welcoming environment. In some cases, transportation to assist access is provided.

Consideration is given to the young person's needs in the wider context of their family and community/whanau, hapu and iwi. Services wrap around the client to ensure their individual needs are addressed in a seamless and coordinated way.

Services are delivered in a manner that is non-judgmental, culturally appropriate and respectful to young people. This promotes trust and the perception of confidentiality and safety for youth.

Services are holistic and strengths-based, focused on improving health and wellbeing and encourage long-term independence.

The integrated and youth-specific model of care attracts young people, particularly those who have higher need.

The top reasons young people use Youth One Stop Shops relate to cost, service flexibility and confidentiality, convenient location and perceptions of non-judgment, welcoming and safe staff who know about youth related issues.

Comprehensive, longitudinal health status measurement is complex and not routinely undertaken by any of the Youth One Stop Shops. Health measures are debated by the sector and there is no consensus on the best method for evaluating effectiveness. Measures of determinants of health are often used as proxy measure to reflect health status. Despite this

lack of available evidence managers are strongly of the belief that their services are effective in improving the health and wellbeing of their clients. 89% of stakeholders surveyed and 94% of clients surveyed agreed.

Youth One Stop Shops in New Zealand.

Whangarei Youth Space	Whangarei
Rotovegas	Rotorua
Anamata Café for Youth Health	Taupo
Youth Services Trust	Whanganui
Directions Youth Health Centre	Hastings and Napier
Youth One Stop Shop	Palmerston North
Kapiti Youth Support	Kapiti Coast
Vibe	Lower Hutt and Upper Hutt
Evolve	Wellington
Korowai Youth Well-being Trust (298) Youth Hub Trust	Christchurch
Te Hurihanga o Rangatahi	Christchurch
Number 10	Invercargill

Youth Kinex Masterton

Youth Kinex was opened in May 2014 by Masterton Medical Centre in partnership with Compass Health and Connecting Communities. The idea behind this was to create a youth hub in a central location where youth specific services could be delivered. The purpose was to alleviate some of the barriers young people encounter when accessing healthcare, to provide timely, free and appropriate care in a confidential youth friendly environment.
Currently this service is still emerging and has potential to grow into a fully integrated community youth hub.

Enrolments

The service is available for youth aged between 13 and 23 years old.

Total no of consultations (April 2018 - March 2019) 2170

Enrolments in other medical practices throughout the Wairarapa
(a sample over a two month period 3/10/19- 28/11/19)

229	MML
8	Whaiora
7	Kuripuni
11	Carterton
6	Greytown
4	Feathy
3	Martinborough
10	other

Consultations by Ethnicity (April 2018 - March 2019)

1382	NZ European

134 Other European
548 Maori,
49 Pacifica

Consultations by gender (April 2018 - March 2019)
1960 Female
210 Male

Consultations by age (April 2018 - March 2019)
13 22
14 39
15 105
16 191
17 257
18 382
19 337
20 293
21 272
22 169
23 70
24 26
24 + 7

Presenting youth health issues (Masterton Medical April 2018 - March 2019)

The predominant presenting issues relate to mental and sexual health although there are a large range of health issues seen at the clinic. The following is a breakdown of consults over a year.

819 GP visit (not specified)
0 Drugs and alcohol
330 GP mental health
102 Nurse consult (not specified)
431 GP sexual health
488 Nurse sexual health
0 Stop smoking

Privacy and confidentiality

The environment

The clinic has a small waiting room right off the front door. Despite music playing there is no privacy for anyone waiting.

Consult rooms are very close together and voices can be heard from both consult rooms.

The toilet is through the waiting room so everyone will see a person having to use it during a consult.

There is only one entry and exit to the building. One exit through the nurse's consult room can be used if a Young person does not want to be seen exiting through the waiting room.

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Enrolment

All young people are required to complete an enrolment form as a casual patient where they are asked to provide details of their enrolled GP. The GP can then be informed of relevant information about the patient's care. There is also an opportunity to refuse to share information with their GP. Many young people do not submit their GPs details and refuse permission to share information outside of the clinic.

Consult

The GP ensures the young person is aware of codes of confidentiality around sharing information and risk management.

Cost

There is no cost to young people for attending the clinic.

The clinic is away from the main centre of town but walking distance from most Masterton schools thus cost of travel is minimised.

Funding

Masterton Medical provide 6 hours GP plus nurse plus admin time per week including equipment and resources.

Tu Ora Compass Health PHO funds a mental health nurse 1 day per week offering up to 6 booked appointments. The nurse delivers the PIKI programme (expanded on later in the report).

Tu Ora Compass Health fund rental, and administration costs of the building.

Connecting communities manage the contract. This agreement is in place until 31st December 2019.

The clawback system is used to claim from young peoples enrolled medical centres if they present at the youth clinic, however some young people do not complete a casual enrolment form indicating their GP practice therefore the Youth Kinex cannot clawback from their GP.

Service access

The clinic is open 2 afternoons a week. Monday & Thursday from 2 - 5pm.
The clinics operates on a drop in clinic. Wait times can be very long (up to 90 minutes). There is frequently insufficient time for all patients who wish to receive a health service. Demand exceeds supply.

Manaakitanga – Hospitality, Attitudes and Communication

The environment

The waiting room is bright, casual and full of colour. The music is youthful. The interior was designed and painted by the youth council.

There are a range of chairs and couches and beanbags to sit on.

There a range of youth friendly posters and pamphlets around the room.

The consult

The GP takes the time the patient need to listen and respond accordingly. They use a strengths based, positive approach to all assessment and intervention.

Organisational kaupapa - way of doing things

Consults are up to 40 minutes long for a client as the GP takes time to understand and assess their health needs.

The GP uses the HEADSSS framework to understand the issues but does not have the time to conduct formal assessments.

Kotahitanga – Cross sector Collaboration and Collective decision making

Referrals can be made to Changeability CAMHS, specialist services, laboratory, Work and Income.

There is a need for social worker

The current Medtech patient management system used by most medical centres across the Wairarapa does not integrate, thus sharing case information with the patients enrolled GPs is difficult.

Professional Training

The GP is well experienced in all aspects of youth health.

Other services supporting youth health

The following is a list of organisations and services that provide youth health care across the Wairarapa. It is not an exhaustive list and the author apologises if they have missed any service.

Child, Adolescent and Family Mental Health Service (CAMHS)

Service
The service provides mental health information, assessment, treatment and support options for children/Tamariki and young people /Rangatahi considered to have moderate to severe emotional, behavioural, and mental health issues.
Location
Masterton
Referrals
Appointments can be either at the CAMHS base or at an arranged meeting place in the community.
Referrals may be made directly to CAMHS service by young people and their families
Young people may be seen on their own or with their whanau/family.
Age
0 – 19 yrs and their whanau/ families
Cost
Free

Piki

Service
Piki's vision is to enhance young people's quality of life by equipping them with tools to overcome adversity and strengthen their wellbeing.
It provides therapy and support options with a trained Mental Health Therapist,
An emotional wellbeing app that helps keep youth progress on track
Links to 24/7 support through phone and web services
Peer support options
Location
Greater Wellington region.
Age
18-25 years' old
Referral
Self-referrals can be made directly through the Piki website.
Youth can also be referred by a GP, other health providers and other agencies
Cost
No fees apply.

To be heard counselling

Service
The aim is to improve access to health and social services to support mental wellbeing
Location
Counsellors across the Wairarapa
Age
All young people aged 12 to 25 years
Community Services Card holders aged 25 years and over
Māori 12 years and above
Pacific Island people 12 years and above
Referral
The service can be accessed if a young person is enrolled or intends to enrol with a Compass Health doctor/practice, if they are experiencing a mild to moderate mental health issue
Contact can be made through the family doctor, the Coordinator in the area directly, or through a community agency.
Cost
Free

Changeability (formerly Stopping Violence Services)

Service
Services and programmes to empower individuals and families affected by violence and abuse to make positive changes and build respectful and trusting relationships.
Location
Masterton

Counselling Service Family Works Wairarapa

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Service
Family Works offers a range of counselling support for children/Tamariki, young people/Rangatahi and families and whanau who are facing complex challenges.
Location
Featherston

Skylight Trust Grief Counselling

Service
Support for children, young people, families and adults who are experiencing a wide range of grief and loss: including family break-up, bereavement, bereavement through suicide, family member with a chronic illness, children with anger/anxiety/bullying issues, and any major life change involving loss.

Multi systemic therapy

Service
MST is a community based programme to help families manage very challenging behaviours such as truancy, drug use, anti-social behaviour and offending.
MST provides a therapist who works with the family and whānau for 2-5 months, meeting at least 2-3 days per week to support rapid progress towards changing behaviours.
MST focuses on family and whānau goals, working in collaboration with the family whānau and ensures someone from the team is available 24 hours a day, 7 days a week for advice/support.

Te Hauora Runanga o Wairarapa

Service
A community support service for Māori Health in the Wairarapa region. It grew from initiatives developed by Māori Health workers seeking to establish a more focussed approach to the delivery of Community health services.
The service delivers Alcohol and Drug Counselling, Mental Health Support Services and Rongoa/Mirimiri Services, Rongoā, kuia and koroua service, Family Safety Team, Oranga Tamariki contracts, Kuia and koroua programmes, Detox, Peer support life skills, Parenting, Violence Free programmes, Youth justice wrap around, Smashed and Stoned Workshops and Te Mana to te Taiohi Groups.
They are a Kaupapa Maori service delivering to all ethnicities. They work on a Whānau Ora model using Te Aka Matua model.
Location Masterton
Age All

King Street Artworks

Service
A creative space for people who use, or have used mental health services and for their whanau and friends and for the whole community.

Connecting Communities

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Service
Connecting Communities Wairarapa co-ordinate community based activities that enable community resilience and social well-being.The Council also supports projects that involve community and agency co-operation in environmental and other projects that will lead to greater individual and community wellbeing.
Youth council: The Wairarapa Youth Council is made up of a group of young people who meet fortnightly to discuss and address youth related topics such as things to do, places to go, employment opportunities, training programmes, and anything else that relates to the Wairarapa and its young people.
Youth café project
Leadership camp
East side Wairua programme: via schools who have referred
Te Awhina youth group: 12-24 live in Mstn East, no membership, just turn up
Financial capability Money mates programme
Location
Masterton

Featherston Community Centre

Service
A community facility owned by the people of Featherston. They offer classes, activities and events for all ages as well as a warm and welcoming space for groups to meet.

Wairarapa Whanau Trust

Wairarapa Whanau Trust's purpose is to coordinate social services in the Wairarapa region, allowing a more coordinated approach to community engagement, development and care, with specific focus on youth (12-24yrs).

The Trust aims to break down barriers to success for youth in the Wairarapa, and to build positive bridges with the community. This is achieved by providing youth with a safe place to belong, where they can learn new skills, and work with mentors from within the community.

Southern Wairarapa Safer Community Council

Service
Holds the contracts for: Attendance, Life to the Max, Big Brother Big Sister, Safer Wairarapa, Youth Services and Alternative Education.
It aims to get young people into education, training or work-based learning.
Young people work with community-based providers who give guidance, support and encouragement to help them find the education, training or work-based learning that works.
Youth Service offers guidance and practical support to young people.

Rangatahi to Rangatira

Service
R2R is run by a group of Carterton's young people, with support from Hurunui-o-Rangi Marae, Carterton District Council, and Wairarapa Safer Community Trust.

R2R is a youth project that develops and encourages young people in Carterton to be involved in the community, be more aware of political, social, and environmental changes that are happening, and how to change the things they want
Tuia Leadership Programme: Tuia is an intentional, long term, inter-generational approach to develop and enhance the way in which Rangatahi Māori (Māori young people) contribute to communities throughout New Zealand.

Location

Carterton

Age

Young people aged between 12 and 24

Online support

Safer Teen Drivers You can help improve safety in Teenage Driving. A toolkit for parents of teen drivers

Gambling Helpline – Youth Youth Gambling Helpline has younger counsellors who can help you talk through any challenges you may be having with your own or someone else's gambling.

The Lowdown 24/7 email, text and online support for young people with depression or anxiety.

SPARX Online tool for young people with mild to moderate depression.

What's Up

Youthline Youth helpline, counselling, support and youth development services.

Just the Facts Website A new online resource of sexual health information designed with young people in mind.

Just a Thought offers evidence-based Cognitive Behavioural Therapy (CBT) online and is designed for people with mild-to-moderate symptoms of anxiety and depression.

Factors impacting the effective delivery of health services for youth.

> *"Young people need a health service that is available at the right time, in the right place, and delivered by the right people. This will provide equity for young people to access services necessary for them to lead healthy lives" (Health professional.)*

The following factors have been identified in the literature as vital to the effective provision of youth health services. A thematic analysis of Interviews and focus groups from the Wairarapa youth and health professionals provide voice to support these themes.

1. Privacy and confidentiality
2. Cost and funding
3. Access
4. Manaakitanga – Hospitality, Attitudes and Communication.
5. Organisational kaupapa - way of doing things
6. Youth health literacy
7. Kotahitanga – Cross sector Collaboration and Collective decision making
8. Professional training

1. Privacy and confidentiality

Numerous studies have identified privacy and confidentiality as a major factor in young people's health care. Adolescents who forgo health care due to confidentiality concerns are more likely to experience psychological distress, high rates of risk behaviours, and parent– teen communication issues (Denny, 2013).

Young people expressed concerns about GPs disclosing information to their parents and reception staff not protecting confidentiality.

> 28.2% New Zealand youth participants in the Youth 07 surveys were worried their care wouldn't be kept private (Adolescent research group, 2008).
>
> Among New Zealand students who had accessed health care, only 27% reported receiving private and confidential care (Denny, 2013).

Wairarapa health professionals reported that the medical centre billing structure and family enrolment scheme caused challenges to a young persons need for privacy.

> *"As many of the youth are part of a family enrolment, the parents get billed, so they will be aware of the appointment" (Health professional).*

A small community creates further challenges to the privacy of young people.

> *"The Wairarapa has a small population living in small towns where there is a sense that everybody knows everybody else's business. Masterton has three medical centres but the other towns only have one which means there is limited choice. Young people get very concerned about being seen and talked about (Health professional).*
>
> *"Youth don't want to come to a family medical centre where their neighbour or Aunty is sitting next to them in the waiting room making it awkward" (Health professional.*

Young people were worried that their parents and whanau and their peers would judge them and know what they were doing.

> *"Kids are ruthless. If someone sees you going into the clinic they will take the piss out of you' (Young person).*
>
> *"Privacy is an issue. They see you and think you're are just going there for condoms" (Young person).)*
>
> *"You always see lots of people you know. This is a small town!" (Young person).*

Health professionals reported that patients right to privacy created conflict for the delivery of consistent care for young people. They stressed the importance of sharing information across health services to enable consistency of care throughout the life course of a young person. They expressed concern about not getting information about consults from other services.

> *"We don't get any notes for patients seen at the Youth clinic. How are we supposed to deal with them when they turn up to us and we don't know what has happened to them" (Health professional).*

2. Cost of the service

Cost is one of the more common reasons for not accessing health care when needed. Most young people are students without income or on a low income. There are significant cost barriers for adolescents accessing health care from GPs and medical centres. Young people believe they cannot access a GP without payment and are unaware they are able to access services such as the youth clinic for free. They were also unaware of initiatives such as the free sexual health care.

> 14% of Rangatahi interviewed by the Wairarapa Safer community council indicated the cost was too high to go to a GP at a medical centre (WSCT, 2015).

> *"It's expensive and you usually have to get your parents to pay and then they have to know about it" (young person referring to the cost of attending a medical centre).*

> *"It's expensive to go the medical centre. I have overdue bills and I am just not going back 'cause I can't pay them" (Young person).*

In contrast to this the following comment sums up the difference between medical centres and school and the community youth clinic.

> *"It's free and that is huge!" (Young* person referring to the Youth clinic).

The cost of travel

Travel to and from a health service is also a significant contributor to the cost. When identifying barriers to young people accessing and receiving services, physical location, the rural factor, and transport constraints were most commonly identified.

> 10% of Rangatahi interviewed by the Wairarapa Safer community council had no transport (WSCT, 2016, Waldegrave, 2015*).*

The location of the service is paramount to young people and the subsequent cost of their care.

> *"We are a large geographical region but many of the services are based in Masterton. For some people this means travelling up to two hours to attend a service. Many young people have to rely on someone else for transport" (Health professional).*

> *"It's walkable from school. Not too central so everyone sees you" (Young person referring to Youth Kinex).*

Sector funding and Enrolments

The way an organisation is funded can be an important factor for effective health service provision. Current health-related funding streams are decided on by the Ministry of Health and administered by the DHBs. The New Zealand primary care PHO/GP model of care expects an individual to enrol with a single health professional and then use this health professional for the majority of their primary care.

Youth utilise health services in different ways from other sections of the population. Youth often choose to access services from a number of different Health professionals depending on the type of care required, personal preference, geographical access and convenience. Youth are sometimes transient and they often prefer to use different health professionals from their family for health issues which they feel are sensitive. Youth like to access care independently yet are often restricted by their transport options.

Any funding model needs to promote a holistic, population health approach to primary care and account for their "grazing" and the need for multiple services in the one place often required by youth.

The cost of a free service

Organisations in the Wairarapa identified funding restrictions as a key area which was not working well. Funding issues were identified as creating uncertainty and tensions between health professionals.

> *"A GP practice is a business and the onus should not be on them to pay for youth services. We need funding to run a Youth Health Clinic where a GP gets paid for the time regardless of how many patients come in. You cannot run a youth clinic out of the goodness of your heart" (Health professional).*

Some organisations discussed the unfair targeting of funding, and the negative impacts of competition for funding on their core work. (Waldegrave, 2015) One Health professional expressed concern that patients were being taken away from their practice as a result of the 'free' youth clinic.

> *"Previously the youth did come to the Medical centre but now they go to Youth Kinex because it is free. There was never an issue before" (Health professional).*

The cost of being 'casual'

They also highlighted the increased cost to the young person when they became a casual patient at their family clinic as a result of attending another clinic.

> *"It is a problem. There needs to be openness where a non-enrolled patient can just turn up anywhere and not get charged the casual fee" (Health professional).*

> *"A young woman who attended the centre with her mother found she was no longer enrolled at this clinic and subsequently would have been charged the higher rate as a casual patient. She did not want to inform her mother she had been to the Youth clinic. It put me in a very difficult position" (Health professional).*

One solution cited by a health professional working in a medical centre was to run free youth clinics from their own practice using the free sexual health funding available.

> *"Every medical centre should run a free youth clinic once a week" (Health professional).*

GP's have also cited problems with inadequate remuneration for longer consultations required for young people (Collaborative Trust, 2011).

Young people identified problems with some of the organisations that were funded to help them referring to changing staff, changing appointment times and not being able to get hold of staff when they felt they needed them. This was mirrored by Health professionals who felt services were often over-stretched, inadequately funded and under-paid (WSCT 2016).

3. Service Access.

Adolescents, by nature of their brain development, are impulsive. As the prefrontal cortex matures and the pathways between the prefrontal cortex and the limbic system becomes more efficient, they become better at reasoning, thinking logically, planning, solving problems and making good decisions. They need a lot of guidance from adults as they learn these skills. Having an immediate health service available where they can 'drop in' is an important biologically respectful factor in accessing health care. Appointment times and availability of the service were consistently cited as challenges to accessing a health service. Clinic opening hours and long waiting times can lead young people to forgo much needed health care.

> *"The current enrolment rules disadvantage youth as they are often transient e.g. move to University, travel, visit more convenient practices and then get de enrolled at their family practice" (Health professional).*

Appointments

Young people had difficulty knowing how to contact, when to contact and who to contact with regards to health care. Wairarapa Rangatahi interviewed by the Wairarapa Safer community council (WSCT 2016) reported they were:

> "unable to get in contact with the health professional" (11%)
>
> "were unable to access health care when required" (27%)
>
> "there was no suitable appointment time."
>
> *"It takes ages and I just can't be bothered waiting" (Young person).*

Service availability

Varied opening times and service availability were a barrier to young peoples' health care.

> *"It's only open on this day and this day at this time. I can't remember and its always too late when I do" (Young person).*
>
> *"We need more school clinics. They are there all the time and easy to get to" (Young person).*

One young person talked about the impact of a limited service in her school.

Our school nurse is a 'woman of mystery'. I have never seen her. We were all told she would be meeting with us individually for an assessment but it never happened. I am still waiting" (Young person).

Wairarapa health professionals supported this concern

"Services are open for short periods or restricted to certain days. As a drop-in clinic there is uncertainty to how long a visit will take. This makes it even more challenging to attend a service, particularly if travelling long distances" (Health professional).

'Drop in' service

One medical centre had begun an informal policy of allowing any young person who came to the clinic to be seen by a nurse immediately if possible.

School based health clinics and the youth health service have a 'drop in' policy where young people can present at any time the clinic is open and do not have to make an appointment.

"We are readily available to them. They are not forgotten" (School based Health professional).

"You can't just pop into the medical centre like you can at Youth Kinex" (young person).

4. Manaakitanga

The concept of manaakitanga includes values of hospitality, kindness, generosity, integrity, trust and sincerity, support, showing respect, generosity and care for others. These are essential factors to young peoples' health care.

Manaakitanga includes the way a young person is greeted when they arrive and the acknowledgement of who and where they come from. Young people's lasting impression of a health professional is often determined when they walk in the door. The clinic environment can have a negative impact on the utilisation of the service.

Manaakitanga involves caring for young people as culturally located human beings through providing safe, nurturing environments. A health professional has an immediate responsibility and authority to care for the young person's emotional, spiritual, physical and mental wellbeing.

Service provider communication

The health professional's communication style and approach has a significant impact on the young person's level of comfort and ease of communication when seeking health care.

Young people's consistent articulation was for listening, support, non-judgemental attitudes and practical help from a health professional. They have reported concerns that health professionals have unsympathetic, authoritarian and judgemental attitudes towards them (Collaborative trust, 2011).

All youth participants in the Wairarapa social sector trials referred to the importance of being treated fairly and given respect, being consistent and patient, non-judgemental, and honest, showing youth they cared about them and listening to youth voice (Waldegrave 2015).

The young people called for an improvement in attitudinal approaches to them. They reported experiencing assumptions, judgements, being spoken down to and at times, a lack of respect. They wanted health professionals to be more honest and real. They certainly wanted to work on solutions but they needed to feel comfortable, accepted and respected first (WSCT 2016).

Young people report that the youth clinic 'Youth Kinex' and school based services provide a safe, friendly environment encompassing all the tenants of manaakitanga.

> *"There is no judgement – It's just for youth. No one looks down at you. Everyone is the same as you" (Young person).*
>
> *"I love the sense of welcoming. The wait is long but worth it" (Young person).*
>
> *"The Doctor at Youth Kinex seems nicer. She is not so scary" (Young person).*
>
> *"The staff were extremely helpful considering that I came in off the street. I cannot speak highly enough about them" (Young person writing on Facebook).*

The waiting room

Young people are intimidated by a formal clinic and waiting room environment, appointment and booking procedures.

> *"You walk into the Doctors and feel intimidated "(Young person).*
>
> *"The waiting room is scary" (Young person).*
>
> *"The waiting room is so open and there's no privacy" (Young person).*
>
> *"The waiting room is boring. The music is shit and the magazines are ancient. The TV plays old peoples stuff. Why can't we have a space for us? They do it for little kids" (Young person).*
>
> *"Paint it so it doesn't look so clinical. It feels so clinical. Its ugly and boring" (Young person referring to the medical centre).*
>
> *"It looks like you are there to die when you walk in!" (Young person).*

Reception

Young people referred to their initial reception as a significant factor when accessing a health service. Many talked about the environment in their local medical centre.

> *"There was an old lady there at the counter and she was really rude to me" (Young person).*
>
> 10% of young people interviewed for Wairarapa safer community council indicated the Staff at the medical centres were 'unfriendly' and the Rangatahi were made to 'feel uncomfortable' (WSCT, 2016).

One health professional talked about the need for a youth focussed space in their local medical centre.

> *"It would not be too hard to make a youth focused private waiting area just like they do for young children. I've seen it work elsewhere and it made a significant difference e.g. USB ports, music, paintings and art work (health professional).*

Health professionals in school based health services discussed the importance of relationship and the need to provide a positive, friendly service.

> *"Greeting is important. We must be friendly and have a laugh. They need to feel like they are not a patient and that we are just having a conversation. It's important to get the rapport, not be rushed" (School based Health professional).*
>
> *" You have to build rapport. They won't just bowl in. I have list of regulars. I know their names. They are on my radar and I always follow up. I often give them a hug" (School based Health professional).*

5. Organisational Kaupapa

The kaupapa, theory and ideology of a youth health service should embrace youth-focused, youth-centred and strengths-based practice. These should be integrated into all areas and levels of the organisation, and drive all decision making and interaction with young people.

Youth friendly

Consulting with young people requires understanding of the unique emotional, psychological and cognitive changes in adolescence, effective engagement and a culturally responsive approach.

Some of the youth comments illustrate this concept

> *"At Youth Kinex they are more targeted to me. They come up with long term solutions not just your quick fix" (young person).*
>
> *"Youth Kinex is more teenage based" (young person).*

Assessments

> *"A psychosocial assessment of their functioning is at least as important as the physical exam" (Goldenring, 2004 cited in Collaborative trust, 2011).*

Assessments that are holistic and strengths-based, focused on improving health and wellbeing and encourage long-term independence are required for young people.

Young people interviewed in the social sector trials recognised that they needed help to move forward on with their real issues. They considered helpers should get to know them before assuming a negative outlook. They wanted encouragement for positive change rather than continually going back over their past (Waldegrave, 2015).

"I want to have a Doctor that really gets me and gets the problem sorted" (Young person).

A holistic view of health

A holistic approach to health considers the whole person and how he or she interacts with his or her environment and emphasises the connection of mind, body, and spirit.

Te Whare Tapa Whā is a well-known Māori model of holistic health. Te Whare Tapa Whā compares health to the four walls of a house where all four walls are necessary to ensure strength and symmetry (Durie, 1984). Te Whare Tapa Whā can be applied to any health issue (physical, spiritual, psychological or connections with family).

Looking after all aspects of wellbeing, Te Whare Tapa Whā consists of taha wairua(spiritual), taha hinengaro (mental and emotional), taha tinana(physical) and taha whānau(family) considerations. Together, all four are necessary and in balance, represent 'best health'. Each taha is also intertwined with the other. Accordingly, if any one of these components is deficient this will negatively impact on a person's health (Durie & Kingi, 1997).

One school based Health professional summed up a holistic approach

"I am not just a nurse dealing with injuries. I'm dealing with the whole person. I work holistically. You can't just fix one thing. There is a whole picture that you have to put together to come to some solution" (School based Health professional).

Culturally appropriate service

When consideration is given to the young person's needs in the wider context of their family and community/whanau, hapu and iwi and services wrap around the client to ensure their individual needs are addressed in a seamless and coordinated way, young people are more likely to utilise health services

Whakawhanaungatanga is the process of establishing links, making connections and relating to the people one meets by identifying in culturally appropriate ways, whakapapa linkages, past heritages, points of engagement, or other relationships. It embodies the centrality of extended family-like relationships and the "rights and responsibilities, commitments and obligations, and supports that are fundamental to the collective. Within this type of relationship, a young person is likely to engage and receive more effective treatment.

Health professionals talked about the need for their staff to reflect their patient population in gender, ethnicity and age. One talked about their organisations equity policy of employment and the difference that had made in their practice.

"We employed a young Maori girl who had just left school. It was bit of a risk as she did not have much experience but the way she communicated with the young people coming in made a significant difference to the practice. It was amazing!" (Health professional).

"Most people working with youth health in the Wairarapa are white female. We need a better gender balance to encourage male attendance as well as better Maori representation" (Health professional).

6. Youth Health literacy

> *"The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make informed and appropriate health decisions is essential"* (Healthy People, 2010).

Health literacy also includes the capacity of professionals and institutions to communicate effectively so that young people can make informed decisions and take appropriate actions to protect and promote their health.

Poor health literacy is very common. Over 50% of the adult NZ population are likely to have some difficulties with health literacy and they are:

- Less likely to use preventative services
- Less likely to recognise the first signs of medical problems
- Less likely to effectively manage their long-term condition
- Less likely to communicate concerns to health professionals
- More likely to be hospitalised due to a chronic condition
- More likely to use emergency services
- More vulnerable to workplace injury

Limited knowledge of what is available

It is evident that young people have limited health literacy or knowledge of services available.

> 26% of Wairarapa Rangatahi interviewed by the Wairarapa Safer Community council *"didn't know where to go" (WSCT, 2016).*

> *27% said they "didn't really know how to access services if needed" (WSCT 2016).*

It was astounding to discover that none of the youth who had left school (18-24-year-old Work and Income clients') knew anything about the Youth clinic or that they could get any free health care from a medical centre.

The level of youth knowledge about services available was identified by several health professionals as a barrier to them knowing about and therefore accessing the services in the first place (Waldegrave, 2015).

> *"There are challenges in communicating what we can do and how we do it. We need to get young people to understand and know about the service" (Health professional).*

> *"Youth and whanau have little awareness and knowledge of the range of services available to them" (Health professional).*

One school based clinic developed and disseminated a school leaver package of information on available health services and enrolment procedures for local medical centres. One medical centre also distributed a 'summer survival' pack for the youth clinic to ensure young people had information on what support is available to them.

Attitude towards health care

Some young people indicated their own attitudes and knowledge of health issues were a barrier.

> Wairarapa Rangatahi interviewed by the Wairarapa Safer community stated they did not receive health care because they hoped *"the problem would go away or get better" (49%).*
>
> *"Some might not bother to get help 'cause they are lazy. They think "She'll be right. It'll be fine. Let it pass by" (Young person).*
>
> 90% of the youth interviewed by the Wairarapa Whanau Trust indicated they would not seek help due to their own feelings about shame particularly in relation to mental health issues.
>
> A study that was part of the World Mental Health International College Student (WMH-ICS) found the most important barrier was preference to handle the problem alone (rated as "important" or "very important" by 56.4%), being too embarrassed to seek help (32.2%) (Duncanson, 2019).

Attitude towards health professionals

A number of young people indicated a specific attitude towards 'Doctors'. They thought Doctors were only for 'serious health issues'. Interestingly they did not see sexual health and mental health issues such as suicidality or depression as 'serious'.

> *"I just want advice. It's often not serious enough to go and pay for a Doctor. They are over qualified for what I need. Doctors are for serious things" (Young person).*
>
> *"Mostly I think what I have is not good enough to go to a Doctor" (Young person).*

Young people were intimidated by the medical language health professionals used

> *"They just talk in medical terms. I don't understand the technical stuff they say. I just wish they would talk to us normally" (Young person).*
>
> *"They have to make it palatable, not dumb it down but use language we understand" (Young person).*

Some talked about a fear of Doctors

> *"Doctors are terrifying" (Young person).*

Some were concerned about the treatment they would be advised

> *"I don't want to go on any pills and that's all they do" (Young person).*
>
> *"They do a shit job and I just got put off. They didn't even look at me and they didn't see there was an issue" (Young person).*

One young man with a long term health condition talked about finding a Doctor who really cared.

"I got the best service I have ever had. He stopped looking at my notes and what every other Doctor had said. He researched more looking at the issue and talking with me. He really understood me and the underlying problem" (Young person).

Family influences

Family or parental constraints are a factor for some youth accessing services, and this is particularly so for services that require parental consent and a young person was unwilling to ask for this consent. Old fashioned, unhealthy, or entrenched attitudes, could be barriers to young people accessing services. Examples of this are attitudes towards teen pregnancy, and the social stigma associated with accessing mental health services. One health professional talked about the challenges of establishing a new clinic and the resistance from the parent community.

"The expectations of parents around confidentiality indicates they don't get it. We need the ability to provide an environment that encourages privacy" (School based health professional).

"You get drilled into your head as a child that if you aren't bleeding or dying you don't go to a Doctor" (Young person).

There were clear concerns about not wanting to be judged, not wanting parents to know what they were up to and not wanting to hurt or embarrass them. There were also concerns that family/whānau could make things worse instead of supporting them (Waldegrave 2015).

Peer pressure, in particular negative peer attitudes about accessing health services including mental or sexual health support could also be barrier to youth accessing services. Others commented that parents were supportive

"My friends don't influence me and my Mum knows I go ther." (Young person referring to Youth Kinex).

Social influences such as economic deprivation also played a role in health care.

"The biggest challenge we have is that we have many young people surviving in difficult living situations. Increasing numbers of broken families; poverty, parents on drugs, parents on alcohol, death of parent from illness, accidents or suicide, young people with no fixed abode due to home situations, violence, gangs.... It's overwhelming and there are minimal services to refer to, to address these needs. "(Health professional)

7. Kotahitanga- collective decision making

He whanau ko tahi tatau - We are all one family.

Kotahitanga involves collective decision making, collective action and solidarity, unity and togetherness. To address the growing number of issues and improve the level of health and wellbeing of Rangatahi a coordinated, collaborative approach is required.

> *"The environments in which Rangatahi move in must recognise the importance of family, culture, educational institutions and communities in helping to shape happy and healthy young people "(WSCT, 2015).*

The youth health workforce is small, highly specialised and is geographically widespread. Professional isolation of youth health professionals is an issue that can impact on individuals and services, sharing of resources and ideas, collegial support and governance and peer review processes (Ministry of Health, 2009).

Cross sector collaboration

Health professionals reported that networking was important to: gain knowledge about work practices; maintain relationships; ensure ongoing collaboration; ensure that duplication of services does not occur; and facilitate holding agencies to account to ensure transparency (Waldegrave, 2015).

Wairarapa Health professionals emphasised the good working relationships that they considered to exist among health services and other organisations in the Wairarapa.

> *Cross-agency networking and relationships are working well, and close and positive working relationships and collaboration between organisations are widely discussed. There is a shared commitment to addressing issues (Waldegrave, 2015).*

Networking and cohesion across agencies were also frequently discussed as something working poorly. Communication between agencies can be difficult due to time and work commitments. (Waldegrave, 2015). Time constraints were discussed by multiple organisation respondents who argued that time limited the ability of agencies to work together (Waldegrave, 2015).

> *"Youth services in the Wairarapa are fragmented and there is considerable variation in how the different sectors engage with, and follow-up with youth; and within localities (schools, health services and the community) (Health professional).*
>
> *"Our community is not really addressing these issues. Keeping our young people safe is all of our jobs"(Health professional).*

Equitable distribution of service

> *"Everything goes to Masterton. The rest of the Wairarapa misses out. Our youth are disadvantaged as a result" (Health professional).*

Sharing information across services

Some talked about the challenges of networking and information sharing between medical centres and the local school and youth clinics.

> *"There is a problem with sharing information between practices and the schools and youth clinic" (Health professional).*

"We don't get any notes for patients seen at the Youth Kinex" (Health professional).

Managing transitions

Professionals reported concern about the transition between school and youth services to an adult medical practice and he impact this would have on the continued health care.

"How does a youth health centre link up with other medical centres? How do they get continuous care?" (Health professional).

"How does the school and youth clinic transition young people to a medical practice once they have turned 24?" (Health professional).

Young people also cited this as a barrier to continued care

"What do we do once we have finished school? I don't understand all the technical words and how to do it or where to go." (Young person).

8. Education and training of health professionals

Health professional's confidence, knowledge and skills in communicating, identifying, and treating adolescent health issues is an important factor in the provision of effective health care. The social sector trials health professionals indicated relationships with clients, having youth friendly staff, and continuity of staff were considered important (Waldegrave, 2015).

Inadequate training in consultation skills and managing psychosocial problems in adolescents have been cited as barriers for health professionals (Collaborative trust, 2011).

Nationally almost all of the health professionals working in or visiting schools have had some level of training in youth health (Denny 2014).

58% had attended a study day on youth health,

9% had completed some postgraduate papers in youth health

7.5% had completed a postgraduate certificate or diploma in youth health

25% had received more general postgraduate training in child and youth health.

73%) have also had training in sexual health, either from Family Planning or other training institutions

Clearly one of the most important factors in the provision of an effective health service is the passion of the health professionals. This was evident when asking health professionals why they provided support to youth and school clinics.

"We did it because we were asked to do it. We see there is a need and it is part of being a community organisation. There is clearly a need and we have to step up" (Health professional).

"It's supporting our patients in a manner that is perhaps more accessible, comfortable, convenient for them" (Health professional).

"We did this because it is supporting a passion and interest of our employees. As a business we need to think about retaining staff and that involves supporting their interests and talents" (Health professional).

Although many had undergone training in youth health issues they wanted a greater understanding of youth development and their needs.

"There is no specific youth focussed training and we would love it" (Health professional).

The term 'Youth'

One last interesting comment made by a group of young people was using the word 'youth'. They want a 'youth friendly' environment but do not want to be labelled as such.

"As soon as you put the word 'youth' in front of something no one will go. It's a stigma. People think its lame. You don't want to go somewhere your mum will tell you to!" (young person).

Summary of Youth Health Service provision across the Wairarapa

The youth health sector needs a comprehensive strategy that incorporates kaupapa, theory and ideology that embraces youth-focused, youth-centred and strengths-based practice.

Young people want to be involved in the planning implementation and delivery of services that they will use. They want to be involved in designing the environment, be engaged as staff members and to be seen as positive contributing members of the community.

Young people:

They need understanding of what health care services are available to them and how they can access free health care.

Young people want a private, confidential health service where they can drop in and receive the health care they need, when they need it, in their own communities.

They want a service where they can access all different types of support to develop their health, wellbeing, employability skills and social connections.

They need mental health services integrated with, and disguised as other services and timely access to sexual and reproductive health care.

Young people want to get health care in an environment that is welcoming, physically appealing and youth friendly.

Young people want professionals to be welcoming, use informal communication styles, and use a variety of ways to establish rapport with them.

Health professionals

Health professionals want equitable, biologically respectful funding models to provide free health care for all young people regardless of what setting they are in.

Health professionals need training in youth specific health care. They need understanding of adolescent brain development and behaviour and strategies to meet their needs. They also need support to develop cultural competency.

Health professionals want opportunities to share best practice and network. They want support and access to specialist health professionals to share case management and support young people for further intervention.

They want systems and processes that make it easy to share information with other relevant professionals in the life of the young person. They want to provide continuous care for all young people regardless of the service the youth chooses to use

They need the time and skills to assess and intervene in a holistic manner.

Opportunities for cross sector collaboration are also important.

Strengths and gaps in the provision of youth services across the Wairarapa

Medical Centres

Privacy and confidentiality: Young people report that privacy and confidentiality issues are barrier to their utilisation of local medical centres. They are worried that their parents and whanau, community and their peers will judge them and know what they were doing when they attend a medical centre.

Young people expressed concerns about GPs disclosing information to their parents and reception staff not protecting confidentiality.

Cost and funding: Cost is a major barrier for young people accessing health care in local medical centres across the Wairarapa. Young people believe they cannot access a GP without payment and are unaware they are able to access services such as the Youth clinics for free. Many were also unaware of initiatives such as the free sexual health care.

The location of the service is paramount to young people. Transport issues place a further cost and barrier to accessing effective health care. This is particularly important for those who have left school. They need services in their own communities.

Health professionals report that funding and enrolment constraints conflict with adolescent health seeking behaviour across a variety of services and negatively impacts competition for funding on their core work.

Access: Young people are intimidated by appointment and booking procedures.

Manaakitanga – Hospitality, Attitudes and Communication: Young people report that medical centres are not youth friendly and the waiting room and reception is intimidating. They have reported concerns that health professionals have unsympathetic, authoritarian and judgemental attitudes towards them.

Organisational kaupapa - way of doing things; There are no reported youth specific policies, and practices across medical centres.

There is a need to improve the cultural capability of the services.

Youth health literacy: Health professional have made attempts to improve the knowledge of young people about how to enrol in a medical centre.

Young people have limited health literacy or knowledge of services available. They have difficulty knowing how to contact, when to contact and who to contact with regards to health care

Some young people indicated their own attitudes and knowledge of health issues are a barrier to receiving health care.

A number of young people indicated a specific attitude towards 'Doctors'. They thought Doctors were only for 'serious health issues'.

School based health services

Privacy and confidentiality: Young people trust the health professionals in schools to maintain privacy and confidentiality.

Having a health service on a school site can sometimes be a barrier for young people worried about peers and teachers' attitudes and assumptions.

Cost and funding: All Young people are appreciative of the free access to health care in school based services and believe this is an important

Access: Varied opening times and service availability were a concern for young people

Manaakitanga – Hospitality, Attitudes and Communication: Young people believe health professionals in school based clinics are friendly, welcoming, and provide them with the care they need.

Organisational kaupapa - way of doing things: Young people report that school based health services provide a holistic, youth focussed service

School based health professionals report a strong focus on holistic health and being youth friendly in all their approaches

Youth health literacy: Young people have varied health literacy. Some have limited help seeking behaviours and their own attitudes towards health can act as a barrier to receiving appropriate health care. This is particularly true for those with mental health issues and those who have left school.

Kotahitanga – Cross sector Collaboration and Collective decision making: Some health professionals working across school based services are isolated professionally and need support for complex cases particularly in relation to mental health.

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Wairarapa Health professionals emphasised the good working relationships that they considered to exist among health services and other organisations in the Wairarapa.

Professional training: There is varied training in consultation skills and managing psychosocial problems in adolescents.

Youth Kinex

Privacy and confidentiality: The current venue hinders confidentiality of the service. It is small and the current configuration does not allow for privacy

Cost and funding: Some health professionals report concerns that the free clinic may impact on current enrolments in local medical centres

All Young people are deeply appreciative of the free access to health care in school based services and believe this is an important to receiving the health care they need

Access: Both health professionals and young people report the service is woefully under resourced and the limited availability of the service hinders their health care.

Although the majority of young people are either educated, live, or are employed in Masterton, there is limited access to youth friendly health services for young people out of school in the South Wairarapa.

Manaakitanga – Hospitality, Attitudes and Communication: Young people report that the youth clinic 'Youth Kinex' provides a safe, friendly environment encompassing all the tenets of manaakitanga.

Organisational kaupapa - way of doing things: Applying a comprehensive youth friendly approach is hindered by the lack of capacity of the service. There is not enough time available and too many young people requiring support to take the time needed to provide comprehensive, holistic youth health care.

Youth health literacy: Many young people who have left school are not aware of the availability of the service

Kotahitanga – Cross sector Collaboration and Collective decision making: There is a huge opportunity to extend the services available to include all aspects of youth health and wellbeing. This will require coordination and cross sector collaboration.

Professional training: Professionals are experienced and trained to provide youth health services

Recommendations for the effective provision of a Wairarapa youth health service

There is no one integrated model of youth services that will achieve optimal outcomes for all young people. Rather, it is a mixed model comprising school-based services, community-based services such as youth one-stop shops services and general practice services.

One young person summed up the recommendations succinctly.

"Everyone is different. We are all individual. Don't put money into just one thing. Don't narrow it down and think that's it sorted." (Young person)

The following is a series of recommendations based on:

- Feedback from stakeholders including young people and health professionals across the Wairarapa
- Best practice principles identified by Youth One Stop Shops (Gibson-Rothman, 2017).
- Examples of innovative best practice already existing across the Wairarapa health sector
- Recommendations made in the Wairarapa District Health Board 'Life to go' strategy 2005
- It is hoped these recommendations will be combined with those of the DHB Mental Health and Addictions report (2018)

Robust Governance

1. Develop a District Health Board Youth Health Plan

Develop a Youth Health Plan and incorporate it into the overall District Health Board strategy. Develop specific measurable actions that are implemented, resourced and monitored and evaluated.

Each District Health Board is required to have a youth health plan as part of their responsibilities for the health of their catchment population. Kaupapa, theory and ideology should embrace youth-focused, youth-centred and strengths-based practice. These should be integrated into all areas and levels of the organisation, and drive all decision making and interaction with young people. Young people have specific health needs and evidence on ACE studies strongly suggest that intervention at a vulnerable and early age determine help seeking behaviour and lifelong health.

Although the 2005 DHB health strategy incorporates many of the above aspects there is an opportunity to update and formally embed a current youth health strategy into the governance of the organisation.

2. Create a vision for youth health across the Wairarapa

Develop a strategy that incorporates the principles of effective youth health.

- **Holistic service**: that support young people to thrive physically, mentally, socially and spiritually.
- **For young people:** designed and delivered specifically for the youth age range. It would recognise that young people have specific health needs and requirements that differ from the wider population.
- **Equal outcomes for Rangatahi:** The youth health service should recognise Māori as tangata whenua and their right to equitable health care and outcomes. It should have specific policies, plans and procedures to support the health and wellbeing of Māori.
- **Bigger picture:** The youth health service should contribute to the bigger picture of the health and wellbeing of young people in New Zealand.

3. **Establish a cross sector, collaborative steering group**

Create a Youth health steering group governed by a partnership of local organisations

> *"To address the growing number of issues and improve the level of health and wellbeing of Rangatahi requires a coordinated, collaborative approach. The environments in which Rangatahi move in must recognise the importance of family, culture, educational institutions and communities in helping to shape happy and healthy young people." (DHB, 2015)*

The governing body of the service should steer the services and ensure robust governance policies and procedures throughout. As many of the young people have complex social, emotional and health needs they would benefit from holistic services and an environment that supports integration and collaborative practice across service delivery boundaries (including primary care) to ensure 'any door is the right door'

This may include, but not be limited to the Education, Health, Iwi, Community development, Not For Profit and Government sector. Organisations could be approached such as Compass Health, District Councils, Wairarapa DHB, Maori Health Directorate, Iwi, Connecting Communities, REAP, YETE, the Whakaoriori and South Wairarapa Kahui ako (Schools community of learning).

4. **Commit to Youth participation.**

Create a Youth Advisory Group to provide governance over the implementation of the DHB youth health plan.

Youth participation in the planning and delivery of services is a fundamental principle that should be applied to the implementation of a DHB youth strategy. Youth health services need to be acceptable to young people to increase their engagement with services. Youth should be involved in planning, implementation and delivery of services. They should also be involved in designing the environment, be engaged as staff members and their feedback should be incorporated in services.

5. **Develop a Fair, Flexible Youth Centred Funding Model**

Develop a flexible funding model for youth regardless of what health service they access across the Wairarapa. The funding should be allocated to the young person regardless of what service they choose to access and fair and equitable across all health services.

The New Zealand primary care PHO/GP model of care expects an individual to enrol with a single health professional and then use this health professional for the majority of their primary care. The current funding model is not biologically respectful to youth. Young people are developmentally transient as they learn, train, work and live in a variety of different areas. They are known to 'snack' or 'graze' on services according to their present situation and needs.

Medical centres who have young people present as a casual are faced with complex funding issues where they have to spend time 'clawing back' from the patients enrolled service.

6. **Implement a coordinated Patient management systems and reporting**

Implement a patient management system that is consolidated and supported so that the function provides:

- **valuable information**
- **consistent information across providers**
- **mechanisms for feedback**
- **automated reporting from clinical management IT systems**
- **supports transitions from school and youth based clinics to a general practice.**

Reporting on outcomes for youth across medical centres, school based and the youth clinic is inconsistent and cumbersome. It is difficult to share information across services to ensure consistency of care.

There is a need for early electronic flagging of clients as they turn 24 years to prompt transition planning, guide choices for clients on appropriate services and facilitating contact between clients and providers if support is needed.

Robust workforce development

7. **Establish a Wairarapa Youth Health Service Specialist team**

Create a specialist Youth Health team that are mobile and can support all school, practices and the youth clinic. These would be dedicated professionals who are trained in youth health and development.

There are pockets of collaborative practice, shared case management and informal networking across the youth health sector with experienced health professionals, however the majority of Nurses, Doctors and health professionally are isolated professionally and geographically.

The Youth Health Service Specialist team would:

- Synthesise common health issues across the region and advocate for services to address them
- Create opportunities to share best practice on how to address youth health issues
- Share expertise, case management and provide supervision for health professionals working with high risk young people
- Support nurses in all school and youth clinics
- Convene regular network meetings with all health professional who are working with youth.
- Visit colleges on a regular basis that don't have school-based health care.
- Support youth events and areas where there are high density youth e.g. Castlepoint, Riversdale at holiday time.

8. **Train health professionals to provide best practice health care**

Develop and implement a training programme for health professionals in youth development, adolescent brain development and their behaviour, social, emotional development, health needs and holistic assessments.

There is evidence of huge passion, good will and interest in providing quality health services to young people across the sector. Every person interviewed for this report displayed a commitment far beyond their job descriptions to understand young people and help.

Many have received training in specific health issues e.g. sexual health, self-harm, suicide risk assessment, however there was little evidence of training in 'youth' as a whole. As anyone working with youth will know, their needs are complex, their developmental needs are specific and best practice in youth health care is challenging.

It is vital that all professionals that come into contact with young people have an understanding of their needs. Staff at reception, and health professionals would benefit from an understanding of the barriers and enablers to effective youth engagement, assessment and intervention.

Improve youth and whanau 'health literacy'

9. Increase health literacy and knowledge about services through promotion and increased publicity

Develop and distribute a Wairarapa wide health education information pack

The youth health service should contribute to the bigger picture of the health and wellbeing of young people in New Zealand.

Young people and their whanau need

- better education on the short and long term consequences of 'forgone care'
- better education on the consequence of risky behaviours such as drug and alcohol use, risky sexual behaviour, driving and the impact of toxic stress
- increased knowledge of what services are available
- simple instructions on how to access services
- improved understanding of current health issues

Some of the solutions are already in place but need more consistency and coverage for all young people

Develop and distribute a comprehensive School leavers pack to all schools.

Kuranui health clinic develop a pack of handouts that is provided to all school leavers across the region. The aim of this pack is to increase knowledge of youth health issues and available services for young people and improve access through increased knowledge of enrolment procedures. The pack contains information on available local services and instructions on how to enrol in a local medical centre.

Create a health Survival pack across all medical centres

As a social enterprise Masterton Medical applies "commercial strategies to maximize improvements in financial, social and environmental well-being." (health professional)

Currently Masterton Medical provide a 'Summer survival pack' available to all young people who attend the Youth Kinex service. This pack is funded by Masterton Medical and contains information on on-line and other available health services, sexual health information, and contains takeaways such as lip balm, sunscreen and condoms. They plan also to include a guide on how to enrol in a medical centre and it is branded with the organisations logo.

Making this pack 'youth friendly' and freely accessible to all young people would provide young people with information on health issues, helps to improve access to health services through an improved knowledge of how to enrol and increases potential new enrolments through branding awareness.

10. **Investigate educational partnerships with schools that improve youth health literacy.**

Develop a collaborative partnership with the Whakaoriori and South Wairarapa Kahui Ako (Communities of Learning) to improve their wellbeing and health literacy.

Schools are struggling to educate and manage the complex health issues they are presented with each day. Health professionals can improve health literacy by supporting educational programmes that are linked to the NZ health and PE curriculum in schools. This support must align with educational curriculum requirements and be flexible enough to suit individual schools' timetables and curriculum restraints.

Youth Friendly Medical Centres

11. **Incorporate best practice for youth health care across all medical centres**

Integrate kaupapa, theory and ideology that embraces youth-focused, youth-centred and strengths-based practice into all areas and levels of the organisation, and drive all decision making and interaction with young people.

This would require a review of

- Waiting rooms and reception areas to ensure they are 'youth friendly'.
- Communication on the availability of free youth health care for those under 21 years old e.g. sexual health.
- Confidentiality policy's clearly and regularly explained to young people and staff
- Holistic assessments to understand the young person in their entire context. These should use non-judgemental, strengths-based and youth appropriate language.
- Enrolment processes for youth that support flexible and allow them to access a variety of health services across the Wairarapa.

Equitable School based services

12. **Provide a fully resourced, equitable school based health service to every school in the Wairarapa.**

A fully resourced school based service would have:

- **Regular access to and support from a GP or health practitioner.**
- **Health professionals who are trained and resourced to complete a HEADSS assessment for targeted students.**
- **Regular networking and professional development opportunities for staff working across the sector.**
- **A social worker to work collaboratively with the Guidance counsellor and Health professionals**

School based services address many of the barriers to effective youth health service provision. They resolve transport barriers, play an important role in de-stigmatising service access, are immediate, free, private and have a youth friendly kaupapa. One young person summed up by saying:

> *"We know what works. School health clinics are full. Kids use them. Make them great so we can all benefit."*

Some New Zealand regions are trialling mental health support in primary care settings. These Health coaches are skilled in counselling skills such as brief therapy and acceptance commitment therapy(ACT).

Youth Health Hubs.

13. Expand Youth Kinex to become a hub for holistic youth health care across the Wairarapa

It is clear that Youth Kinex provides a vital service to youth across the Wairarapa, particularly to those who have left school. Demand currently outweighs supply and the current venue is a woefully inadequate space.

Youth Kinex needs to include more privacy, waiting space, increase availability, hours and days it is open and increase and broaden the services to include mental health, social connections, careers advice and other aspects of wellbeing/hauora.

Locate and inhabit a new facility.

The venue would be a centrally located youth friendly place, big enough for groups of young people to meet regularly and professionals to convene.

The venue would be configured to maintain confidentiality with break out, consult rooms and meeting spaces

The venue would allow for expansion of complimentary services

Develop partnerships with community organisations to provide holistic health care for young people

The hub could serve as a base for the Youth health specialist team and support school based clinics across the Wairarapa

This service could hold enrolments and manage the administration for all youth using school based health clinics and Youth Kinex

A collaborative partnership and cohabitation with the Youth Council 'wellbeing café' would increase foot traffic and destigmatise help seeking as well as involve young people in the provision of health services.

A collaborative partnership with YETE (Youth, Education, Training and Employment' providing job clubs and careers services could also encourage young people to access health care.

14. South Wairarapa Community centre and medical centre

Support the development of a Youth health hub in Featherston

The Featherston Medical Centre is moving alongside the new Featherston Community Centre. This new premise could serve as a base for youth health service provision in the South Wairarapa, replicating the model developed at Youth Kinex.

Organisations such as the Featherston Medical Centre, Featherston Community Centre, Fab Feathy community development and Wairarapa Whanau Trust have indicated willingness to work collaboratively to establish a South Wairarapa youth health hub.

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Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

Life2go

- The strategy!

Daniel's story…

Four years back life was looking good. I was studying for a Bachelor of Arts double majoring in sociology and philosophy. Yeah, things were looking up alright.

After having acquired a large bag of marijuana during the holidays I returned to the hostel where I lived and set about getting stoned. At every conceivable opportunity I smoked pot, smoking so much my lungs ached. But no matter how much you abuse a substance it is never enough. So in a short space of 10 days, that large bag was reduced to nothing. To follow this, began the first of several psychotic episodes that would forever change me and plague my mind. I remember being awake for 3 hours and still counting. A deep insomnia possessed me…. but then came the paranoia. My mood would change from elation to desperate despair. Like a surge of power caused by faulty wiring.

Life had taken a sudden u-turn on an already busy motorway and now I was driving on the wrong side of the road with my foot pressed hard down on the accelerator, all the while completely oblivious to the fact that what was going on with me was not real - just in my head. But it is real, it felt real anyway.

For a whole week I had still been unable to get to sleep. I had not even showered all that time, and had little to eat. I was physically drained. Lucky for me, people at the hostel noticed that something was not right with me. My sudden outbursts, muddled speech and appearance must have given a definite indication.

A friend of mine came into my room and asked me to go to the University's medical clinic with her. She was worried. I was deeply psychotic. At the clinic questions were asked and I was given some tablets. That night I got to sleep for the first time in over a week.

I was then introduced to the mental health service through the early intervention service at the hospital and had regular weekly appointments. One thing the psychiatric nurse, Julie, always told me was that there is always hope. This seemed to stick in the farthest corner of my mind. The psychoses had passed how a bad storm does, and now I was left with trying to rebuild my life.

But the psychotic episode had left me numb. By numb I mean, I had little emotion. No longer myself, just an empty shell wandering the streets aimlessly. This was rock bottom. So alone, so bored and so agonisingly depressed. My confidence was shattered, I became withdrawn. Even suicide was a serious, viable option.

A solution came to end this situation. I left the hostel and went home to live in Masterton. At last I was at least half way to some so-called idea of happiness. After having endured the longest and hardest few months of my existence, this experience set a template for times to come, and how it changed my view of life to 'there's always hope".

From a member of the Youth Advisory Group:

Why am I doing this? My life is busy enough just dealing with the demands of school, why would I want to take time to be involved in the formation of the Youth Health Strategy? I believe it is because I want to make a difference to the life, health and future of Wairarapa youth. I can see, and have known myself, how horrible experiences such as Daniel's can be. Daniel's story is not uncommon; it is a real life example of the sometimes troubled state of youth health in the Wairarapa. This strategy works to bring to the floor and address the issues and needs of youth in the Wairarapa, and link these to current and possible future services.

I believe that if we can pull together and coordinate the existing services for youth in the Wairarapa then we will have a greater, more positive and wider reaching effect on youth. The sum of the parts is greater than the individual. I think this would be more appropriate for youth; often many factors contribute to poor health of a young person. To effectively treat and deal with the issues facing any one young person we need to address each aspect of their health. One service on its own can only address the issues that fall into their area of expertise; this is not a realistic approach for youth health. We need to work together.

Every young person's story is different, some extreme, some not so, each are every bit as important. But I believe that all youth in the Wairarapa can benefit from this strategy, be it by the mere publication of it and the improved knowledge and awareness it brings, and the future implications of it. I hope this strategy is more than just picked up and read by the people of the Wairarapa, I hope it is taken in.

Kate Murray
Aged 16
Youth Steering Group Member

Table of Contents

Life2go – The Strategy Tree

Health Priorities	Objectives		3 Strategic Priorities and their key actions		Measures of Progress
Address the incidence and impact of motor vehicle accidents	Reduce Inequalities	Support and build capacity and capability in community and school-based education and support services	Achieving whanau ora	**1. Youth Participation** • Governance of Youth Health Strategy provided by Youth Advisory Group • Management teams developed for each service • Governance and management group membership comprises 50% youth	Motor Vehicle Hospital Admissions
		Increase access to community based youth services			Motor Vehicle Fatalities
Improve the mental wellbeing of all youth		Youth with dual diagnosis are identified and all needs supported			Suicide Rate
		Reduction in at risk use of alcohol and drugs		**2. Communities Working Together** • Increased focus on health promotion and education • Increase in joint approaches that ensure effective use of resources reaches the widest possible audiences • Te Whare Tapa Wha model is applied to actions that advance this strategy	Rates of self harm
		Educate friends and whanau in identifying warning bells			Number of people seeking support for mental health and alcohol and drug issues
Reduce drug and alcohol related incidence		Develop support systems for parents of youth with challenging behaviour			Alcohol and drug related hospital admissions
					Improved management of chronic illnesses such asthma
Improve sexual health		Reduce the incidence of STIs		**3. Youth Health Services** • School based health services developed in secondary schools • Community based clinics targeting young people not connected to school community • Programs targeting specific groups will be developed	Number of people diagnosed with STI
					Reduced sick days from school
		Reduce the number of unwanted teenage pregnancy			Number of terminations of teen pregnancies
					Number of Teenage births
Encourage healthy lifestyles		Promote and encourage healthy eating			Avoidable hospital admissions
		Promote and encourage healthy action			
		Reduce the number of youth who smoke			Incidence of smoking among young people
		Good oral health			Lower level of decayed, missing or filled teeth in adolescents
		Reduction in incidents associated with violence			Vision and hearing outcomes

Life2go – Introduction

Most young people are healthy and think that they have strong positive relationships with their parents and school environment[1]. In fact, over 80% of them report through a range of studies that they feel healthy, do not engage in multiple risky behaviours and report that they have positive connections to families, schools and their peers.

However, there is a lot of evidence that suggests that the other 20% do not connect well with services, and experience significant health issues that have long term effects on their emotional, mental and physical well being. Many of these health issues go untreated for long periods of time which in turn impacts on the seriousness of the illness and the effectiveness of the treatment when it is eventually provided. Education, early identification and early intervention of all health and social issues are the keys to improving health and social outcomes for young people.

However, encouraging young people to seek help from health services is not a simple matter. When asked why they are reluctant to seek help for an illness or health issue, young people indicated the following barriers:

- The cost of health services
- A perceived lack of confidentiality of services
- Embarrassment about their health issue, and
- A lack of understanding of the services currently available and how they operate.

When asked what they really need from health services, young people answered:

- Sexual health advice and access to checkups and contraceptive prescriptions
- Counselling and support for personal problems, and
- Counselling and support for problems associated with being in a family with issues relating to mental health, alcohol or family violence.[2]

In July 2005 the DHB published *'Life2go! Youth health in the Wairarapa'*.[3] This booklet described the many facets of health and social issues, services and points of view that impact on the wellbeing of young people in the Wairarapa. This document – *Life2go – the Strategy* takes things a step further and describes the health objectives that need to be targeted and why. It describes how the DHB will work with young people and agencies to make real health gains in the future. It sets directions and actions that will really make a difference to the health of youth / rangatahi in the long term.

[1] NZ Youth / rangatahi – A profile of their health and wellbeing, April 2003
[2] Wairarapa District Health Board On line survey of youth health issues – October 2004
[3] Life2go! Youth health in the Wairarapa – *Wairarapa District Health Board July 2005*

What are the issues?

Most young people are healthy, many go to the doctor when they do have a health problem, and are well supported by their friends, family / whanau, and school relationships. In many areas of youth health the Wairarapa is doing really well; many serious outcomes of risky behaviour are declining, for example, the number of young people involved in serious car accidents is declining, the number of babies born to young mothers is declining, and the incidence of smoking among teenagers across all age and gender groups is also declining.[4]

However the rate of improvement has slowed down and the communities that young people live in believe that these indicators do not entirely reflect what is happening for youth, that there are many who do not go to the doctor, and who do not know where to find help for emotional and social issues.

There are health indicators that show that there are areas that need a concerted effort if they are to improve. *Life2go – the strategy* will focus on these and take an early intervention approach to addressing them.

Statistics about Wairarapa's young people aged between 10 and 24…

- Make up 21% of the population
- 23% of these are Maori
- 62% live in Masterton, 17% live in Carterton, and 21% live in South Wairarapa
- 68% of them fall into the lower decile population groups
- Overall, the population of young people is declining
- Road traffic accidents are the main cause of fatalities and hospital admissions
- There is a declining rate of births to young mothers, but,
- The rate is 4th highest in New Zealand
- The risk of suicide among young people is of high concern
- Self harm has caused 35 admissions to Masterton Hospital Emergency Department in the past 2 years.
- The rate of self harm in the Wairarapa is high compared to national averages.
- Hospital admissions for self harm are thought to be the tip of the iceberg for this problem
- Binge drinking affects large numbers of under 18's

Healthy Eating - Healthy Action - In Action!

- The number of Year 10 males who smoke is higher than the rest of the country
- Smoking accounted for 3% of stand downs and 2% of suspensions from secondary schools during 2003/04
- Only 67% of 13 – 18 year olds complete their treatment at the dentist each year
- An estimated 8% of young people live with a disability that affects their daily activities

[4] Appendix 1 – Life2go – the background – 1.3 What are their health needs?

What's important?

Through a process of consulting with the community *six overarching principles* that are important in the development or delivery of youth / rangatahi health services in the Wairarapa have been identified.

Six Overarching Principles

1. **Achieving whanau ora** is the overarching objective of this strategy
2. **Youth participation** in the development and delivery of services is essential
3. **Information** is provided to young people, their families and whanau that allows them to make well informed choices about their health and wellbeing
4. **Collaboratio**n between service providers, families / whanau, schools and youth finds coordinated ways to better meet needs of youth / rangatahi and acknowledge the importance of education, employment and health in a young person's life
5. **Accessibility** for young people to health and social services is paramount
6. **Acceptability of services** to youth / rangatahi and their family /whanau is a priority.

Five Health Priorities

A review of a range of information from several sectors was undertaken by the Youth Advisory Group and identified those areas of health concerns that the DHB will channel energy into improving through the implementation of this strategy. These concerns are reflected in *five health priorities* that will be targeted through youth specific services in the future.

1. Reduce motor vehicle accidents
2. Improve the mental wellbeing of all youth / rangatahi
3. Reduce drug and alcohol related disorders and problems
4. Improve sexual health
5. Encourage healthy lifestyles.

These health priorities are not peculiar to the Wairarapa and are in fact, considered high priority areas in most DHBs.

Addressing these health priorities effectively requires a coordinated effort by families / whanau and the whole community, working across all sectors and the agencies that represent them to influence young people and their families and friends to make good choices about health and social issues.

The lives of young people are influenced by many sectors; while education is arguably the most important, health, police, transport, ACC and community groups also have a big role to play and clearly, no one sector or agency can address all health and social issues on their own. Through the collective actions taken by the whole community a *'Magically Wairarapa'* response to improving the health and wellbeing of our young people will emerge.

Three Strategic Priorities

This strategy aligns itself with the DHB's continuum of care identified in the DHBs Strategic Plan.[5] The continuum of care identifies that two different levels of focus are needed in order to make long term health gains. The first level focuses on the whole community working together to improve the health and wellbeing of its young people by supporting and educating the whole community to make better health choices for itself and its young people. The second level of focus is on the specific health needs of each young person individually and meeting these needs as promptly and effectively as possible.

To achieve this, three strategic priorities will be advanced. These priorities require input from all corners of the community, and require a collaborative and intersectoral approach if they are to provide the structure that will support the implementation of this plan.

1. Youth Participation

The DHB intends to adopt a full partnership with youth in the implementation of this strategy. The following groups whose membership comprises 50% young people will be established:

- Wairarapa DHB Youth Advisory Group will provide governance over strategy implementation
- Management teams guide the development and operation of individual services.

2. Communities Working Together

Communities surrounding young people will work together to initiate long term change in behaviours that impact on health and well being. This will involve:

- Increased focus on health promotion and education using many approaches to achieve a greater understanding of the importance of healthier lifestyles
- More joint approaches that ensure effective use of resources reach the widest possible audience
- The health concept Te Whare Tapa Wha underpins all work undertaken in the school community ensuring holistic approaches are developed and applied to support long term behavioral changes in both the young person and their family/whanau

3. Youth Health Services

The DHB will develop a network of youth health services and programs across secondary schools and the community in order of assessed priority as resources become available over the next three to five years:

- School based health services will be developed in secondary schools
- Community based clinics that target young people who are not at school will be developed
- Programs targeting the needs of specific groups will be developed to complement existing ones as opportunities present.

These three directions are discussed further in the sections that follow.

[5] Appendix 3 – Continuum of Care Diagram – WDHB Strategic Plan 2005 - 2008

Strategic Direction 1 – Youth Participation

Actions:

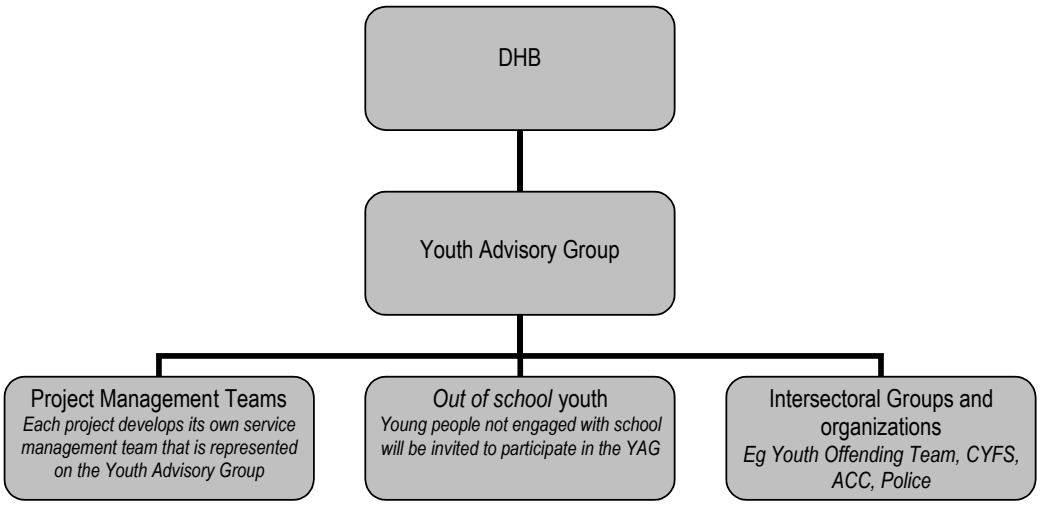
- Governance for the strategy will be provided through the DHB Youth Advisory Group.
- The groups terms of reference and membership will be reviewed to allow it to effectively perform this function
- Management teams will be developed for individual services.

Youth participation in the planning and delivery of services is a fundamental principle that will be applied to the implementation of *Life2go.* The DHB's Youth Advisory Group membership will ideally consist of 50% youth; services will be encouraged to adopt the same principle in establishing their management teams.

Ensuring that *Life2go* is implemented effectively and meets the needs of the community will be the role of the Youth Advisory Group. This group's terms of reference will be reviewed annually.

Each youth service or project will have its own management team. This team will provide oversight of the service and aim to ensure that the it meets the needs of its community. Services will be encouraged to ensure that their management team consists of 50% youth in its members.

The following diagram depicts the relationships between each of the groups mentioned.



Strategic Direction 2 – Communities Working Together

Actions:

- Increased focus on health promotion and education
- More joint approaches to ensure effective use of resources reaching the widest possible audiences
- Te Whare Tapa Wha model is applied to actions that advance this strategy

Developing the Community Approach

Over the past ten years there has been much improvement in several of the key determinants of the health of young people. Statistics show that there has been a gradual reduction in:

- The number of births to teen mums
- The number of young people smoking and
- The number of fatalities and injuries from road accidents.

However, the rates of improvement have declined in recent times and some areas show that things are either, at best, not improving or in some cases, deteriorating:

- The rate of exclusions from secondary schools in the Wairarapa is high
- The extent to which teenagers report incidents of binge drinking has increased
- The number of young teenagers smoking is increasing again
- The level of sexual activity is increasing, and the numbers of terminations of pregnancies is increasing
- Youth offending continues to be a problem with many of the offenders known to be truant from school
- Levels of obesity are increasing and physical activity is decreasing
- The numbers of young adults that engage with dental services remains at about 67%.

It is well identified through work done in other youth specific services throughout New Zealand that it is only by taking a holistic view of all the factors that impact on young people's lives, the negative cycle of deprivation, low income and low educational attainment leading to health related problems can be improved.

DHB health promotion and education teams are currently working across the Wairarapa to promote healthy lifestyle approaches. There is much more yet to be done, obesity is an issue, our under 18s are regularly supplied with alcohol by their friends and families, there are high levels of self harm among young women in particular and suicide affects all too many of our young people.

The importance of effective health promotion and education programmes cannot be understated. Public Health Teams are currently reviewing the way that they work and developing new programs to complement existing ones. These will continue to be linked with all agencies in the Wairarapa. There is a need to extend this work to reach into the lives of families / whanau in order to achieve long term health benefits across all aspects of a young person's life.

Many agencies have contributed to the development of this strategy and in doing so demonstrate a genuine willingness to work together to increase the likelihood that any new initiatives are well co-ordinated and will result in improving health, educational and wellbeing outcomes for both the students and their communities. Health services that target only the unwell person will be opportunistic and unlikely to result in long term behaviour changes therefore health promotion and education are key to affecting this change but it will also involve working intersectorally to:

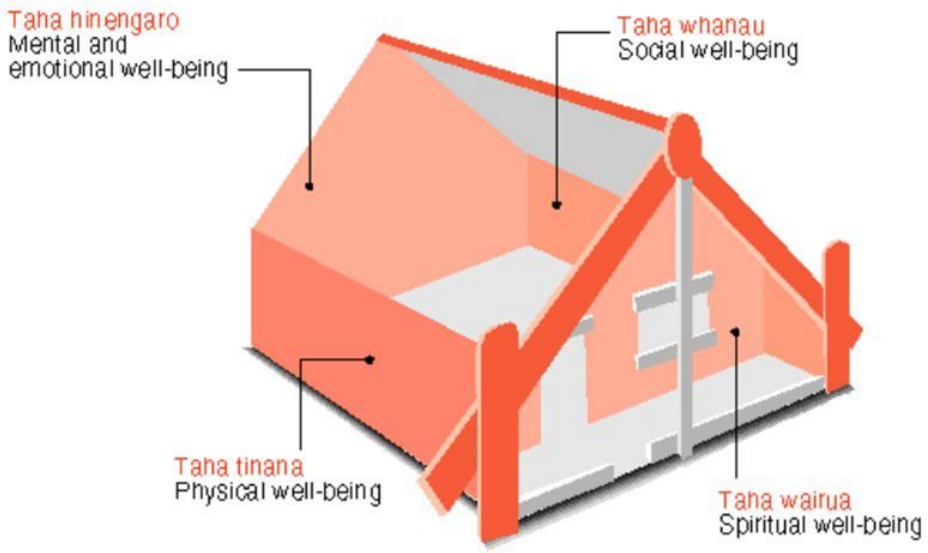
- Develop programs that target truants, young offenders and students at risk of harmful behaviours
- Use multiple channels to assist families / whanau to work with their children to make healthy choices
- Provide resources and support to school staff in the delivery of the health curriculum and the education of their school community.

Te Whare Tapa Wha model applies

Mason Duries' Te Whare Tapa Wha model clarifies the importance of adopting a 'whole person' approach to improving the health of young people by recognising the importance of the balance between the four aspects of a person's health:

- Taha wairua - spiritual health
- Taha hinengaro – mental and emotional health
- Taha tinana – physical health
- Taha whanau – whanau health

This model depicts the components of Hauora (wellbeing) as the four walls of the whare. Each wall represents a different aspect that relates to the above dimensions of health.



Each of these four dimensions influences and supports the others; not one can be seen in isolation of the others and from a youth health perspective, importantly recognises the role of friends and family / whanau in the health and well being of youth.

The Wairarapa community must be encouraged to provide support and leadership to its young people, set reasonable boundaries, and guide them as they move through adolescence to adulthood.

The Wairarapa DHB is committed to a partnership with Maori under the Treaty of Waitangi. Population forecasts show that the numbers of Maori youth in the Wairarapa are increasing to a significantly larger percentage of the total Wairarapa population from currently comprising approximately 20% of the total youth population in 2006 to almost 40% in 20 years time**.**

The involvement of whanau in the planning of Wairarapa youth health services is central to their effectiveness. Maori community consultation and input will enable the development of services that are comfortable, accessible and helpful for the rangatahi and family / whanau using them.

Strategic Direction 3 – Youth Health Services

Actions:

- School based health services will be developed in secondary schools
- Community based clinics that target young people who are not at school will be developed
- Programs targeting the needs of specific groups will be developed to complement existing ones as opportunities present.

Early intervention approach will be adopted across all services

This strategy identifies that a proactive approach to early identification and appropriate follow up of all health and social issues is paramount in ensuring that improved health outcomes for youth are achieved. Evaluations of school based services provided in other DHBs indicate clearly that there are many significant health problems that would have remained undetected if a service responds only to requests for health assistance. Undetected health issues impact on the student's ability to function well in the education environment and can often lead to much larger issues if they remain untreated.

Current Services for Youth in the Wairarapa

Youth health services in the Wairarapa have been developed in schools on an ad hoc basis in direct response to specific needs or service gaps.

Over the past few years it has been the DHBs Public Health Service and the Nursing Innovations Programme (now delivered by the Wairarapa Primary Health Organisation) that has responded to the need to deliver health services in the communities where young people live. This has resulted in several schools in the Wairarapa having access to nurse led clinics either on site or nearby as is the case in Greytown. Some also have a doctor provide services on site once a week. Wairarapa College provides and funds a nurse and GP hours from their own funds, while the three boarding schools also provide some access to health professionals for their students.

All of these clinics have been limited in the number of hours that they are available to students, and are also limited in the numbers of schools that have access to them. While there is no doubt that they have been well received by the young people that they target, there is anecdotal community perception that this is not sufficient to make a real difference to the overall health of the young people in the Wairarapa.

School Based Services in Counties Manakau

Studies done in Counties Manakau DHB where school based services have been developed through the Ministry of Education's AIMHI[1] program revealed:

- 75% of Year 9 students received a comprehensive health assessment and of these:
  - 34% required referral to further health care due to unmet needs
  - 18% of students required referral to social services
  - 13% of students failed the vision screen – most did not know that they had visual problems
  - 7% failed the hearing screen
  - 31% had BMIs of over 30.

Across all students in the schools involved there was:

- An increased awareness of personal hygiene through regular assessments significantly reducing the need for more acute treatment for conditions such as boils and abscesses
- Reduced fragmentation and frustration and improved outcomes for students who have multiple agencies and providers involved in their care through better coordination
- Reduced impact of sports related injuries through better follow up and the inclusion of a physiotherapist on the youth health team
- A reduction in one school from 17 unplanned and unsupported pregnancies per year to an average of 2 supported pregnancies per year
- A reduction in school average Body Mass Index from 31 to 27
- A changing culture across the schools eg 'Healthy Eating'

Youth Services in the Wairarapa in the future

Community Based Services
Some communities have developed Youth One Stop Shops (YOSS). In December 2004 a group of 15 YAG members visited three Youth One Stop Shops in the lower North Island. The services visited were:

- Youth One Stop Shop – Palmerston North
- Evolve – Wellington City
- Hutt Valley Youth Health Service – Lower Hutt

YAG members had mixed sentiments about these services. Comments from them included:

- They appreciated the youth friendly environments especially those with 'drop in centre' approaches
- Liked the concept of a youth focused centre
- Noted the centres tended to focus on 'the naughty kids' and acknowledged the risk that this may exclude kids not in a particular group

The DHB aims to increase resourcing of youth health services to a level that allows health professionals to provide holistic services including comprehensive screening of all students as they enter their secondary school years. It is expected that this will also allow young people to develop better relationships with health professionals which in turn will improve the likelihood of them seeking help when problems occur in the future.

Providers will be encouraged to work holistically with young people in the context of their whole lives, in ways that ensure all services are working collaboratively, are well coordinated and no matter where a young person seeks help from, ensuring that their needs can be met; that they are not turned away feeling there is no one service or person that can help them. Feedback from the Greytown community based youth health clinic, which works in this collaborative way, shows that this approach produces very positive outcomes.

Having explored a range of options for increasing youth health services the DHB is committed to ensuring that new services developed increases access for as many young people as possible.

For this reason, first priority will be given to the development of health services based in secondary schools with the highest level of need. A staged roll out of these services will allow for a robust model of service delivery to be developed in one or two schools that is also flexible enough to adapt to meet the needs of each schools community.

WIPA Services in Porirua Schools
Porirua City School Based Services
Wellington Independent Practitioners Association has been providing school based clinics in 4 secondary schools in the Wellington district since May 2000. Key learnings from their experience include:

- Schools with a nurse on site every day have higher access rates than those where the nurse does not attend every day
- School services are resourced at a rate of 7 nurse hours and 3 GP hours per 500 pupils
- This level of resourcing does not allow nurses to participate in longer consultations, counselling, or health promotion and education
- Service uptake was instant
- 56% of Maori students in the schools access services

Once higher needs secondary schools have robust health services operating, the next priority will be given to establishing a youth health clinic in the Masterton community to cater for those young people who are no longer associated with a school, or for those young people that attend schools that do not have a health clinic on site. Due to a relatively small population such a clinic will operate in carefully selected timeslots such as later afternoons or Saturday mornings to maximize the opportunities to capture clients.

All services will be developed in ways that enable the most efficient use of both existing and new resources and that services are not duplicated. Therefore, it is anticipated that the Nursing Innovations Programme will continue to provide clinics in the Greytown community and that the Public Health Team will also continue to work in secondary schools in ways that complement any school based health service yet to be developed.

Next Steps

Strategic Direction 1 – Youth Participation
• Work with 3 District Council Youth council to develop a Wairarapa wide, multi agency youth council • DHB and Youth Council annually identify a health focused project • Support Youth Council to provide advice to the DHB on youth related health issues
Establish management committees for youth health services as needed *Membership* – no more than 10 – 12 members with representatives from the service base (eg the school) and health professionals. Membership should consist of, at least 50% youth *Purpose* – to ensure onsite youth focussed input into youth health service development and delivery *Responsibilities* – meet regularly – at least 4 times a year • Oversee each service development and delivery • Monitor performance of service and provide advice regarding service efficacy
Strategic Direction 2 – Community collaboration
Take an 'all of school community ' approach to working intersectorally to promote healthy living and reducing risky behaviours *Purpose:* improve child and youth health through health promotion and education for families, teachers and students together
Clarify and improve understanding of roles and boundaries within the 'healthy schools' service
Provide resourcing for intersectoral forums and projects that aim to improve the health and well being of youth eg obesity
Establish a DHB wide Youth Health Promotion Annual Plan Process
Fully implement the Family Violence Intervention Guidelines as applied to youth health, linking with other providers and agencies
Participate in nationwide project to improve collaboration between Child and Youth Family Services and Child and Adolescent Mental Health Services
Strategic direction 3 – Youth health services
Increase access for youth to youth specific health services including: • Development of school based health services prioritised to reduce inequalities • Ongoing development of community based youth health services • Access to allied health services – physiotherapy, speech language, dietician • Specialist mental health and addiction services • Clinical nurse and GP services
Reshape service agreements to achieve: • Support for youth focussed outcomes • Coordination and collaboration between agencies • Identification and removal of contractual barriers or disincentives preventing improvements in child health • Collaboration between community and DHB provided specialist medical and nursing services, PHOs and Public Health teams
Increase the level of expertise in youth health by supporting and promoting youth related professional development of all staff involved with youth health services

Develop wider range of respite care and support options for CAMHS service users and their families
Develop a wider range of alcohol and drug programs across the health care continuum

PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**CPHAC DISCUSSION PAPER** **Date: 19 March 2020**

From	Sandra Williams, Executive Leader, Planning & Performance
Author	Nigel Broom, Executive Advisor
Endorsed By	Dale Oliff, Chief Executive
Subject	**2020/21 first draft Annual Plan including the 2020/21 Statement of Service Performance Expectations (SPE) and the 2020/21 System Level Measures Improvement Plan (SLM)**

APPENDIX:

1. Draft Annual Plan 2020/21 incorporating SPE and SLM.
2. Letter of Expectations from the Minister of Health.

1 PURPOSE

The purpose of this paper is to seek the Community & Public Health Advisory Committee's (CPHAC) feedback on the first draft of the 2020/21 Annual Plan incorporating the 2020/21 Statement of Performance Expectations (SPE) and the 2020/21 System Level Measures Improvement Plan (SLM).

2 BACKGROUND AND 2020/21 ANNUAL PLANNING UPDATE

Planning Guidance was issued by the MOH on 19 December. Since then, CPHAC received papers outlining the 2020/21 planning process and timelines. The plans are retaining a very similar format to that used for the previous three years.

The main changes to last year that are signalled in the Ministry's 2020/21 Guidance document are:

1. Public Health Plans are now expected to be fully integrated into the DHB Annual Plan-we will be working closely with Regional Public Health to enable this.
2. A new section called: "Give practical effect to He Korowai Oranga – the Maori Health Strategy". Noting that the Maori Health Action Plan consultation is still going and therefore MOH guidance will be finalised later.
3. A new section called: "Improving sustainability". This focuses on improving out year planning (specifically financial and workforce) and also requires DHBs to identify a subset of their top 5 savings plan initiatives-in both the short term (20/21) and the longer term (next two outyears).

The attached first draft Annual Plan (excluding financials) has been collated by management through consultation with staff, the PHO, RPH and our neighbouring DHBs. On the 10th March we received the Minister's Letter of Expectations (Appendix 2).

The Board approved the first draft and for parts to be circulated more widely to stakeholders for their feedback which can be incorporated into the next draft.

MOH feedback on the first draft is expected by 9 April 2020. There is no date set for submission of the next draft.

PUBLIC

3 CONCLUSION

MOH feedback on the first drafts are due back on 9 April 2020 after which further drafts will be required prior to Ministerial sign off.

We expect to receive further MOH planning guidance following the release of the government budget on 14 May 2020 after which we will also receive the 2020/21 confirmed Funding Envelope.

It is recommended that CPHAC discusses and feeds back on the first draft 2020/21 Annual Plan (including the SPE and the SLM) which will be incorporated into the second draft of the Annual Plan and System Level Improvement Plan.

End of paper

E94

Wairarapa DHB 2020/21 Annual Plan

incorporating the 2020/21 Statement of Performance Expectations

DRAFT V2

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004.

Table of Contents

Minister's 2020/21 Letter of Approval to Wairarapa DHB

[PLACEHOLDER FOR MINISTERS LETTER]

PART A – Annual Plan

SECTION 1: Overview of Strategic Priorities

1.1 Strategic Direction

The 2020/21 annual plan comes at a time of change and newness, we have new DHB Board members and an Iwi Kainga who are both dedicated to achieving our vision. We know we cannot do this alone, having good health and wellbeing is about everyone having a part to play. Wairarapa DHB's vision is 'Well Wairarapa: Better Health for All' and our mission is to improve, promote, and protect the health status of the people of the Wairarapa, and the independent living of those with disabilities, by supporting and encouraging healthy choices. The values underpinning what we do, will help us deliver on our vision, mission and direction.

1.1.1 Te Tiriti o Waitangi

Te Tiriti o Waitangi is the founding document of Aotearoa-New Zealand, it is historically significant and as we learn more we understand its significance as a living document. Disparities are wholly unacceptable and the consistently poor health outcomes experienced by Māori - cannot continue. Finding new ways of working and rejuvenating our approach are key themes for our treaty partnership moving into 2020/21. The Treaty of Waitangi is also the stage for historical redress and through recent inquiries we gain a better understanding of what the right solutions for Māori health improvement could be.

1.1.2 Our Values

WELLNESS
Finding ways to create a healthier community

EQUITY
Acting to support equity across our community

RESPECT
Caring and empathy in all that we do

INNOVATION
Finding future-focused solutions

RELATIONSHIPS
Working together with people as partners

1.1.3 Strategic Priorities

Our strategic priorities are based on our new direction, they are about changing our mind-set and looking at what is important to the communities we serve:

HAUORA MŌ TĀTOU

We are Wairarapa, we are surrounded by natural beauty and we have an affinity with this place, our coastline feeds us and has served us well, over many centuries. This priority is about sustainability of our place and our people, hauora is not simply health it acknowledges the breath of life and the sustenance of simply being. Therefore, Hauora Mō Tātou is about making the best decisions for us and our children after us.

EVERY DOOR IS THE RIGHT DOOR

As a population we are too small to have arbitrary borders to good healthcare and our smallness is a gift that allows for greater communication and the seamless provision of services to the people we see in our towns and in the neighbourhoods we work in - everyday.

NEIGHBOURHOODS

Neighbourhoods are the places we spend most of our time, unlike larger communities our neighbourhoods are more intimate spaces we gather. Increasing our mobility and taking the services to where people work, live and play is the theme that runs through neighbourhoods.

SERVING THE PEOPLE OF WAIRARAPA

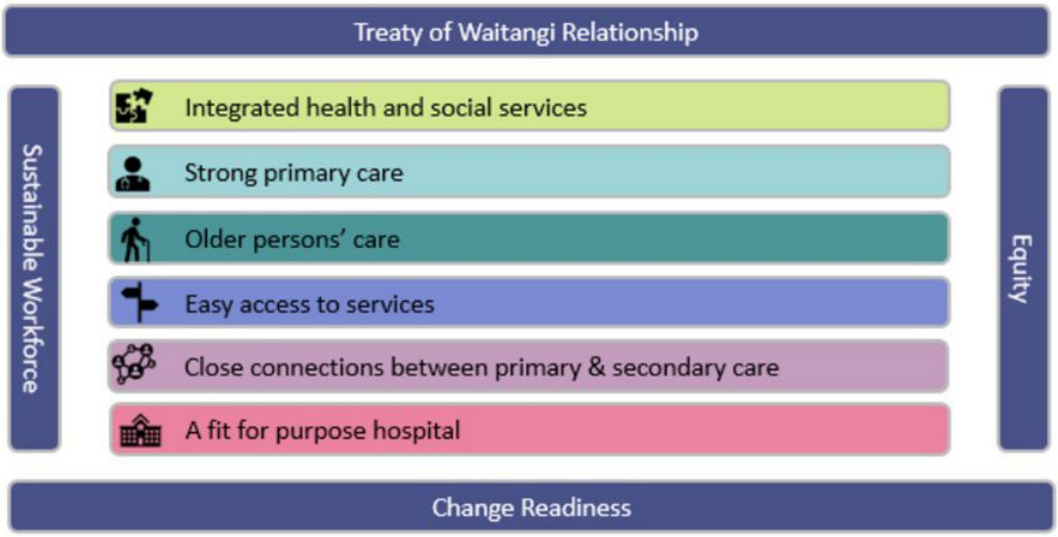
This priority reminds the DHB of our stewardship role in the community and it's about putting the servant back into the public service. Our community spans a large geographical area and our decisions will be made with this in mind. The goal is to tailor our services to meet the needs of our communities - where they live.

MANAAKI TĀNGATA

In each and every interaction we have as individuals we have the power to increase or diminish the other person's mana, it's in the way we act and treat one another. Manaaki tangata is about recognising the inherent mana within each and every person and in each and every interaction whether it's in the community, hospital or a general practice. Manaaki tangata acknowledges that each and every individual is inherently sovereign by way of birthright.

1.1.4 Strategic Objectives

There are seven broad areas of activity where change is needed in order to shift to a responsive, effective health system that achieves equitable outcomes for our community.



Integrated health and social services
Change our approach to contracting to ensure services are more directly focussed upon outcomes and addressing inequity, rather than on short term outputs. Getting communities involved in the co-design of services so that they are responsive and effective. Reviewing referral mechanisms to streamline any handover and collaboration between providers. Supporting roles in the community, particularly those working with young people and children and developing Kaiāwhina Navigator style roles that provide support for whānau. A focus on prevention and health promotion, and particularly health promotion that has been designed alongside communities.

Strong primary care

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Improving the information and communication technology we use, so that referrals, discharge and appointment information is managed in a more timely manner. Increased allied health located in and working with primary care services. Good use of outreach, mobile services and telehealth across the district to improve access. Building upon existing multidisciplinary team programmes, to ensure that primary care services are well supported to manage complex patients.

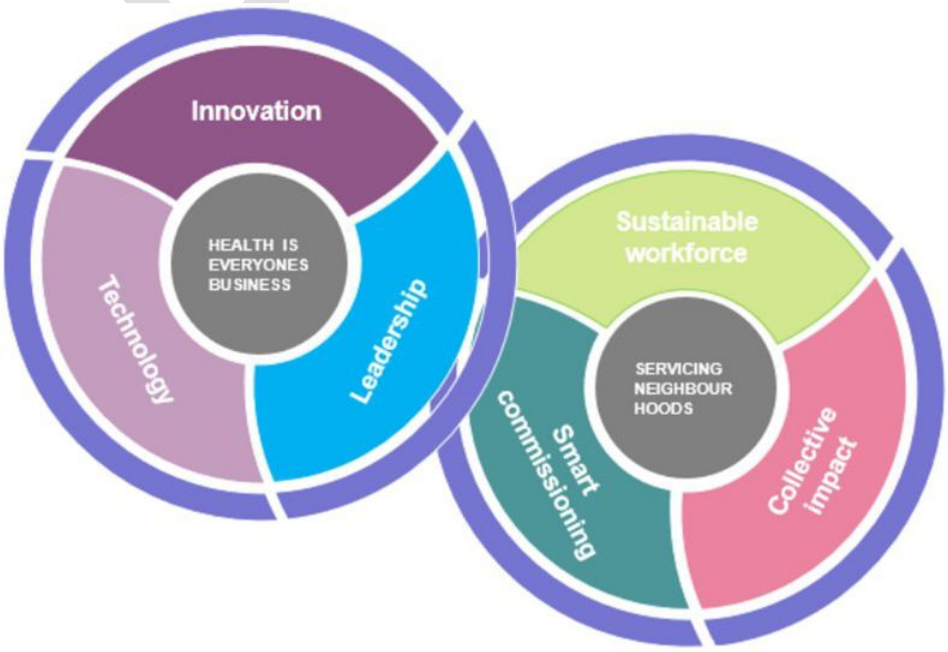
Older persons care
To the maximum possible extent providing services for the elderly in community settings, including in primary care services and in the home. Working with Māori communities to ensure that services are responsive and appropriate for kaumatua and their whānau. Reviewing the provision of wider services in the community to support social connection, and ensuring that health services have the information needed to support people into such services. Ensuring after hours healthcare services are fit for purpose and meet the needs of older people.

Easy access to services
Ensure that our service commissioning is more oriented towards people receiving services, using co-design and wider input into how services are developed. Consider location and transport options to and from services, and coordinating existing transport options better (eg. those provided by different NGOs for different conditions). Increased use of telehealth tools in order to improve access to information for service users, simplify booking and appointments, and reduce the need to travel where appropriate. A review of how well after hours services are working for our communities, and options for improving access where appropriate.

Close connections between primary and secondary care
Review our Alliance Leadership Team, improving shared understanding of the system and the community, including Iwi perspectives. Improve our approach to InterDistrict Flow referrals, with centralised triage, coordinated review processes, better data collection, and improved information and support for people when they are discharged from hospitals in other districts. Review our IT, identifying short term and longer term differences. Building on our use of HealthPathways and improved IT systems to improve our referral, coordination and assessment services, achieving more consistent responses to referrals from primary care, and offering better coordination of services with primary care.

A fit for purpose hospital
Reset the hospital - avoid providing services within the hospital that do not need to be there. To the maximum extent feasible provide rehabilitation, outpatient care and community services in other settings, on the basis of improved relationships with communities based providers and co-design with patients. Improve communication and relationships with the rest of the health system, including effective localised pathways for care and better information sharing, both at the level of individual patient clinical information, and at the level of information about services. Improve discharge processes and support for discharge into the community.

Enablers to the change



Our commitment to key legislation and national strategies

In all that we do we are guided by key overarching national strategies and international conventions as shown in the table below:

The Treaty of Waitangi	Improving equity is a key goal for Wairarapa DHB. We prioritise actions which improve equity of health outcomes for Māori
The New Zealand Health Strategy	We ensure our plans and actions are aligned with the New Zealand Health Strategy
He Korowai Oranga	In all that we do we aim for Pae ora, Wai ora, Whanau ora, and Mauri ora.
The Healthy Aging Strategy	We ensure our work in aged care and improving management of long term conditions promotes and supports healthy aging and independence
UN Convention on the Rights of Persons with Disabilities	We are continuing to develop systems and supports to promote respect for the independence and needs of people with disabilities
Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-18	In partnership with our small Pacific community we work to ensure their appropriate utilisation of social and health services.

1.2 Message from the Board Chair and Chief Executive

[PLACEHOLDER FOR MESSAGE FROM CHAIR AND CE]

1.3 Message from Te Oranga o Te Iwi Kainga Chair

[PLACEHOLDER FOR MESSAGE FROM IWI KAINGA]

Signing Page

Agreement for the Wairarapa DHB 2020-21 Annual Plan between

_____

Hon. Dr David Clark — Date
Minister of Health

_____

Sir Paul Collins — Date
Board Chair
Wairarapa District Health Board

_____

Dale Oliff — Date
Chief Executive
Wairarapa District Health Board

_____

Deborah Davidson — Date
Chair
Te Oranga o Te Iwi Kainga

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SECTION 2: Delivering on Priorities and Targets

This section demonstrates Wairarapa DHB's commitments to the Minister's Letter of Expectations and to the agreed Planning Priorities.

2.1 The Government Health Planning Priorities

The whole-of-government priority is:

Improving the wellbeing of New Zealanders and their families.

The health outcomes that will contribute to this are:

- We live longer in good health
- We have improved quality of life
- We have health equity for Māori and other groups.

To achieve the above, the Government has identified the following 2020/21 Planning Priorities for the health system:

- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention
- Better population health outcomes supported by a strong and equitable public health and disability system
- Better population health outcomes supported by primary health care
- Strong fiscal management.

Section 2 outlines the key activities Wairarapa DHB has planned for 2020/21 under each Planning Priority.

2.2 Health and disability system outcomes framework

The health and disability system outcomes framework supports a stable system by clearly articulating what outcomes the system intends to achieve for New Zealanders, and the areas of focus through which to obtain those outcomes. Figure 1 shows the elements of health and disability system outcomes framework.

Figure 1 The health and disability system outcomes framework elements

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2.3 Maori health improvement in DHB Annual Plans

[PLACEHOLDER]

2.4 Achieving Health Equity in DHB Annual Plans

[PLACEHOLDER]

2.8.1 Give practical effect to He Korowai Oranga – the Māori Health Strategy

He Korowai Oranga, the Māori Health Strategy sets a vision of pae ora – healthy futures – comprising three key elements:

- mauri ora – healthy individuals
- whānau ora – healthy families
- wai ora – healthy environments.

He Korowai Oranga continues to set a strong direction for Māori health. Importantly, the health and disability system is being challenged to do better and to go further. That includes continuing to meet our responsibilities under Te Tiriti o Waitangi (the Treaty of Waitangi), to address and improve substantial health inequities, and to ensure all services for Māori are appropriate and safe.

These challenges are substantial and require a strong plan to implement actions and meet expectations. As such, the development of a new Māori Health Action Plan is underway.

The first part of this section, Engagement and obligations as a Treaty partner, is based on your current legislative responsibilities. The other sections are based on the Māori Health Action Plan discussions to date. The guidance will be updated when the interim plan is released, and the final plan is completed.

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Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
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<table>
<tr><td colspan="3">Engagement and obligations as a Treaty partner
The NZPHD Act specifies the DHBs Te Tiriti o Waitangi obligations; please specify in the annual plan how the DHB will meet these obligations. This includes, but is not limited to, information on:
• The DHBs obligation to maintain processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement. Note: these processes already be established but a description of how they operate, and any improvements planned, should be included.
• Specific plans and strategies for Māori health improvement. Including how the DHB will be working in partnership with Māori to develop and implement these.
• This includes the training of Board members (as per the NZPHD Act 2000) in Te Tiriti o Waitangi and Māori health and disability outcomes.</td><td>This is an equitable outcomes action (EOA) focus area
(All DHBs are to include equity focus for Māori in this area and clear actions to improve Māori health outcomes. It is expected that the actions are designed in partnership with Māori and incorporate mātauranga Māori)
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Work in partnership with Māori to define and co-design the best mechanisms for Māori to participate and contribute to decision making in the WrDHB.
2. Review our policy platform and resolve any gaps related to the Treaty of Waitangi, and the Principles of the Treaty.
3. Outline and execute a plan for the development of a comprehensive strategy to address Māori health needs within WrDHB.
4. Provide specific training and upskilling for Board members and Senior Management on operationalising the Treaty in their collective work programmes.</td><td>Milestone
Q1-Q4: Refresh our current relationship documentation i.e. MOU’s.
Q1: Complete review and fill any gaps in policy platform.
Q1-Q3: Outline a staged approach for delivery of a Māori Health Plan. Approve a Māori Health Plan acceptable to Māori.
Q1-Q4: Invest in specified training for Board members and Senior Management.</td><td>Measure
1. Survey Māori.
2. The proliferation of the Treaty of Waitangi in WrDHB policy.
3. Survey Māori.
4. Survey Board & Senior management.</td><td>Government theme:
Improving the well-being of New Zealanders and their families
System outcome
We have health equity for Māori and other groups
Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

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<table>
<tr><td colspan="3">Māori Health Action Plan – Accelerate the spread and delivery of Kaupapa Māori services
[The consultation period for the Māori Health Action Plan has been extended and this guidance will be finalised following confirmation of the Action Plan]
• Accelerating the spread and delivery of Kaupapa Māori services is an important element in enabling Māori to exercise their authority under Article Two. It enables Māori to have options when choosing care providers and pathways. DHBs will have plans to ensure that Māori capability and capacity is supported, enabling Māori to participate in the health and disability sector and provide for the needs of Māori.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(All DHBs are to include equity focus for Māori in this area and clear actions to improve Māori health outcomes. It is expected that the actions are designed in partnership with Māori and incorporate mātauranga Māori)
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Facilitate Māori health providers seeking to expand capacity and strengthen capability by:
a. supporting Māori Provider Development Scheme (MPDS) applications
b. supporting HWNZ Hauora Māori applications
c. connecting to Hauora Māori scholarships
d. promoting other development opportunities.
2. In partnership with Māori, define what Kaupapa Māori services are within the WrDHB
3. Commission Iwi to design a Kaupapa Māori Framework for implementation across the WrDHB.
4. Formulate a model of service commissioning that draws on the strengths of Māori Health Providers in the WrDHB region.</td><td>Milestone
Q3-Q4: Wānanga with Māori Health Providers.
Q1: Wānanga with Iwi Māori to define Kaupapa Māori.
Q2-Q3: Draw up and implement a Kaupapa Māori Framework prescribed by local Iwi.
Q3-Q4: Wānanga with Māori Health Providers.</td><td>Measure
1. Status Report.
2. The definition is fit for purpose ad acceptable to Māori.
3. The Kaupapa Māori Framework is implemented as prescribed by Iwi Māori.
4. A Māori model of service commissioning is designed and implemented.</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families
System outcome
We have health equity for Māori and other groups
Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

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<table>
<tr><td colspan="3">Māori Health Action Plan – Shifting cultural and social norms
[The consultation period for the Māori Health Action Plan has been extended and this guidance will be finalised following confirmation of the Action Plan]
Shifting cultural norms within the health and disability system is critical to ensuring that Māori can live and thrive as Māori and that we address racism and discrimination in all its forms. DHBs will have plans to further these aims through actions like:
• Building the knowledge of all DHB staff in Te Tiriti o Waitangi.
• Addressing bias in decision making (e.g. build on https://www.hqsc.govt.nz/our-programmes/patient-safety-week/publications-and-resources/publication/3866/)
• Enabling staff to participate in cultural competence and cultural safety training and development (e.g. support the implementation of: https://www.mcnz.org.nz/assets/standards/8a24a64029/Statement-on-cultural-safety.pdf)</td><td>This is an equitable outcomes action (EOA) focus area
(All DHBs are to include equity focus for Māori in this area and clear actions to improve Māori health outcomes. It is expected that the actions are designed in partnership with Māori and incorporate mātauranga Māori)
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Continue the delivery of Treaty of Waitangi [TOW] training to all staff and investigate the opportunities to grow the training package
2. Provide a training package that is tailored to the Board and Senior Managers.
3. Investigate the opportunity to build the Māori health workforce with an emphasis on cultural advice.
4. Modify the WrDHB physical environment to be conducive to tikanga Māori.
5. Incorporate aspect of tikanga Māori into the operating environment of the WrDHB.
6. Choose and install cultural signs and symbols to reinforce culture change.
7. Identify gaps in the fitness of the WrDHB workforce to deliver on culture change and partner with Māori.</td><td>Milestone
Q1-Q4: Continue TOW training.
Q1: Provide options paper for a more comprehensive training package to CE & Board.
Q4: Deliver new training package
Survey staff & Board members.
Q1-Q2: Produce a description of the quality of input to the CE, Iwi Kainga and Board.</td><td>Measure
1. Attendance and survey staff experience.
2. Options paper is supported and resourced.
3. Attendance and survey experience.
4. Māori are at all levels and expectations are clear.
5-7. An audit is conducted and reviewed.</td><td>Government theme:
Improving the well-being of New Zealanders and their families
System outcome
We have health equity for Māori and other groups
Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

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	Q2-Q4: Make necessary changes to agreements, mandates and positions. Q1-Q3: Conduct a cultural audit. Q4: Report back on the outcome of a cultural audit to the CE, Iwi Kainga and Board. Q1-Q3: Conduct a cultural audit with a focus on workforce. Q4: Report back on the outcome of a cultural audit to the CE, Iwi Kainga and Board.	Culture change can be seen in the WrDHB.		

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<table>
<tr><td colspan="3">Māori Health Action Plan – Reducing health inequities- the burden of disease for Māori
[The consultation period for the Māori Health Action Plan has been extended and this guidance will be finalised following confirmation of the Action Plan]
Achieving equity in health and wellness for Māori is an overall goal of the health and disability system. It is mandated by article three of Te Tiriti o Waitangi and is an enduring principle of Te Tiriti. Achieving equity for Māori will be a key element of many of the DHB's plans throughout the rest of the document. DHBs should use this section to:
• Outline any equity focused initiatives that don't fit elsewhere.
• Provide a summary and cross reference for those major initiatives elsewhere in their plan.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(All DHBs are to include equity focus for Māori in this area and clear actions to improve Māori health outcomes. It is expected that the actions are designed in partnership with Māori and incorporate mātauranga Māori)</td></tr>
<tr><td>Activity
1. Implement a kaupapa Māori programme of work focussed on whānau during pregnancy out to the first thousand days of a child's life.
2. Investigate options for providing micro-suctioning to vulnerable children, Māori, Pacific and Low-Socioeconomic.
3. Survey South Wairarapa Māori leaders to better understand local solutions to hauora Māori.
4. Continue to invest in the Tapu Te Ha programme of work focussed on increasing Māori quit rates and smokefree kainga.
5. Design an improved dental service for the delivery of high needs surgical care to address long wait times for Māori, Pacific and Low-Socioeconomic children.</td><td>Milestone
Q1-4: Contract for service.
Q1-4: Increase funding to programme.
Q1-2: Secure theatre space and dental support.</td><td>Measure
Status report
Increased numbers accessing service</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td colspan="3"></td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

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<table>
<tr><td colspan="3">Māori Health Action Plan – Strengthening system settings
[The consultation period for the Māori Health Action Plan has been extended and this guidance will be finalised following confirmation of the Action Plan]
• DHBs have a role to play in ensuring that the system settings across their parts of the health and disability system support the overall goal of pae ora (healthy futures). Included in this area are matters to do with how services are commissioned and provided and joint ventures with other local agencies. Please document the plans you have in this area.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(All DHBs are to include equity focus for Māori in this area and clear actions to improve Māori health outcomes. It is expected that the actions are designed in partnership with Māori and incorporate mātauranga Māori)
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Continue to provide support and engage with the Tihei Wairarapa Alliance.
2. Investigate the opportunity to resource a multidisciplinary analytical and insights team focussed on Māori health and Equity.
3. Increase support to the Wairarapa DHB Whānau Ora Collective to deliver Whānau Ora on the ground in WrDHB.
4. Work in partnership with Māori to define and co-design the best mechanisms for Māori to participate and contribute to decision making in the WrDHB.
5. Formulate a model of service commissioning that draws on the strengths of Māori Health Providers in the WrDHB region.</td><td>Milestone
Q1-Q4: Business as usual status report.
Q1: Draw up draft terms of reference.
Q2-Q4: Align with CE and implement.
Q1: Meet with the Whānau Ora Collective.
Q2-Q4: Partner with the Whānau Ora Collective.
Q1-Q4: Refresh our current relationship documentation i.e. MOU’s.
Q1-Q2: Wānanga with Māori Health Providers.</td><td>Measure
1. Survey Participants.
2. Test with CE and Te Iwi Kainga.
3. Survey Whānau Ora Collective members.
4. Survey Māori.
5. A Māori model of service commissioning is designed.</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td colspan="3"></td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

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2.8.2 Improving sustainability

As New Zealand's population has continued to grow and age, with more complex health needs, the system has worked hard to keep up with demand, however the financial performance of DHBs is variable and has deteriorated in recent years. An enhanced focus on improving sustainability is required.

DHBs are expected to clearly demonstrate how strategic and service planning, both immediate and medium term supports improvements in system sustainability including significant consideration of models of care and the scope of practice of the workforce.

Consideration of sustainability objectives and actions should include how your DHB will work collectively with your sector partners to deliver the Government's priorities and outcomes for the health and disability system while also contributing to a reduction in cost growth paths and deficit levels.

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Improved out year planning processes

Financial

- Identify the three or four most significant actions the DHB will take to improve its outyear planning processes.
  At least two of the actions should identify milestones for delivery to be completed by December 2020 to support 2021/22 planning.

Workforce

- Identify the three or four most significant actions the DHB will take to improve its outyear planning processes.
  At least two of the actions should identify milestones for delivery to be completed by December 2020 to support 2021/22 planning.

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
[PLACEHOLDER]	(DHB selected milestone)	(DHBs select the most appropriate measure/s note: when measures are reported, data should be disaggregated by ethnicity and other demographic information where data allows)	**System outcome** (please select **ONE** system outcome for this priority) We have health equity for Māori and other groups **OR** We live longer in good health **OR** We have improved quality of life	**Government priority outcome** (please select **ONE** Government priority outcome for this priority) Support healthier, safer and more connected communities **OR** Make New Zealand the best place in the world to be a child **OR** Ensure everyone who is able to, is earning, learning, caring or volunteering

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Savings plans – in-year gains

DHBs are expected to undertake appropriate cost analysis and develop realistic savings plans that do not risk compromising the quality and safety of services or improved equity for their populations.

- The DHB's annual plan should highlight a subset of five initiatives from its saving plan that are expected to have most significant impact in the 2020/21 year and include a brief rationale explaining why the action was selected.
- Please identify key actions and milestones that support delivery of the initiative each quarter and include quantification of the expected in-year impact.

Initiatives identified must not compromise quality and safety or equity of services for the DHB's population

Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
1. Establishment of a Long Term Sustainability Action Group (LTSAG) to provide direction, oversight and decision making for continuous improvements of our financial sustainability aimed at achieving budget break even by financial year 2023/24. 2. Labour cost analysis and savings initiatives for increased efficiency, optimised sourcing and allocation and overall reduction of waste in using our workforce, through better planning, workflow and process management, use of (smart) technology and aligned roles and responsibilities. 3. Care protocol analysis and savings initiatives for improved efficiency in patient flow, workforce planning and reduction of avoidable intervention rates / IDF outflows etc. and collaboration with our primary care partners to lower unnecessary hospitalisation. 4. Clinical supply chain analysis and savings initiatives for reduction of waste through leveraging product change opportunities from PHARMAC hospital devices, implementation of Choosing Wisely program, trading disposables for reusable supplies, improving team/staff 'waste awareness'. 5. Unfavourable contracts analysis and savings initiatives to improve performance by exiting contracts that no longer meet the strategic direction and/or meet the service customer requirements, better managing all contacts to agreed volumes and service levels, pursuing opportunities for smart local contract negotiations, partnering with other DHB's and blocking preferential physician supplies.	1. Q1 LTSAG work plan in place. 1. Q1-4: 2/3 Weekly action group meetings. 2. Q1 Cost analysis done and savings initiatives included in LTSAG work plan. 2. Q1-4: ongoing improvement per work plan 3. Q1 Cost analysis done and savings initiatives included in LTSAG work plan.	1. 4 years savings plan achieving budget break even by FY 2023/24. 2. Savings target set at $1.4m to be achieved in 4 years: Y1 - $0.3m Y2 - $0.3m Y3 - $0.4m Y4 - $0.4m 3. Savings target set at $2.8m to be	We have improved quality of life	Support healthier, safer and more connected communities

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	3. Q1-4: ongoing improvement per work plan. 4. Q1 Cost analysis done and savings initiatives included in LTSAG work plan. 5. Q1-4: ongoing improvement per work plan 6. Q1 Cost analysis done and savings initiatives included in LTSAG work plan. 6. Q1-4: ongoing improvement per work plan.	achieved in 4 years: Y1 - $ 0.5m Y2 - $ 0.7m Y3 - $ 0.8m Y4 - $ 0.8m 4. Savings target set at $1.9m to be achieved in 4 years: Y1 - $ 0.4m Y2 - $ 0.5m Y3 - $ 0.5m Y4 - $ 0.5m 5. Savings target set at $3.3m to be achieved in 4 years: Y1 - $ 0.7m Y2 - $ 0.8m Y3 - $ 0.9m Y4 - $ 0.9m		

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Savings plans – out year gains

DHBs are expected to undertake appropriate cost analysis and develop realistic savings plans that do not risk compromising the quality and safety of services or improved equity for their populations.

- The DHB's annual plan should highlight a subset of five initiatives from its saving plan that are expected to have most significant impact in the next two out years and include a brief rationale explaining why the action was selected. Please also include quantification of the expected impact in each of the out years.

(Where in-year initiatives continue into out years as the most significant activity the DHB is undertaking, please cross refer to the in-year gains section)

Consideration of innovative models of care and the scope of practice of the workforce to support system sustainability

Ensuring workforce planning supports innovative models of care is a key factor supporting improved system sustainability in the medium term.

- Please specify five key workforce development actions and initiatives the DHB will undertake during 2020/21 to support innovative models of care to be delivered in out years. At least one action should be focused on strengthening Māori workforce.

</td><td>

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

</td></tr>
<tr><td>

Activity

Please refer to in year savings initiatives above:

- Labour
- Care protocols
- Supply / waste
- Unfavourable contracts

</td><td>

Milestone

As per above

</td><td>

Measure

As per above

</td><td>

Government theme:

Improving the well-being of New Zealanders and their families

System outcome

We have improved quality of life

Government priority outcome

Support healthier, safer and more connected communities

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Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
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<table>
<tr><td colspan="3">Working with sector partners to support sustainable system improvements
• Identify the three or four most significant actions the DHB will undertake during 2021 collaboratively with sector partners to support sustainable system improvements that also support improved Māori health outcomes and Pacific health outcomes.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Working in partnership with our health sector colleagues and refining practices and processes to provide seamless support tor whānau.
2. Co-design and contract our Māori providers to deliver a programme focussed on whānau ora centred on creating the best start in life for tamariki mokopuna.
3. Working in partnership with Māori health providers extend the healthy homes project to include a greater number of vulnerable whānau.
4. Investigate opportunities to build a closer relationship with the Pacific community representatives in order to improve service delivery to whānau Pacifica.</td><td>Milestone
Q1-4: Documented practice/ process changes.
Q1-2: Contract for services.
Q1-2: Contract for services.</td><td>Measure
1. Status report.
2. Prototype project implemented over 2 years.
3. Prototype project implemented over 2 years.
4. Meetings held.</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td colspan="3"></td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

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2.8.3 Improving Child Wellbeing - improving maternal, child and youth wellbeing

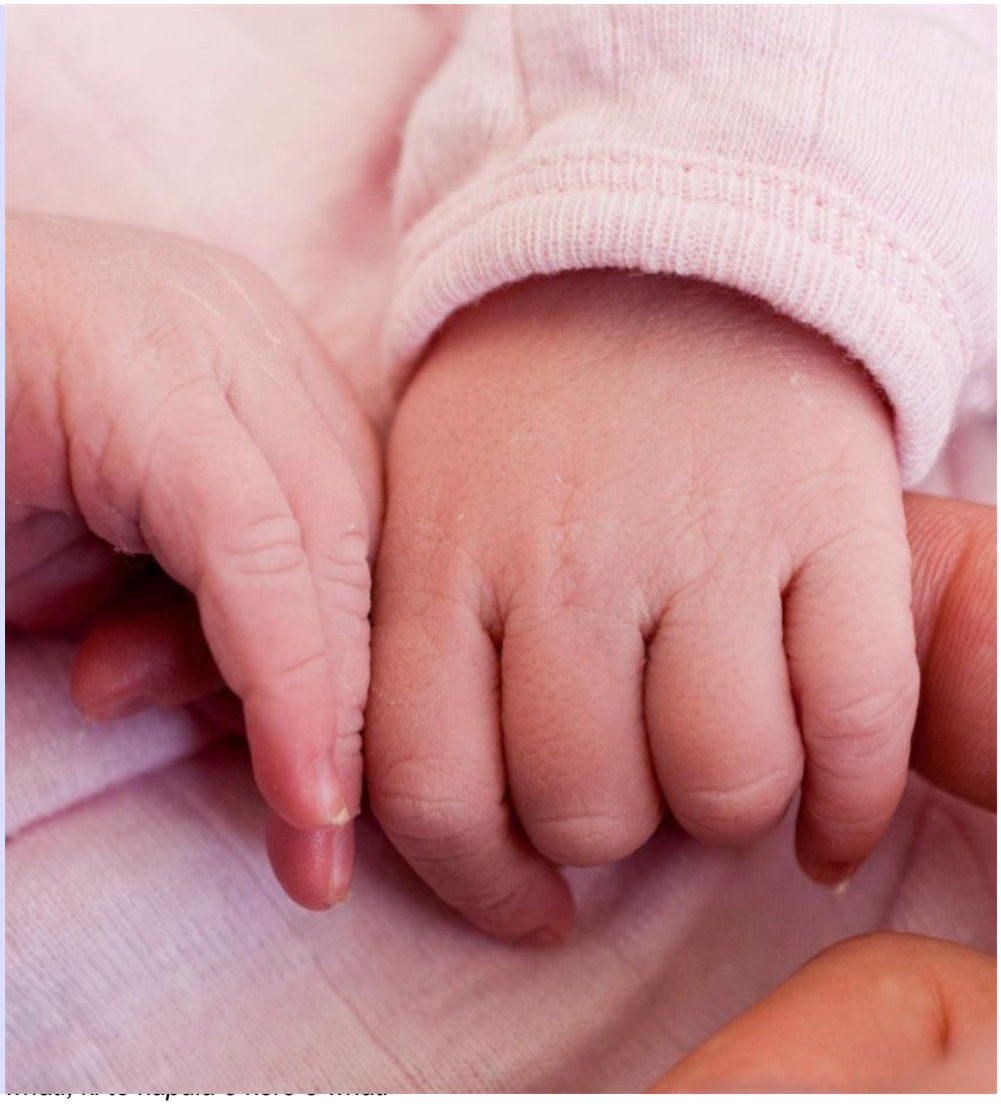
The Child and Youth Wellbeing Strategy (the Strategy) provides a framework to align the work of government and others to achieve the vision of 'Making New Zealand the best place in the world for children and young people'.

The nine principles promoting wellbeing and equity for all children and young people, operationalised for the Health and Disability system, are:

- Children and young people are taonga
- Māori are tangata whenua and the Māori-Crown relationship is foundational
- Children and young people's rights need to be respected and upheld
- All children and young people deserve to live a good life
- Wellbeing needs holistic and comprehensive approaches
- Children and young people's wellbeing are interwoven with family and whānau wellbeing
- Change requires action by all of us
- Actions must deliver better life outcomes
- Early support is needed - maintain contact across the early years and beyond and be alert and responsive to developing issues and opportunities.

There is an expectation that DHBs will actively work to improve the health and wellbeing of infants, children, young people and their whānau and carers with a particular focus on improving equity of outcomes.

DHB annual plans will consider the above principles in all their activities, as part of their contribution to delivering the Strategy, and preparing the health and disability sector for system transformation over time.



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<table>
<tr><td colspan="3">Maternity and Midwifery workforce
Ensure population needs for pregnant women, babies, children and their whānau are well understood; and identify key actions that demonstrate how the DHB will meet these needs, including realising a measurable improvement in equity for your DHB. Actions should include a comprehensive approach to prevention and early intervention across maternity, Well Child Tamariki Ora and primary care services.
All DHBs will continue to implement and evaluate a midwifery workforce plan to support:
undergraduate midwifery training, including clinical placements
recruitment and retention of midwives, including looking at the full range of the midwifery workforce within the DHB region especially rural areas
service delivery mechanisms including strategies to address predicted seasonal changes in service demand and showing initiatives that make best use of other health work forces to support both midwives in their roles and pregnant people.
Please refer to the Care Capacity Demand Management (CCDM) section regarding reporting requirements for implementing CCDM for the midwifery workforce.
Examples of equity actions that could be included in your plan are found in the in the Supporting Information and FAQ page, see section 2.6 for the link.</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Implement the National Hauora Coalition Generation 2040 initiative across primary care.</td><td>Milestone
Q1–Q4 Practice and Midwifery Engagement; practices implementing initiative</td><td>Measure
Number of Early Pregnancy Assessments completed for Hapū Mama of Māori pēpi</td><td colspan="3">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td colspan="3"></td><td>System outcome
We have health equity for Māori and other groups</td><td colspan="2">Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
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<table>
<tr><td colspan="5">Maternity and early years
• Identify actions that contribute to the Strategy's Plan of Action to redesign maternity and early years interventions that support the needs of pregnant women, infants, babies, children and their whānau. Demonstrate how the DHB will meet these needs, including commitments to health equity for Māori, Pacific and other vulnerable groups and how outcomes will be addressed.
• Actions should include comprehensive approaches to prevention and early intervention across pregnancy, parenting and Well Child Tamariki Ora services including integrated approaches with primary care and mental health and addiction services, as well as SUDI prevention initiatives.
• Identify the health promotion and health protection activities the DHB can undertake to advance progress on your SUDI work. Activities that DHBs could carry out can be found in the Supporting Information and FAQ page, see section 2.6 for the link.
• Outline the specific actions the DHB is taking intended to reduce inequity of access to community-based midwifery services, ultrasound scanning, pregnancy and parenting education and Well Child Tamariki Ora services.</td><td>This is an equitable outcomes action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Design and implement a two [2] year prototype of a Hapūtanga - first thousand days programme focussed on the journey through pregnancy and the first few crucial years of life for a child.
2. Design and implement a child health coordination service within primary care that tracks children from birth through to aged 5. The service will ensure all Wairarapa children are connected to and accessing the health services and screening required to live a happy health life. Māori, Pacific and those living in the most deprived areas will be priority.</td><td>Milestone
Q1-4: Contract Māori provider to deliver and evaluate.
Q1-4: Establishment of the service
Q2-4: Implement Child Health Coordination Service.</td><td>Measure
Feedback from Māori.
Immunisation rates.
B4SC rates.
Number of families engaged with TOWC services.</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td colspan="3"></td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

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<table>
<tr><td colspan="3">Immunisation
All DHBs are to contribute to healthier populations by establishing innovative solutions to improve and maintain high immunisation rates at all childhood milestones from infancy to age 5 years.
Specify actions to improve delivery and uptake of immunisation from infancy to age 5 years that will meet the needs of your overall and, in particular, Māori populations and identify how each action will address equity and what outcomes will be achieved.</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
Continue implementation of the Wairarapa Childhood Immunisation plan which includes proactive automatic referral to outreach services for babies where the family is not engaged in immunisation via their primary care practice.
Integrated Childhood Immunisation Services (both NIR and outreach services) with the new Child Health Coordination Service.</td><td>Milestone
Q1-4

Q1</td><td>Measure
8 month immunisation rates.
24 month immunisation rates.
5 year old immunisation rates.</td><td colspan="3">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td colspan="3"></td><td>System outcome
We have health equity for Māori and other groups</td><td colspan="2">Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
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Family violence and sexual violence

Reducing family violence and sexual violence is an important priority for the Government, and something we want all DHBs to be working on, in partnership with other agencies and contributions

- Please provide the actions for the upcoming year that your DHB considers is the most important contribution to this, including: the reasons why the action(s) are important and the expected impact.

</td><td colspan="3">

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

</td></tr>
<tr><td>

Activity

1. Increase awareness and implementation of the Violence Intervention Programme (VIP) across the DHB by;
   - Developing a policy to support DHB Staff impacted by family violence
   - Implement a Peer support group for DHB staff, impacted by violence, professionally or personally on a monthly basis
   - For senior leaders within the WrDHB to complete the VIP training programme within the year.
2. Provide a culturally appropriate, effective and timely response to those affected by family violence by strengthening relationships and creating clear pathways for clinicians to effectively utilise services available for Māori. This will be achieved by;
   - Hui with kaumātua to explore how we can better support/ work alongside whānau members when they present to ED after a family harm incident.
   - Explore the possibility of partnering with iwi services in providing support when whānau present at hospital due to family violence.

</td><td>

Milestone

(DHB selected milestone)

</td><td>

Measure

CW: Child wellbeing measures

</td><td colspan="2">

Government theme:

Improving the well-being of New Zealanders and their families

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<tr><td></td><td></td><td>

System outcome

We have improved quality of life

</td><td>

Government priority outcome

(please select **ONE** Government priority outcome for this priority)

Make New Zealand the best place in the world to be a child

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2.8.4 Improving mental wellbeing

Together we must continue to build a whole-of-system, integrated approach to mental health, addiction and wellbeing that provides holistic options for New Zealanders across the full continuum of need.

People with lived experience of accessing mental health or addiction services and their families must be central to this.

There is an expectation that annual plans reflect how DHBs will embed a focus on wellbeing and equity at all points of the system, while continuing to increase focus on mental health promotion, prevention, identification and early intervention.

Alongside building missing components of our continuum, annual plans should demonstrate how existing services can be strengthened to ensure that mental health and addiction services are cost effective, results focused and have regard to the service impacts on people who experience mental illness.

DHBs will provide a range of services that are of high quality, safe, evidence based and provided in the least restrictive environment.

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Mental Health and Addiction System Transformation

The Government's response to *He Ara Oranga* (the report of the Mental Health and Addiction Inquiry) confirmed a transformational direction for New Zealand's approach to mental health and addiction (https://www.health.govt.nz/our-work/mental-health-and-addictions/government-inquiry-mental-health-and-addiction). This approach is grounded in wellbeing and recovery. It is underpinned by a deliberate focus on achieving equity of outcomes, in particular for Māori, as well as for other population groups who experience disproportionately poorer outcomes including Pacific peoples and youth.

DHBs must demonstrate collaborative engagement with Māori, Pacific peoples, people with lived experience, NGOs, primary and community organisations, Rainbow communities and other stakeholders to build a whole-of-system, integrated approach to mental health, addiction and wellbeing that provides options for New Zealanders across the full continuum of need.

The mental health and addiction system must be responsive to people at different life stages, and at different levels of need. In particular all mental health and addiction services must be responsive to people with coexisting needs. We must continue to work together to embed a focus on mental health promotion, prevention, identification and early intervention at the primary and community level. At the specialist end of the continuum, we must ensure sustainable, quality services for those with most need.

Collective action across multiple years will be required to achieve transformation of our approach. It is expected that DHBs will work along with the Ministry of Health and other leadership bodies to implement the Government's agreed actions following the Mental Health and Addiction Inquiry and implement relevant Budget 2020/21 initiatives.

This transformation will lead to increased access and choice of supports for people, whatever their needs and wherever they are, and improved and equitable health and wellbeing outcomes for all.

DHB Activity

DHBs should identify opportunities to build on existing foundations and include actions in the annual plan in relation to improving and / or addressing **all** these focus areas and subpoints:

Placing people at the centre of all service planning, implementation and monitoring programmes

- Demonstrate a commitment to lived experience and whānau roles being supported and employed across policy, strategy and quality programmes.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

- Improve mechanisms that will enable real time feedback from service users and their families into quality programmes.
- Demonstrate how consideration will be given to addressing equity for Māori, Pacific, young people and other population groups who experience disproportionately poorer outcomes, into recruitment and feedback mechanisms.
- Demonstrate leadership in promoting respect for and observance of the Code of Health and Disability Services Consumers' Rights.
- Demonstrate measures to minimise compulsory or coercive treatment.

Embedding a wellbeing and equity focus

- Demonstrate a focus on wellbeing and equity at all points of the system including working with your partners on, for example, implementing Healthy Active Learning and promoting sleep and physical activity.
- Improve the physical health outcomes for people with mental health and addiction conditions.
- Improve responses to co-existing problems via stronger integration and collaboration between other health and social services.
- Improve employment, education and training options for people with low prevalence conditions including, for example, Individual Placement Support.
- Improve engagement strategies with Māori, people with lived experience, and population groups who experience disproportionately poorer outcomes including Pacific peoples, youth and Rainbow communities.
- Continue to implement Supporting Parents, Healthy Children (COPMIA) to support early intervention in the life course.

  Collaborate and work with the Ministry, the Mental Health and Wellbeing Commission, the Suicide Prevention Office and other leadership bodies and key partners in your region to help drive transformation in line with *He Ara Oranga*.

Increasing access and choice of sustainable, quality, integrated services across the continuum

- Outline how you will support the sustainability of acute services.

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- Improve options for acute responses, including improving crisis team responses, respite options, and community support and work with the Ministry to plan future responses that will contribute to decreasing acute demand.
- Commit to expand access to services for people with mild to moderate and moderate to severe mental health and addiction needs.
- Commit to increased choice by broadening the types of mental health and addiction services across the full continuum of care and available in a range of settings.
- Work in partnership with the Ministry and in collaboration with Māori, Pacific peoples, young people, people with lived experience, NGOs, primary and community organisations, and other stakeholders to plan an integrated approach to mental health, addiction and wellbeing and roll out new primary-level responses from Budget investment.
- Strengthen and increase the focus on mental health promotion, prevention, identification and early intervention.
- Continue existing initiatives and services that contribute to primary mental health and addiction outcomes and align with the future direction set by *He Ara Oranga,* including strengthening delivery of psychological therapies.
- Identify how you will use cost pressure funding to ensure NGOs in your district are sustainable.

Suicide prevention

- Undertake to reduce suicide by implementing and monitoring key DHB-led actions from *Every Life Matters* - He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024.
- Work with the Ministry in developing DHB suicide prevention and postvention plans to enable and monitor the outcomes of *Every Life Matters* – to promote wellbeing, respond to suicide distress, respond to suicidal behaviour and support people after a suicide.

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- Continue existing suicide prevention and postvention efforts to provide a range of activities such as mental health literacy and suicide prevention training, community-led prevention and postvention initiatives and integration of suicide prevention within mental health and addiction services.
- Continue to gather data, information and evaluative reports around the monitoring and evaluation of mental health literacy and suicide prevention training, community-led prevention and postvention initiatives and integration of suicide prevention within mental health and addiction services.
- Support the implementation of *Every Life Matters* and the national suicide prevention research plan, through the contribution of agreed data capture.

Workforce

Central to achieving better outcomes for New Zealanders is a sustainable, skilled workforce. This requires investment to diversify, upskill and expand existing and new workforces, and to ensure worker wellbeing.

- Work in partnership with workforce centres to strengthen current workforces, including a focus on retention, recruitment and training, and wellbeing.
- Support workforce development of the appropriate knowledge and skills to support people with mental health and addiction needs, including those with co-existing needs, for example through use of the Let's Get Real framework.
- Demonstrate how lived experience, peer and whānau roles can be strengthened, supported and employed across all services.

Forensics

- Work with the Ministry to improve and expand the capacity of forensic responses from Budget investment.
- Contribute, where appropriate, to the Ministry's Forensic Framework project to improve the consistency and quality of services and to guide development of future services.

Commitment to demonstrating quality services and positive outcomes

Demonstrating quality, safe services, and positive health outcomes, requires a commitment to collecting meaningful information and data, and continuous monitoring and evaluation. This includes performance, quality, and outcome measures.

As such, you will commit to the development of any new measures alongside providing reporting on priority measures, including:

- Access (MH01) and reducing waiting times (MH03), completion of transition/discharge plans and care plans for people using mental health and addiction services (MH02), mental health and addiction service development (MH04)
- Reducing inequities including reducing the rate of Māori under community treatment orders (MH05).
- Ongoing commitment on reporting to PRIMHD.

Activity	**Milestone**	**Measures**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
		MH01	**System outcome**	**Government priority outcome**
Placing people at the centre of all service planning, implementation and monitoring programmes:			We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
The Lived Experience Advisory Group (The LEAG) will continue to provide input into key strategic and transformational projects across the 3DHB's including the MHAIDS restructure, the review of the triage and urgent response system, and other initiatives.	Q1 – Q4	MH02 MH03 MH05 MH06 Status update report		
1) Embedding a wellbeing and equity focus (EOA):				
a) WrDHB will provide support to Māori providers responding to the Ministry of Health Primary mental Health and Addictions RFP. The DHB will also support implementation of any new initiatives. These actions are subject to MoH funding. **(EOA)**	Q1 – Q4			
b) Subject to Ministry of Health funding, WrDHB will support the development of a kaupapa Māori youth primary mental health team which will work across a range of youth specific settings ,including school based services and the youth health clinic. **(EOA)**	Q2			
c) WrDHB will work with providers working with young people to develop of an integrated youth health team, which is able to provide services in a range of settings appropriate to young people **(EOA).**	Q1 – Q4			
2) Increasing access and choice of sustainable, quality, integrated services across the continuum:				
a) Refresh the terms of reference and work programme of the Wairarapa Mental Health and Addictions Leadership Group, to provide oversight of initiatives to better integrate mental health and addictions services across the continuum.	Q1			

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b) Along with CCDHB and HVDHB, WrDHB is a member of the recently established Greater Wellington Regional Collaborative (GWRC) which has been established to support the implementation of the integrated primary mental health and addictions service (Te Tumu Waiora model) which will improve access into primary care/GP services for those presenting in distress. GP practices with high Māori, Pacific, Youth and rural populations will be prioritised in the first tranche. (3DHB)	Q4			
c) WrDHB will work with local and sub-regional providers to align and streamline psychological therapies services in primary care (Piki, Te Tumu Waiora, To Be Heard).	Q4			
d) Implement the 'Acute Continuum of Care' to better match need to service provision, enhance coordinated service provision across a range of providers, and improve integration and patient flow through the system both locally and across 3DHBs.. This will include supporting prioritised pathways for responding to Māori mental health needs. (3DHB)	Q4			
e) Collaborate with CCDHB and HVDHB to consider options for an integrated community mental health and wellbeing hub model that will provide a timely response at a local community level to those who present in distress (3DHB).				
3) Suicide prevention:				
a) Develop and begin implementation of a 3DHB suicide prevention and postvention plan. This plan and subsequent actions will incorporate goals from the national suicide prevention strategic plan 'Every Life Matters', and will focus on population groups at higher risk of suicide. **(EOA)** (3DHB)	Q2 – 4			
b) Streamline and improve data collection and reporting on suicide numbers/self-harm presentations across the 3DHBs. This will include standardising documentation and electronic data capture to reflect sector standards. (3DHB)	Q1 – 4			
4) Workforce:				
a) Undertake workforce planning in partnership with NGO providers, including the development of a collective workforce development plan that will consider				

opportunities for investment. The plan will also include support for NZQA recognised peer support training, and links with training institutions.	Q1 – 4			
5) Forensics:				
a) Work with the Ministry to improve and expand the capacity of forensic responses from Budget 2020.	Q1 – 4			
b) Contribute, where appropriate, to the Forensic Framework project.				
6) Commitment to demonstrating quality services and positive outcomes:				
a) Support and contribute to the National KPI Programme, established to focus on improvements in specific Key performance indicators. Whanau Engagement-Adult services are focusing on improving whanau engagement across the services by establishing practise standards, auditing against those standards, and using data to inform improvement work.	Q1 – 4 Q1 - 4			
b) Undertake a Connecting Care project, which focuses on service transitions and the coordinated transfer of care between one health care or social service provider and another. The project aims to ensure that mental health and addiction service consumers receive continuous quality care between providers.	Q2 – 4			
c) Implement a Creating Safety Through Practice project to improve the way we learn from adverse events. This project will engage all stakeholders and improve the experience of consumers, family and whānau and staff involved in an adverse event, as well as supporting DHBs to define a consistent approach to responding to events which result in harm or have the potential to. The focus is on improving the review process to ensure we review events appropriately and in a timely way. We will also be looking at how we action any resulting recommendations.	Q2 – 4 Q2 - 4			

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<table>
<tr><td colspan="3">Mental health and addictions improvement activities
• In order to support an independent/high quality of life please outline your commitment to mental health and addictions improvement activities with a continued focus on minimising restrictive care and improving transitions.
Please note the percentage and quality of transition plans forms part of the MH02 (formally PP7) performance measure.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Toward Zero Seclusion (TZS) Complete TZS the National collaborative between District health board (DHB) teams, mental health and addiction service consumers, the Health Quality & Safety Commission and Te Pou o te Whakaaro Nui (Te Pou), towards the elimination of seclusion by 2020
2. Improving Māori and Pacific Health Workforce Grow the Maori and Pacific workforce by increasing the number of scholarships offered to support workers and administrators to engage in the Bachelor of Nursing Programme. Increase the number of New Entrant to Specialist MH positions in Mental health and Addictions and target Maori and Pacific graduates. (EOA)
3. Marama RTF Complete implementation of the Marama Real Time Feedback project to collect client and whanau experience of the service in real time. Data collected will inform service performance and improvements.
4. Client Pathway Continue to develop and implement quality improvements for the He Ara Oranga (client pathway), ensuring best practise standards and high quality care for clients while providing visibility of digital client records that are accessible to GPs
5. ICT Implementation of the MH digital and data Intelligence projects, advancing and enabling an integrated system across the 3 DHBs, improved visibility, monitoring, and reporting through technology.</td><td>Milestone
All activities: Q1-Q4</td><td>Measure
MH02
MH05
Status update report</td><td>Government theme:
Improving the well-being of New Zealanders and their families
System outcome
We have improved quality of life</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

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6. Greater Wellington Collaborative Allocate and appoint a Psychiatrist to the MHAIDS GP Liaison service to support, and provide advice to GPS in the Wellington, Hutt Valley and Wairarapa areas. 7. Learning from Adverse Events Creating safety through practice – improving the way we learn from adverse events. This project is engage all stakeholders and improve the experience of consumers, family and whānau and staff involved in an adverse event, as well as supporting district health boards (DHBs) to define a consistent approach to responding to events which result in harm or have the potential to. Focus is on improving the review process to ensure we review events appropriately and in a timely way. We will also be looking at how we action any resulting recommendations. 8. Talking Therapies A project to increase the skills of current staff to deliver strong evidence based talking therapies and to improve access for clients to those therapies 9. Supporting Parents Healthy Children A project that aims to support MHAIDS to develop a workforce that is confident and competent to have conversations with people about their parenting and their children; knows about the SPHC resources and links to local parenting and community supports and services; is able to recognise and respond to the needs of children and their family and whanau 10. Younger persons services are focusing on reducing the number of non-attendances (DNA)				

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Addiction

- For those DHBs that are not currently meeting the *MH03 (formally PP8)* addiction related waiting times targets (for total population or all population groups), please identify actions to improve performance to support an independent/high quality of life for people with addiction issues.
- Please provide information on how your DHB is reconfiguring or expanding services in line with the AOD national model of care
- Demonstrate local level, cross-agency coordination for alcohol and other drug issues, including with local AOD service providers.
- Noting that mental health and addictions services are a priority for Government please describe how your DHB is giving appropriate priority to meeting service demands within baseline funding.

Note: DHBs should take into account both DHB provided services and those that are DHB funded but provided by NGOs.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
			System outcome	**Government priority outcome**
1. Complete the 3DHB AOD Model of care and priority pathways for Māori, Pasifika, Youth, Rural and Remote areas, and Severe AOD. **(EOA)** (3DHB)	Q3	MH03	We have improved quality of life	Support healthier, safer and more connected communities
2. Investigate Māori provider reporting options that ensure accurate reporting of waiting times and facilitate alignment with whanau ora activities.	Q1			

Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
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<table>
<tr><td colspan="3">Maternal mental health services
Please advise the actions you plan to take in 2020/2021 to ensure a continuum of care is evident for maternal mental health to increase responsiveness to women and their whānau during and post pregnancy. This includes services in primary, secondary and tertiary level. Please document the links to infant mental health services and early parenting support. Your plans should indicate how equity of access and outcomes for Māori and Pacific women are addressed and measured.</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
In 2020/21, we will develop and expand existing maternal mental health services through the following activities:
1 Implement Hapu Wananga service that engages the mother and her whānau from conception through to the first thousand days of a child’s life. (EOA)
2 Consider options to improve effective access to services according to presenting need, and enhance service integration to ensure the seamless transition of women between services.</td><td>Milestone
Q1 – Q4
Q1 – Q4</td><td>Measure
Status Update Report</td><td colspan="3">Government theme:
Improving the well-being of New Zealanders and their families
System outcome
We have health equity for Māori and other groups
Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
</table>

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2.8.5 Improving wellbeing through prevention

Preventing and reducing risk of ill health and promoting wellness is vital to improving the wellbeing of New Zealanders. As the population grows and ages, it is important to orient the health and disability system towards a public health and prevention focus. This focus, includes working with other agencies to address key determinants of health, creating supportive health enhancing environments, identifying and treating health concerns early and ensuring all people have the opportunity and support to live active and healthy lives.

PHUs have an important role to play to address key determinants of health, improve Māori health and achieve health equity and wellbeing by supporting greater integration of public health action and effort. DHBs and their PHU both have a role in contributing to improving the health and wellbeing of the population through prevention.

Please also refer to section 2.5 – responding to the Guidance.

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<table>
<tr><td colspan="3">Environmental sustainability
• Undertake actions that mitigate and adapt to the impacts of climate change, and that enhance the co-benefits to health from these actions. Where possible, actions should have a pro-equity focus. See the Supporting Information and FAQ page for further information, see section 2.6 for the link.
• As appropriate, develop and implement a sustainability action plan.
• As appropriate, identify actions that improve the use of environmental sustainability criteria in procurement processes, in line with the updated Government Procurement Rules, 4th Edition.[1]
• If already measuring emissions (or other measures of environmental sustainability, such as energy, water or waste data), please work with the Ministry of Health to report baseline measurements of emissions (or other data) to support potential future emissions targets.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Reviewing our car fleet (57 vehicles) to reduce average fleet CO2 emissions by 20% by migrating to hybrid or electronic vehicles and having fewer vehicle

2. Employer e-bike purchase support scheme for our employees to help lower our carbon footprint and our staff to stay healthy.</td><td>Milestone
Q1: analysis done
Q2-4:Fleet reduction
Q2-4: car fleet replaced with hybrid or EV

Q1 E-bike program closed</td><td>Measure
10 cars less

20% lower car fleet emission

65 e-bike purchases (10% of staff)</td><td colspan="2">Government themes:
Improving the well-being of New Zealanders and their families
Build a productive, sustainable and inclusive economy (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand)
System outcome
We have improved quality of life
Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
</table>

[1] (https://www.procurement.govt.nz/procurement/principles-and-rules/government-procurement-rules/)

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Antimicrobial Resistance (AMR)

- Identify activities that advance progress towards managing the threat of antimicrobial resistance, including alignment with the New Zealand Antimicrobial Resistance (AMR) Action Plan (2017 – 2022).

  These activities should align with the NZ AMR Action Plan's five objectives of: Awareness and understanding, Surveillance and research, Infection prevention and control, Antimicrobial stewardship, Governance, collaboration and investment.

  DHBs should work to undertake and advance AMR management across primary care, community (in particular age-related residential care services) and hospital services.

Activities that could be carried out to support AMR work can be found in the Supporting Information and FAQ page, see section 2.6 for the link.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
			System outcome	**Government priority outcome**
1. Update 3DHB antimicrobial empiric therapy guidelines	Q2	TBC	We live longer in good health	(please select **ONE** Government priority outcome for this priority)
2. Surveillance of antimicrobial usage, including annual inpatient consumption report and point prevalence survey.	Q3			Support healthier, safer and more connected communities
3. Continue surveillance of multidrug resistant organisms and Clostridium difficile.	Q1-4			
4. Maintain hand hygiene compliance above 80 percent across Wairarapa Hospital.	Q1-4			
5. Provide education on AMR and IPC to primary care and residential care services through a study day and continuing medical education sessions.	Q2			

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Drinking water

Core function – Health Protection.

- The DHB must work to ensure high quality drinking water as outlined in the drinking water section of the environmental and border health exemplar. Commit to delivering and reporting on the drinking water activities and measures in the exemplar (in Q2 and Q4).
- Please note that the drinking water section of the current Environmental and Border Health exemplar will be reviewed prior to 31 March 2020 and is likely to be changed.

A reporting template for this is available on the NSFL and the DHB quarterly reporting websites or directly from the Ministry.

Other activities that could be carried out to support drinking water work can be found in the Supporting Information and FAQ page, see section 2.6 for the link.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
			System outcome	**Government priority outcome**
1. Provide a drinking water programme as per the Environmental and Border Health Exemplar for Public Health Units. (RPH) (Core function -health protection)	Q1-4	Status update report Q2 and Q4 (and as per environmental and border health exemplar). Number, quality and usability of PHRMP's PHRA's endorsed by local iwi.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities
2. Use public health risk assessment to identify and target vulnerable populations (including communities with high Māori and Pacific peoples populations. (RPH) (Core function -health protection) **(EOA).**	Q1-4			
3. Visit all marae throughout the region to discuss their Public Health Risk Management Plans [PHRMP] (RPH) (Core function -health protection) **(EOA).**	Q1-4			
4. Undertake a public health risk assessment alongside Ngāti Kahungunu and Rangitāne to understand iwi perspective on water values and cultural impacts (RPH) (Core function -health protection) **(EOA).**	Q1-4			

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Environmental and Border Health (note that the drinking water section is separate) Core function – Health Protection. Commit to undertake compliance and enforcement activities relating to the Health Act 1956 and other environmental and border health legislation by delivering on the activities and reporting on the performance measures contained in the Environmental and Border Health exemplar. Please note that the current Environmental and Border Health exemplar will be reviewed prior to 31 March 2020 and is likely to be changed. Report in Q1, Q2, Q3 and Q4. Reporting templates are available on the NSFL and the DHB quarterly reporting websites or directly from the Ministry.			**This is an equitable outcomes action (EOA) focus area** (equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs). See section 2.6 *Expectations on developing the activities in your plan* for additional information.	
Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Undertake activities as per the Environmental and Border Health Exemplar for Public Health Units including hazardous substances; border health; emergency planning and response; resource management, regulatory environments and sanitary works; and other regulatory issues. (also refer to the drinking water section). (RPH) (Core function -health protection)	Q1-4	Status update report Q2 and Q4 (and as per environmental and border health exemplar). Number, quality and usability of PHRMP's.	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Use public health risk assessment to identify and target vulnerable populations (including communities with high Māori and Pacific people's populations. (RPH) (Core function -health protection) **(EOA)**	Q1-4			
3. Visit all marae throughout the region to discuss their Public Health Risk Management Plans [PHRMP] (RPH) (Core function -health protection) **(EOA)**	Q1-4			

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Healthy food and drink

1. Create supportive environments for healthy eating and health weight by undertaking the following activities:
   - Continue to implement your DHB Healthy Food and Drink Policy, and ensure that it aligns with the National Healthy Food and Drink Policy
   - Continue to include a clause in your contracts with health provider organisations stipulating an expectation that they develop a Healthy Food and Drink Policy covering all food and drinks sold on site/s and provided by their organisation to clients/service users/patients[2], staff and visitors under their jurisdiction. Any policy must align with the Healthy Food and Drink Policy for Organisations (https://www.health.govt.nz/publication/healthy-food-and-drink-policy-organisations)
   - Commit to reporting in Q2 and Q4 on the number of contracts with a Healthy Food and Drink Policy, and as a proportion of total contracts.
2. In line with the implementation of the Healthy Active Learning initiative, continue to report in Q2 and Q4 on the number of Early Learning Services, primary, intermediate and secondary schools that have current:
   - water-only (including plain milk) policies
   - healthy food policies. Healthy food policies should be consistent with the Ministry of Health's Eating and Activity Guidelines.

Activities that can be carried out to support healthy food and drink can be found in the Supporting Information and FAQ page, see section 2.6 for the link.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Update DHB Food and Beverage Guidelines to align with National Healthy Food and Drink Policy (drinks will remain stricter than the national policy). (including RPH).	Q2	Status update: Q2 and Q4. Water-only polices and food policies consistent with guidelines.	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Develop a standard clause stipulating an expectation that service providers have a Healthy Food and Drink Policy covering all food and drinks sold on site/s and provided by their organisation to clients/service users/patients, staff and visitors.	Q2			
3. Include the standard clause in all contracts and licences to occupy, as and when these contracts are agreed or renewed. The clause will becomes a standard inclusion in procurement and property related templates.	Q2-4			

[2] Excluding inpatient meals and meals on wheels

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4. Work with food service providers operating on site at Wairarapa DHB to ensure that they are 100% compliant with the updated Food and Beverage Guidelines by Q4. 5. Work in partnership with Sport Wellington and the Ministry of Education to provide the Healthy Active Learning programme to schools and early learning services, with a continued emphasis on (a) water-only and (b) low decile schools with higher numbers of Māori and Pacific students. Report on the number of Early Learning Services, primary, intermediate and secondary schools that have current water-only (including plain milk) policies and healthy food policies (that are consistent with the Ministry of Health's Eating and Activity Guidelines**. (EOA)** (RPH) (core function - health promotion). 6. Provide healthy food and drink promotion to all local kohanga reo and kura kaupapa Māori in te reo Māori. (EOA) (RPH) (core function - health promotion)	Q4 Q1-4 Q1-4	Q4: Ability to deliver messaging in Te Reo Māori to Kohanga Reo and Kura Kaupapa Māori.		

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Smokefree 2025

Core functions – Health Promotion, Health Protection, Health Assessment & Surveillance and Public Health Capacity Development.

- Commit to undertake compliance and enforcement activities relating to the Smoke-free Environments Act 1990. This must include delivering on the activities and reporting on the five regulatory performance measures contained in the previous Vital Few Report. Reporting templates for this are available on the NSFL and the DHB quarterly reporting websites or directly from the Ministry.
- In addition to the above, outline the activities the DHB will undertake to advance progress towards the Smokefree 2025 goal, including supporting Ministry funded wrap-around stop smoking services for people who want to stop smoking, and which address the needs of hāpu wāhine and Māori.

  Report in Q2 and Q4.
- Activities that could be carried out to support Smokefree 2025 can be found in the Supporting Information and FAQ page, see section 2.6 for the link.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
			System outcome	**Government priority outcome**
1. Undertake compliance and enforcement activities relating to the Smokefree Environments Act 1990. (RPH) (core function – health protection)	1. Report in Q2 and Q4.	1. Number of compliance and enforcement activities.	We have health equity for Māori and other groups	Support healthier, safer and more connected communities
2. Promote access to stop smoking services, particularly for priority populations (including RPH) (core function- health promotion) **(EOA)**	2. Report in Q2 and Q4.	2. Survey Māori		
3. Provide administrative support and resource to the *hapūtanga first thousand days* project alongside Te Hauora [Māori Health Provider].	3. Q1-4.			
4. Continue to support the implementation of Tapu te Hā the WrDHB Tobacco Control Plan.	4. Q1-4.			
5. Work with hapū wāhine and Māori to co-design wrap-around stop smoking services that will work for them.	5. Q1			
6. Continue Hapu Mama stop smoking incentive programme	6. Q1-Q4			

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7. Review the Kohanga Reo initiative co-designed to support Kaiako to quit smoking using the concept of shared medical appointments/group work integrated with the local stop smoking service. 8. Implement place based solutions to support Māori to quit smoking i.e. kura, sports clubs and kapa haka. 9. Review the smoke free outdoor dining café initiative led by the Cancer Society in terms of resourcing 10. Continue to support smoking brief advice and cessation support delivered by community pharmacy	7. Q1 8. Q2-Q4 9. Q1 10. Q1-Q4			

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Breast Screening

The Ministry of Health, DHBs and Breast Screening Lead Providers all have an important role in ensuring that participation targets are achieved and in eliminating equity gaps between Maori and non-Māori, Pacific and non-Pacific/non-Māori.

DHBs will describe and implement initiatives that contribute to the achievement of national targets for BreastScreen Aotearoa (BSA). All initiatives will demonstrate clear strategies for increasing health gains for priority groups and improving equitable participation and timely access to breast screening services.

ALL DHBs will describe actions to:

- Eliminate equity gaps in participation between Māori and non-Māori/Non-Pacific women and between Pacific and non-Māori/Non-Pacific women.
- Achieve a participation rate of at least 70% for Māori and Pacific women aged 50-69 years in the most recent 24 month period.

Improvement activities must be supported by visible leadership, effective community engagement and engagement with BSA Lead Providers, and clear accountability for equity. Please refer to the Supporting Information and FAQ page for further guidance, see section 2.6 for the link.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government themes:** **Improving the well-being of New Zealanders and their families**	
1. Regional Screening Services will continue to provide six **weekend breast-screening** clinics at each of the DHBs and aim to screen a target of 40 women at each clinic (dependent on medical imaging technologist resource). (Also a Cancer Services activity) (2DHB). 2. Regional Screening Service will implement more regular monthly **evening breast-screening** clinics during the working week and aim to screen a target of 15-20 women at each clinic (dependent on medical imaging technologist resource). (2DHB). 3. To support the national (BreastScreen Aotearoa) two-year pathway to achieve the 70% **screening target for Māori and Pacific women**, Regional Screening Services' recruitment and retention team will aim to support as many additional Māori	TBC	TBC	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities

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and Pacific women as possible who are overdue or unscreened to attend a breast screening clinic. **(EOA)** (2DHB) Across the 3 DHBs R&R home visit hard to reach overdue and unscreened priority women. Transport to screening appointments and assessment is also provided if needed. R&R refer priority women to ISP's who have contracts with the NSU or the RSS. There is no ISP for the Wairarapa DHB to refer to which is a gap for equity. 4. Regional Screening Services will use the results of the BreastScreen Central Mammography Project to inform changes the provide the most effective and efficient way of **increasing access to breast screening services,** with a particular focus on improving access for Māori and Pacific women. The project will look at additional fixed sites and/or a replacement mobile unit. **(EOA)** (2DHB). 5. Regional Screening Services will continue to trial same **day biopsies and first specialist appointments** at the breast symptomatic clinic to facilitate access and faster cancer treatments depending on surgeon and radiologist resource. (Also a Cancer Services activity) (2DHB).				

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Cervical Screening

ALL DHBs will set measurable participation and equity targets from baseline data and describe actions to:

- Eliminate equity gaps in participation between Māori and non-Māori/non-Pacific/non-Asian women and between Pacific and non-Māori/non-Pacific/non-Asian women and between Asian and non-Māori/non-Pacific/non-Asian women.
- Achieve a participation rate of at least 80% for Māori, Pacific and Asian woman aged 25-69 years in the most recent 36 month period.

Improvement activities must be supported by visible leadership, effective community engagement, resources and clear accountability for equity. Please refer to the Supporting Information and FAQ page for further guidance, see section 2.6 for the link.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government themes:** **Improving the well-being of New Zealanders and their families**	
			System outcome	**Government priority outcome**
Wairarapa DHB aims to achieve at least 80 percent participation of women aged 25-69 years in the most recent 36 month period, and eliminate equity gaps for priority group women. 1. Regional Screening Services will continue to **promote the key messages** around the importance and benefits of cervical screening by attending events where priority populations gather, and educating and supporting women into the screening pathway. 2. Regional Screening Services will **increase linkages with general practices** in the Wairarapa region and will work with them using data matching reports to identify and offer support to priority group Māori, Pacific, and Asian women who are unscreened and under screened**. (EOA)** (Also a Cancer Services activity) 3. Invite and support overdue and unscreened women to **combined breast and cervical screening** Saturdays. **(EOA)** (Also a Cervical Screening activity and a Cancer Services activity) 4. Provide Support to Services i.e. transport and support for women to Colposcopy Services, follow-up of overdue and not screened women identified via the PHO Data Match Reports. 5.	TBC	TBC	We have health equity for Māori and other groups	Support healthier, safer and more connected communities

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Reducing alcohol related harm

Core function – Health Promotion, Health Protection, Health Assessment & Surveillance and Public Health Capacity Development.

- Commit to undertake compliance activities relating to the Sale and Supply of Alcohol Act 2012. This must include delivering and reporting on the activities relating to the nine public health regulatory performance measures contained in the previous Vital Few report.

  Reporting templates for this are available on the NSFL and the DHB quarterly reporting websites or directly from the Ministry;

- In addition to the above, outline the activities the DHB will undertake to advance activities relating to reducing alcohol related harm.

  Report in Q2 and Q4.

Activities that DHBs could carry out to reduce alcohol related harm can be found in the Supporting Information and FAQ page, see section 2.6 for the link.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	Milestone	Measure	Government themes: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
1. Provide analytical support to by developing trends and insights for decision making from using hospital and emergency department data. (RPH) (core function – health assessment and surveillance)	Q1-4	Status update: Q2 and Q4	We have health equity for Māori and other groups	Support healthier, safer and more connected communities
2. Provide health protection activities relating to the Sale and Supply of Alcohol Act 2012. (RPH) (core function – health protection)	Q1-4			
3. Influence policies related to reducing alcohol related harm, e.g. Councils' local alcohol policies. (RPH) (core function – health promotion)	Q1-4			
4. Support communities to have a voice in local alcohol licensing decisions, alcohol and drug policy and legislation development. Communities with a high proportion of Māori, Pacific, or people on low incomes are prioritised**. (EOA)** (RPH) (core function – health promotion)	Q1-4			
5. Continue implementing the PHO led multi-agency what about you campaign focusing in on Rugby clubs	Q1-Q4			

Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
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<table>
<tr><td colspan="3">Sexual health
Core function – Health Promotion.
• Outline the activities the DHB will undertake to advance sexual health services and sexual health promotion work.
Report in Q2 and Q4.
Activities that could be carried out to support sexual health services and health promotion can be found in the Supporting Information and FAQ page, see section 2.6 for the link.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Provide information and advice to communities and health providers for sexually transmitted infections (STIs) outbreaks. (RPH) (core function – health promotion)
2. Lead collaboration with relevant sexual health services and health providers, to support sexual health workforce development. (EOA) (RPH) (core function – health promotion)
3. Support providers (e.g. Primary Care, Nurses in secondary schools, Māori Providers and Social Services) by providing ongoing support, information and advice including linking with other relevant agencies. (EOA) (RPH) (core function – health promotion)
4. Implement the National Syphilis Action Plan. (including RPH) (core function - health promotion)
5. Provide contact tracing/partner notification (RPH)</td><td>Milestone
Q1-4
Q1-4
Q1-4
Q1-4
Q1-4</td><td>Measure
Status update: Q2 and Q4</td><td colspan="2">Government themes:
Improving the well-being of New Zealanders and their families
Build a productive, sustainable and inclusive economy (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand)
System outcome
We have health equity for Māori and other groups
Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

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<table>
<tr><td colspan="3">Communicable Diseases
Core function – Health Promotion, Health Protection, Health Assessment & Surveillance, Public Health Capacity Development and Preventive Interventions.
• Outline the activities the DHB will undertake to advance communicable diseases control work.
Report in Q2 and Q4.
• Activities that could be carried out to deliver communicable diseases work can be found in the Supporting Information and FAQ page, see section 2.6 for the link.</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Improve access to infectious disease related services for Māori and Pacific peoples (RPH) (core function – health promotion) (EOA)
2. Provide a notifiable communicable disease programme to prevent, identify and respond to exiting/emerging communicable diseases including prompt follow up of notifiable communicable diseases; detect and control of outbreaks; facilitate TB drug regimens completion; and promote infection prevention, control and immunisation in community and healthcare settings. (RPH) (core function – Health Promotion, Health Protection, Health Assessment & Surveillance, Public Health Capacity Development and Preventive Interventions)</td><td>Milestone
Q1-4
Q1-4</td><td>Measure
Status update: Q2 and Q4</td><td colspan="3">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td colspan="3"></td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

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Cross Sectoral Collaboration including Health in All Policies

Core function – Health Promotion.

The wider determinants of health[3] play a major role in the health and wellbeing of the community. Many of the opportunities to control or influence the determinants of health sit beyond individuals and outside the health system.

Inequitable health outcomes are evident amongst populations with different levels of underlying social advantage/ disadvantage. This may be on the basis of socioeconomic status, ethnicity, gender, stage of the life course (children/older people), locality, or due to discrimination or marginalisation (including on the basis of disability, religious affiliation, and sexual orientation or refugee status). These inequities result in cumulative effects throughout life and across generations.

DHBs have an important role in supporting cross sectoral approaches to address the wider determinants of health and a critical role in ensuring health services themselves do not exacerbate inequities in health outcomes between population groups. Services must ensure they are accessible and relevant to all people and groups.

Health in All Policies (HiAP) is an approach to working on public policies across sectors (both health and non-health) and with communities. It systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and achieve health equity. HiAP is an evolving and ongoing process that works at both strategic and operational levels to ensure health, wellbeing, sustainability and equity issues are explicitly addressed in all policy, planning and decision-making processes.

- Outline the activities the DHB will undertake to advance work relating to implementing a cross sectoral collaboration approach, including using the HiAP model, to influence healthy public policy and thereby achieve equity.

  Report in Q2 and Q4.

Information relating to cross sectoral collaboration, HiAP can be found in the Supporting Information and FAQ page, see section 2.6 for the link.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

[3] The causes of inequities in health outcomes are complex and largely arise from the inequitable distribution of and access to, the wider determinants of health such as income, education, employment, housing and quality health care amongst populations

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Provide the Health in All Policies programme (HiAP) focusing on influencing Councils' spatial planning and district plan reviews. (EOA) (RPH) (core function – health promotion)	Q1-4	Status update: Q2 and Q4	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Continue to support and grow the Tihei Wairarapa Alliance, Te Iwi Kainga and Tūhono to design a (HiAP) process for WrDHB.	Q1-4			

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2.8.6 Better population health outcomes supported by strong and equitable public health and disability system

New Zealanders are living longer, but also spending more time in poor health and living with more disability.
This means we can expect strong demand for health services in the community, our hospitals, and other care settings.

Responding to this challenge will require effective and co-ordinated care in the community supported by strategic capital investment, workforce development and joined-up service planning to maximise system resources; to improve system sustainability, to improve health and to reduce differences in health outcomes.

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<table>
<tr><td colspan="3">Delivery of Whānau Ora
DHBs are placed to action system-level changes by delivering whanau-centred approaches to contribute to Māori health advancement and to achieve health equity.
Please identify the significant actions that the DHB will undertake in this planning year to:
• contribute to the strategic change for whānau-centred approaches within the DHB systems and services, across the district, and to demonstrate meaningful activity moving towards improved service delivery
• support and to collaborate, including through investment, with the Whānau Ora Initiative and its Commissioning Agencies and partners, and to identify opportunities for alignment.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Collaborate with Te Pou Matakana and Whānau Ora providers within WrDHB to implement and identify opportunities for service delivery, service mix and investment.
2. Continue working with local Māori health providers to jointly develop systems for collecting and analysing data.</td><td>Milestone
Q1-4
Q1-4</td><td>Measure
Quarterly status reports</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families
System outcome
We have health equity for Māori and other groups
Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
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<table>
<tr><td colspan="3">Pacific Health Action Plan
• Commit to supporting delivery of the Pacific Health Action plan once it is agreed.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
1. Co-design, support and develop services that best meet the needs of our Pacific population, especially services delivered locally in primary care.
2. Investigate opportunities to grow local leadership alongside support from the Director Pacific Health.
3. Resource pacific health promotion opportunities in breast and cervical screening.</td><td>Milestone
Q1-4
Q1-4
Q1-4</td><td>Measure
Status Reports
Increase in Pacific representation on decision making tables
Increase in uptake of free screening for Pacific women</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td></td><td></td><td></td><td>System outcome
We have health equity for Māori and other groups (Pacific).</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
</table>

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Care Capacity Demand Management (CCDM)

- Detail the actions that you will take towards to ensure fully implementing Care Capacity Demand Management (CCDM) for nursing and midwifery in all units/wards by June 2021 in your annual plans.
- Outline the most significant actions the DHB will undertake in 2020/21 to progress implementation of CCDM in each component of the programme; governance, patient acuity data, core data set, variance response management and FTE calculations.

Ensure the equitable outcomes actions (EOA) are clearly identified.

This is an equitable outcome action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
1. Prioritise ICT system support for CCDM implementation; then achieve required level of ICT system interface and functionality to enable CCDM systems to be embedded.	Q1	Achievement of Planned Activities	We live longer in good health	Support healthier, safer and more connected communities
2. Complete TrendCare version 3.6 upgrade project for all inpatient areas.	Q1			
3. Complete FTE calculations, roster adjustments and business cases for any required additions to FTE.	Q2			
4. Scope end user requirement and develop business case for ICT hardware support to CCDM establishment of variance response management systems (integrated operations centre, electronic white boards, hospital at a glance technology).	Q2			
5. Expand TrendCare system engagement alongside and aligned to CCDM programme expansion.	Q2			
6. Complete governance framework with establishment of inpatient quality group BAU activities aligned to quality improvement, safety, professional development. ***EOA*** – These groups will be developing improvement initiatives designed to improve health outcomes and equity; promote relationship centred care; and enhance healthcare environments.	Q2			
7. Establish 'paper-based' variance response management processes and systems in preparation for the introduction of automated variance response management.	Q3			

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<table>
<tr><td colspan="3">Disability Action Plan
Commit to working with the Ministry of Health to develop your own or a regional Disability Action Plan to be published by July 2021. The purpose of the Plan is to improve access to quality health services and improve the health outcomes of disabled people. The Plan will focus on data, access and workforce.</td><td colspan="2">This is an equitable outcomes action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
There is a 3DHB Strategy that is in place 2017-2022.
1. Extend data governance working group.
2. Source and secure Data points across the 3 DHBs and external partners.
Redesign information requirements of referrals ensuring disability is detailed and appropriate t
3. inform a data strategy for the purpose of improving health outcomes.
4. Education processes to enhance data capture are developed and actioned across the DHBs.</td><td>Milestone

Q1
Q2
Q4

Q4</td><td>Measure
Status Update Report</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td></td><td></td><td></td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

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Disability

Statistics NZ surveys consistently show that disabled people experience poorer outcomes across multiple domains, including income, employment and health compared with non-disabled people.

Disabled people are generally at higher risk of illness than non-disabled people. People with intellectual disabilities and Māori with disability have some of the poorest health outcomes of any group in the country, and are at higher risk of illness, disease, disability and early death. This is an important ongoing challenge for the health and disability system.

Inequity of access to health care and health outcomes for disabled people both within the health and disability support system and nationally is not comprehensively assessed or measured.

In New Zealand, health data collection on disabled people is limited. Health data on the general disability population is needed to assess disabled peoples' health and wellbeing and examine inequalities in health and wellbeing outcomes within the group and with non-disabled people.

- Commit to ongoing training for front line staff and clinicians that provides advice and information on what needs to be considered when interacting with a person with a disability. Report on what percentage of staff have completed the training by the end of quarter 4 2020/21.
- Outline in your plan how the DHB knows if a patient has a disability and communicates this to staff. (This is to ensure that staff can respond to the person's disability needs, especially communication).
- Outline in your plan how the DHB will work with the Ministry of Health ensure that key health information for the public and public health alerts and warnings are accessible by people with a disability.
- Report on the number of key public health information messages, public health alerts and warnings your DHB issues each year and the number of these translated into New Zealand Sign Language by the end of quarter 4 2020/21. (See the Supporting Information and FAQ page for further information, see section 2.6 for the link.

This is an equitable outcome action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
			System outcome	**Government priority outcome**
1. Provide a human rights based staff training framework, one that promotes equity and barrier free engagement with health services by disabled people. This will result in significant attitudinal change across the DHB's. Core disability responsive education will comprise of an initial e-learning programme of three modules that all staff must complete. This programme will ensure that all staff have foundational knowledge about disability, the rights based approach, the importance of attitude and how to	Q2	Status Update Report		

make reasonable accommodations. Once this core learning has been completed additional modules can be provided that gradually build on knowledge and information as required - this can be taken to advanced levels. 2. Deployment of effective disability alert system that is evident on all patient records. This will include a launch and education program for the workforce. 3. Collaborate with the Ministry on targeted engagement by DHB's with disabled people in each region. 4. Health information is to be accessible for disabled people in ways that promote their independence and dignity. The DHB is committed to working progressively to ensure all information intended for the public is accessible to everyone and that everyone can interact with services in a way that meets the individual need to promote their independence and dignity. NZSL will be used to convey public alerts across the DHB. 5. Finalise the revised hard copy Health Passport and launch, with education program for public and staff across the 3 DHBs: (a) Agree version of prototype e-version of Health Passport	Q4 Q2 Q4 Q3; (a) Q4		We have health equity for Māori and other groups	Ensure everyone who is able to, is earning, learning, caring or volunteering

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Planned Care

Planned Care Vision: 'New Zealanders receive equitable and timely access to Planned Care Services in the most appropriate setting, which supports improved health outcomes'.

Planned Care is patient centred and includes a range of treatments funded by DHBs, which can be delivered in inpatient, outpatient, primary or community settings. It includes selected early intervention programmes that can prevent or delay the need for more complex healthcare interventions. Planned Care includes, but is a wider concept than, the medical and surgical services traditionally known as Electives or Arranged services.

Planned Care is centred around five key principles, (Equity, Access, Quality, Timeliness and Experience) which build on the Electives policy principles of clarity, timeliness and fairness. (Planned Care Engagement support pack and FAQs is available on QUICKR)

In 2020/21 DHBs will be in the first year of implementing their Three-Year Plans to improve Planned Care delivery. The Three-Year Plans will be addressing the five Planned Care Strategic Priorities of:

- *Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed.*
- *Balance national consistency and the local context*
- *Support consumers to navigate their health journeys*
- *Optimise sector capacity and capability and*
- *Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future.*

DHB Annual Plans will identify five key actions (one for each Strategic Priority) that will be undertaken in 2020/21 as part of the Three-Year Plan.

DHBs are expected to engage with DHB Consumer Councils and other key stakeholders in the ongoing implementation of their plan.

DHB plans need to be explicit about **HOW** their planned actions will address the Strategic Priorities for Planned Care and the five underling principles, and will:

- enable delivery of the agreed level of Planned Care interventions
- prioritise patients using nationally recognised prioritisation tools
- ensure patients wait no longer than the clinically appropriate time for a specialist assessment or treatment

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

DHBs should identify who in their population is experiencing inequities and include actions or strategies to address these inequities.

<table>
<tr><td colspan="5">

- identify and address inequities in access to Planned Care services.

Delivery and improvements will be measured against the agreed Planned Care Measures, and quarterly qualitative reports.

</td></tr>
<tr><td>Activity

In 2020/21, the DHB will be implementing the first year of its Three-Year Plan to improve Planned Care delivery.

[Placeholder - More detail required here to meet MOH expectations above. 3 Year Plan due by end of 19/20]</td><td>Milestone

Q1-Q4</td><td>Measure

SS07
Planned Care Measures</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td colspan="3"></td><td>System outcome
(please select ONE system outcome for this priority)
We have health equity for Māori and other groups
OR
We live longer in good health
OR
We have improved quality of life</td><td>Government priority outcome
(please select ONE Government priority outcome for this priority)
Support healthier, safer and more connected communities
OR
Make New Zealand the best place in the world to be a child
OR
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

Acute Demand

Following on from your 2019/20 activities please provide:
Acute Data Capturing:

- a plan on how the DHB will implement SNOMED coding in Emergency Departments to submit to NNPAC by 2021. For example, this should include a description of the information technology actions and ED clinical staff training actions, milestones and timeframes.

Acute Demand:

- a plan on how the DHB will address the growth in acute inpatient admissions. This should include detail on: how patients will be better managed in the community, emergency department and hospital, and; the organisations that you will work with to plan and achieve improvements.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

DHBs should identify who in their population is experiencing inequities and include actions or strategies to address these inequities.

Activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome	**Government priority outcome**
1. Continue working with ACC to implement the Wairarapa programme for reducing the incidence and impact of falls across Primary Care, Community and in home settings and hospital services.	Q1 – Q4	SS04: Implementing the Healthy Ageing Strategy	We live longer in good health	Support healthier, safer and more connected communities
2. Reduce inappropriate hospital admissions by providing safe and supportive post discharge processes for those identified at risk of readmission. Implement trial of post discharge navigation with people identified at risk of readmission and their whānau to increase health literacy, self-management and resilience.	Q2 & Q4	SS10: Shorter stays in emergency departments		
3. Support rehabilitation closer to home following an acute episode. Develop service for rehabilitation in the community and align with other community based developments – To encompass ACC non-Acute rehab (NAR), MAP and implementation of national community stroke rehabilitation guidelines.	Q4			
4. Monitor implementation and outcomes of Health Care Home model, including the measure of reduction of acute presentations (specifically with an equity lens).	Q1 – Q4	SS05: Ambulatory Sensitive Admissions (ASH adults)		
5. Implement local palliative care resource for supporting generalist health professionals across the Wairarapa to achieve optimum outcomes for their patients.	Q1 – Q4			

Rural health Please describe a minimum of two actions that improve access [eg outreach clinics, use of technology, financially, convenience (extended hours)] to services in rural communities.			**This is an equitable outcomes action (EOA) focus area** (equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).	
Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Continue the South Wairarapa practices collaboration to provide extended hours to the South Wairarapa population.	Q1-Q4	Rural Health quarterly report. SSO4: Implementing the Healthy Ageing Strategy. SS05: Ambulatory Sensitive Admissions (ASH adults). CW09: Better Help for Smokers to Quit (Maternity). CW10: Raising Healthy kids.	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Work with rural practices to implement annual rural alliance plan focusing on Workforce sustainability and facility development to ensure good access to primary care remains for rural communities.	Q1-Q4			
3. Survey community leaders in South Wairarapa to understand the best approach to youth health service delivery.	Q2			
4. Extend reach of psycho-social support for people with life limiting conditions, especially family/whānau carers to South Wairarapa	Q1-Q2			
5. Extend reach of Kaupapa Māori antenatal education programme to South Wairarapa targeting young Māori mothers to be.(EOA)	Q3			
6. Optimise local community connections to improve senior's wellness and social connectivity and to address the growing rates of senior loneliness and social isolation.	Q1-Q4			
7. Establishment of Day Activity Programme in the community for older people and those with long term conditions to support family carers in South Wairarapa.	Q2			
8. Optimise capacity of rural dental bus to provide treatments for targeted populations e.g. removal of ear wax for children of low-decile families.	Q1-Q4			

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Healthy Ageing

Implement actions identified in the Healthy Ageing Strategy 2016 and contribute to the Government's priority of 'Improving the wellbeing of New Zealanders and their families', as follows:

- working with ACC, HQSC and the Ministry of Health to promote and increase enrolment in Strength & Balance programs and improvement of data driven osteoporosis management especially in alliance with Primary Care as reflected in the associated "Live Stronger for Longer" Outcome Framework (This expectation aligns most closely to the Government's 'Prevention and Early Detection' priority outcome; and the Ageing Well and Acute and Restorative Care goals of the Healthy Ageing Strategy)
- working with ACC on the non-acute rehabilitation pathway service objectives to help older people regain or maintain their ability to manage their day-to-day needs after an acute episode (This expectation aligns most closely to the Government's 'Health Maintenance and Independence' priority outcome; and the Acute and Restorative Care goals of the Healthy Ageing Strategy)
- aligning local DHB service specifications for home and community support services (HCSS) to the vision, principles, core components, measures and outcomes of the national framework for HCSS (This expectation aligns most closely to the Government's 'Health Maintenance and Independence' priority outcome; and the Living Well with Long-Term Conditions goal of the Healthy Ageing Strategy)

In addition, please outline current activity in the community and primary care settings in particular to identify frail and vulnerable older people, with a focus on Māori and Pacific peoples, and put interventions in place to prevent the need for acute care and restore function (This expectation aligns most closely to the Government's 'Prevention and Early Detection' priority outcome; and the Acute and Restorative Care goal of the Healthy Ageing Strategy.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Continue working with ACC to implement the Wairarapa programme for reducing the incidence and impact of falls across Primary Care, Community and in home settings and hospital services.	Q1 - Q4	**SSO4: Implementing the Healthy Ageing Strategy:** 1. Ageing well 2. Ageing well	**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
2. Support a regional approach to implementing the Dementia Framework locally	Q1-Q4			
3. Support rehabilitation closer to home following an acute episode. Develop service for rehabilitation in the community and align with other community based	Q4			

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developments – To encompass ACC non-Acute rehab (NAR), MAP and implementation of national community stroke rehabilitation guidelines. 4. Reduce inappropriate hospital admissions by providing safe and supportive post discharge processes for those identified at risk of readmission. Implement trial of post discharge navigation with people identified at risk of readmission and their whānau to increase health literacy, self-management and resilience. **5.** Align the Wairarapa model for integrated support of older people with the National framework for Home and Community Support services. 6. Establish a palliative care 'coach' role to support ARC providers to strengthen knowledge and skill of the workforce and endorse their role in the Wairarapa integrated palliative care model.	Q2 &Q4 Q2, Q3 & Q4 Q1 - Q4	3. Acute and Restorative Care 4. Living well with long term conditions 5. Living well with long term conditions 6. A Respectful end of Life		

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Improving Quality

1. Improving equity

Using the Health Service Access Atlas (Atlas of Healthcare Variation) which reports seven questions from the national primary care patient experience survey, consider which of your patient groups are experiencing the most barriers.

Specify improvement activity to address these barriers and drive equity of outcomes in one of the three identified topics of:

- Diabetes
- Gout
- Asthma.

Please ***specify the measure including baseline and anticipated improvement***.

The Health Service Access Atlas has a tab (long-term conditions - LTCs) that allows you to filter responses by one of six LTCs.

2. Improving Consumer engagement

DHBs are expected to participate in the quality and safety marker for consumer engagement by:

- Setting up a governance group (or an oversight group) of staff and consumers to guide implementation of the marker
- Upload data onto the consumer engagement QSM dashboard using the SURE framework as a guide
- Report against the framework twice yearly.

3. Spreading hand hygiene practice *for Canterbury, Hawke's Bay, Hutt Valley, Northland, Taranaki, Tairāwhiti, Waikato and Whanganui DHBs only*

Identify actions to increase compliance with best practice hand hygiene (as defined by the Hand Hygiene NZ programme) across hospital clinical areas and across categories of healthcare workers. Please specify actions and measures.

4. Zero Seclusion, National Mental Health & Addiction Programme *for Bay of Plenty, Canterbury, Nelson Marlborough, Northland and Waikato DHBs only*

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

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Specify actions that will contribute towards zero seclusion in your DHB. Please include how you will use the family of measures, including outcome, process and balancing measures, for Zero Seclusion (e.g. demonstration of where project teams regularly use data to inform improvement work).

System Level Measures

Implementation of the System Level Measures (SLMs) continues in 20120/21. The *Guide to Using the System Level Measures Framework for Quality Improvement* (SLM guide), which has been updated and should be used for the development of the Improvement Plans and should be used in conjunction with *The System Level Measures – Annual Plan guidance 20/21*

Activity	**Milestone**	**Measure**	**Government theme: Improving the well-being of New Zealanders and their families**	
			System outcome	**Government priority outcome**
Improving equity 20/21 'priority equity project' TBC. **Improving Consumer engagement** *** draft only, needs further discussion with HQSC as details of QSM programme still in pilot phase, activities will need to be discussed/co-designed with Consumer Council and fit within overall new strategic plan to ensure it is a strategic priority to ensure consumer engagement is embedded at all levels of our service with the aim to improve engagement, equity and services across the wider health service, not just hospital.* 1. Identify a governance group, existing or new (possibly the Consumer Council), to oversee the implementation of the Consumer Engagement Quality Safety Marker. 2. Identify the most efficient methodology to gather and upload the data required to meet the Consumer Engagement QSM dashboard requirements and reporting framework, including evidence of engagement, responsiveness and experience.	Q2 – upload QSM data by Dec 2020. Q2 – confirm TOR of governance group. Q4 – combined review of primary care and adult inpatient survey results using new survey tool.	TBC	We have health equity for Māori and other groups	Support healthier, safer and more connected communities

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New Zealand Cancer Action Plan 2019 – 2029	**This is an equitable outcomes action (EOA) focus area**
Please review the information found in the Supporting Information and FAQ page to support you with this section, see section 2.6 for the link. On 1 September 2019 the Prime Minister and Minister of Health launched the New Zealand Cancer Action Plan 2019-2029 (the Plan). The Plan outlines four key outcomes; *Outcome 1: New Zealanders have a system that delivers consistent and modern cancer care.* *Outcome 2: New Zealanders experience equitable cancer outcomes.* *Outcome 3: New Zealanders have fewer cancers* *Outcome 4: New Zealanders have better cancer survival.* District Health Boards will have key responsibility for the successful achievement of these outcomes. The plan is guided by three overarching principles: • equity-led • knowledge-driven • outcomes-focused. The Plan enables the Ministry of Health, the sector and all those affected by cancer to work collaboratively to prevent cancer and improve detection, diagnosis, treatment and care after treatment. The Plan includes primary care, tobacco control, screening and palliative care. Effective planning, skilled management and informed governance is required to deliver the outcomes in this plan. The Plan sets out the actions required over the next 10 years and beyond. Work on the priority actions has commenced. The Plan is a living document and it will be reviewed and updated in five years, to ensure our efforts stay relevant to the needs and aspirations of all New Zealanders. The actions will be reviewed by the Interim Cancer Control Agency Board and adjusted as required to ensure the plan is on track. The Ministry has established a National Cancer Control Agency and appointed a National Director of Cancer Control. DHBs are required to work with and take direction from the Cancer Control Agency. The Agency has a leadership and monitoring function and will be required to report progress against performance of the Plan to the Minister. The Plan requires that services are delivered against nationally agreed standards of care and that quality improvements will be made for agreed quality performance indicators as they are further developed across all	(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs). See section 2.6 *Expectations on developing the activities in your plan* for additional information. DHBs should identify in both part one and two who in their population is experiencing inequities and include actions or strategies to be implemented to address the identified inequities.

tumour streams. Quality Performance Indicators have been developed for Bowel Cancer and it is expected that both lung and prostate indicators will be published in early 2020.

DHBs need to outline the actions they will take in order to support the following:

Part One: Current Performance Actions

1. DHBs are required to outline what actions they will take to sustain or improve cancer care and implement the Cancer Plan. Actions need to include how DHBs will ensure that the 31-day and 62-day cancer waiting time measures are met. (See definitions and business rules in the DHB non-financial monitoring framework and performance measures - reporting section). Quarterly qualitative reports will be required.

Part Two: Three-Year Plan for Cancer Care

2. In 2020/21 DHBs are required to plan, design and start implementation of a Three-Year Plan to improve Cancer services. The Plan is required to include a description of actions that demonstrate how DHBs will address priorities in the Cancer Plan. Further information will be provided to DHBs in early 2020 as the Cancer Agency identifies its priorities.

DHBs are expected to engage with DHB Consumer Councils and other key stakeholders in the development of their Plan.

Improving quality contributes to Outcome 1: (New Zealanders have a system that delivers consistent and modern cancer care) and Outcome 4 (New Zealanders have better cancer survival) of the New Zealand Cancer Action Plan 2019-2029

Healthy food and drink, smokefree 2025, breast screening, cervical screening and bowel screening priorities also contributes to Outcome 3: (New Zealanders have fewer cancers) of the New Zealand Cancer Action Plan 2019-2029

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
[PLACEHOLDER]	(DHB selected milestone)	(DHBs select the most appropriate measure/s note: when measures are reported, data	**System outcome** (please select **ONE** system outcome for this priority)	**Government priority outcome** (please select **ONE** Government priority

Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
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		should be disaggregated by ethnicity and other demographic information where data allows)	We have health equity for Māori and other groups **OR** We live longer in good health **OR** We have improved quality of life	outcome for this priority) Support healthier, safer and more connected communities **OR** Make New Zealand the best place in the world to be a child **OR** Ensure everyone who is able to, is earning, learning, caring or volunteering

Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
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Bowel Screening and colonoscopy wait times

To ensure all patients requiring diagnostic procedures are treated fairly and seen within maximum clinical wait times, the Ministry of Health has developed a dedicated framework for monitoring symptomatic colonoscopy and bowel screening performance. New reporting requirements sit alongside a new escalation process that ensures both the recommended colonoscopy wait times and the numbers of people waiting longer than maximum wait times receive equal focus.

As a DHB prepares to implement bowel screening, it must be consistently meeting all diagnostic colonoscopy wait times and have no patients waiting longer than maximum wait times in the months prior to the readiness assessment. If a DHB does not meet these two requirements, it will not meet the National Bowel Screening Programme readiness criteria, and its go-live date may be delayed.

All DHBs will describe actions to ensure:

- recommended urgent, non-urgent and surveillance diagnostic colonoscopy wait times are consistently met
- there are no people waiting longer than the maximum wait times for any indicator.

In addition to above, DHBs providing the National Bowel Screening Programme will describe actions to ensure:

- they have demonstrated clear strategies for improving equitable participation and timely access to bowel screening services
- the bowel screening indicator 306 target requiring 95% of participants who returned a positive FIT to have a first offered diagnostic date that is within 45 working days of their FIT result being recorded in to the NBSP IT system is consistently met
- they achieve participation of at least 60% of people aged 60-74 years in the most recent 24-month period
- participation equity gaps are eliminated for priority groups.

Improvement activities must be supported by visible leadership, effective community engagement, and clear accountability for equity. Please refer to the Supporting Information and FAQ page for further information, see section 2.6 for the link.

This is an equitable outcome action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government theme:**
[PLACEHOLDER]			**Improving the well-being of New Zealanders and their families**

Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
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	(DHB selected milestone)	(DHBs select the most appropriate measure/s note: when measures are reported, data should be disaggregated by ethnicity and other demographic information where data allows)	**System outcome** (please select **ONE** system outcome for this priority) We have health equity for Māori and other groups **OR** We live longer in good health **OR** We have improved quality of life	**Government priority outcome** (please select **ONE** Government priority outcome for this priority) Support healthier, safer and more connected communities **OR** Make New Zealand the best place in the world to be a child **OR** Ensure everyone who is able to, is earning, learning, caring or volunteering

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Workforce

In responding to this priority area please cross-reference to Section four: Stewardship - Workforce section

DHB workforce priorities

- Set out any workforce actions, specific to your DHB that you intend to work on in the 2020/21 planning year. Outline how these actions relate to both a strong public health system and EOA focus area actions. Ensure that you have considered workforce actions for the priority areas in your plan.

  Any workforce actions should be mindful of:

  - ongoing responsibilities for the upskilling, education and training of health work forces
  - the population health need that initiatives are designed to address. In addition, we expect workforce actions to lead to improved equity in health outcomes and independence for Māori and Pacific peoples
  - the desired health outcomes the initiatives will help to address, including equitable outcomes for populations
  - an assessment of how the initiatives align with the priority areas of strong fiscal management, strong public health system, and primary care
  - evidence that consideration has been given to making best use of the service delivery mechanisms that make best use of transdisciplinary teams to support health workforces in their roles across primary, secondary and tertiary settings.
- It is also expected that DHBs will develop actions that support equitable funding for professional development for nurse practitioners.

Workforce Diversity

This action area builds upon actions set out in the previous planning year to better understand the workforce intelligence gathered at local, regional and national levels and how this intelligence assists DHBs in workforce planning.

DHBs will work in collaboration with DHB Shared Services and, where appropriate, with the Ministry of Health to:

- collect workforce data and intelligence to support workforce planning at a local, regional and national level
- develop actions to meet the six targets agreed by DHB Chief Executives in support of Te Tumu Whakarae's position statement on increasing Māori participation in health and disability work forces
- support your responsibility to upskill, provide education and train health and disability work forces

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Examples of equity actions that could be included in your plan:

- increase Māori participation and retention in health workforces and ensure that Māori have equitable access to training opportunities as others
- increase participation of Pacific people in health workforces
- build cultural competence across the whole health workforce
- actions that facilitate healthy and culturally reinforcing working environments that support health equity.
- actions that support Māori and Pacific peoples into leadership and management roles.

- provide training placements and support transition to practice for eligible health work force graduates and employees. Planning must include PGY1, PGY2 and CBA placements, and how requirements for nursing, allied health, scientific and technical health work forces in training and employment will be met
- continue to build alliances with training bodies such as educational institutes (including secondary and tertiary), professional colleges, responsible authorities, and other professional societies to ensure that we have a workforce with the right skills, in the right place, at the right time.

Health Literacy

The purpose of the actions set out in this advice is to build upon the health literacy action plan that your DHB completed in the 2019/20 planning year towards developing a health literate organisation.

- If you do not have one already in place, continue to develop a Health Literacy Action Plan that describes the service improvements you plan to make in the short, medium and long term.
- Building on your Health Literacy Action Plan, and if not already included in the action plan, please consider any actions that your DHB can do to support to build health literacy in the wider health and disability system.

  For example, you may wish to consider developing actions that support:
  - improving the health literacy of non-clinical staff
  - working with Primary Care to identify and support health literacy education and training needs
  - building on the health literacy of patients, carers and volunteers through providing health literacy education, and information and training specially tailored for volunteers.

Where health literacy actions are set out in other sections of the annual plan ensure that these are considered within the Health Literacy Action Plan, as well as briefly cross-referencing these actions in this section.

Cultural safety

The Health and Disability System Review Interim Report / Pūrongo mō tēnei wā recently released notes the need to both build cultural competence of the entire health and disability workforce and to reduce institutional racism. The Health Services and Outcomes Kaupapa Inquiry (Wai 2575) raises institutional racism as a significant issue for Māori health – both for staff and for people accessing services. In order to meet the needs of and improve outcomes for groups such as Māori, Pacific, migrants and refugees then our work places must be healthy and culturally reinforcing working environments that support health equity.

- In the 2020-21 planning year we want DHBs to consider how they 'do' cultural safety and to identify actions to support cultural safety within their DHB. This may include reference to related actions that are already underway within your DHB.

<u>Leadership</u>

- Please identify actions, initiatives and programmes that your DHB has in place to support staff who are in, and staff who are progressing into leadership, management and governance roles.
- Please identify which actions/initiatives/programmes facilitate healthy and culturally reinforcing working environments that support health equity.

  Leadership pathways may include actions, plans and programmes for:
  - growing leaders
  - supporting new managers into management roles
  - supporting workforces into governance roles
  - supporting clinical leadership and clinical governance
  - succession planning for executive leadership roles
  - supporting Māori and Pacific peoples into leadership, management and governance roles.

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
Turning Values into Action		SS19: Workforce outyear planning.	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
1. Implement values based recruitment practises across the DHB ensuring alignment with the organisational values. This will incl a focus on equity: - Collecting data relating to Maori applicants - Interviewing all eligible Maori applicants - Consideration of Ti Kanga in selection processes - All interview processes to incl Treaty and Cultural focused questions	Q1/Q2			
2. Development of collection and reporting of workforce data to incl information on maori demographics incl iwi of workforce -Set targets in relation to workforce reflecting community	Q1/Q2			

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3. Ensuring our values and culture support a safe work environment including the connection of cultural competency framework.	Q1-Q4			
4. Review and change core organisational training and development requirements to align with new values and a focus on building constructive workforce relationships.	Q1-Q4			
5. Development of HRIS system to address Holidays Act Compliance issues and to developing better reporting on people data	Q1-Q4			
6. Review and develop performance and remuneration framework to attract and retain the right workforce delivering ensuring alignment with regional and national acitivty	Q3/4			
7. Work with the Ministry of Health, regional DHB shared services and unions to progress addressing issues around pay equity and the gender pay gap.	Q1-Q4			
8. Progress the implementation of the Care Capacity Demand Management (CCDM) programme, with the goal of full implementation by 30 June 2021.	Q1-Q4			
9. As part of the Kia Ora Hauora programme the DHB will develop a plan to connect with educational institutes within the region to develop interest in health careers moving forward.	Q1-Q4			

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Data and Digital

In responding to this priority area please cross-reference to Section four: Stewardship - IT section

All DHBs:

- List all major digital initiatives, and associated milestones, and indicate multi-year initiatives.
- Explain how your IT Plan is aligned with the Regional ISSP.
- Note the digital systems/investments that will improve equity of access to services.
- Note the initiatives that demonstrate collaboration across community, primary and secondary care.
- Describe plans/initiatives that will enable the delivery of health services via digital technology for example telehealth, integrated care and working remotely.
- Indicate plans for providing consumers with access to their health information.
- Indicate plans for taking part in the digital maturity assessment programme and/ or implementing an action plan following the assessment.
- Indicate plans for implementing/maintaining Application Portfolio Management to improve asset management.
- Indicate plans to leverage approved standards and architecture in all digital system initiatives and investments.
- Indicate how IT security maturity will be improved across all digital systems.
- Indicate plans for improving alignment with national digital services, national data collections and data governance and stewardship.
- Submit quarterly reports on the DHB ICT Investment Portfolio to Data and Digital.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
			System outcome	**Government priority outcome**
Activity *(strategic intentions of the 3DHB ICT services outlined in Section 4: Stewardship)* **1. Achieving stability of critical systems - Concerto clinical portal consolidation:** This 3DHB initiative will bring Concerto back into support, provide consistent features and enable sharing of patient information across the three DHBs. This will reduce long run costs of the clinical portal, and enable migration to regional	Q4	(DHBs select the most appropriate measure/s note: when measures are	We have health equity for Māori and other groups	Support healthier, safer and more connected communities

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infrastructure. This will also ensure that there is consistent clinical service experience for Māori and other groups across the three DHBs. The software component of this project is an enabler for electronic referrals. CCDHB migrated onto the new Concerto instance 01 May 2021. **(EOA)** **2. Significant improvement to operational efficiency and patient care – Mobile Electronic Patient Observations:** This project is delivering the implementation of a platform for Patient Observations, Early Warning Score Management and Nursing Documentation across our three DHBs. First deployment into the CCDHB children's ward by Q2. 3. **Transforming services to be fully digital - Digital Workplace** The goal of this programme of work is to minimise digital boundaries so staff can securely connect to DHB information anywhere, anytime, anyway. This will transform how our people operate enabling more effective and efficient service delivery. The work is a multi-year change programme based on digital workplace tools such as Information Management, Microsoft Teams, increasing mobility of our workforce, and providing a single interface where a person can access everything they need to do their job. Activities include: first iteration of modern desktop Q1; First delivery of communication tools (i.e. exchange online) Q2; Implemented knowledge management framework Q3. 4. **Mandated outcome - Fax end of life** The Ministry of Health have mandated phasing out the use of analogue fax by health sector agencies by December 2020. The MOH mandate is to support secure digital communication within the NZ health and disability sector. First use case made fax free September 2020. All fax use cases have work arounds or is on new technology by Q4.	Q2 Q3 Q4	reported, data should be disaggregated by ethnicity and other demographic information where data allows)		

<table>
<tr><td colspan="3">Implementing the New Zealand Health Research Strategy
Research and innovation, analytics and technology are all crucial for achieving an equitable, sustainable health system and better patient outcomes.
Commit to working with the Ministry of Health to co-design and co-invest in a programme of work to support the implementation of the New Zealand Health Research Strategy through building the capacity and capability across DHBs to enhance research and innovation.
Identify how you are working regionally to create research and analytics networks to support staff engaged with research and innovation and build capacity and capability.
Identify how research policies and procedures will be developed for your DHB to ensure that clinical staff have a supportive framework to engage in research and innovation activities.
Commit to provide a one-page summary update on progress in Q4 to the Ministry and your DHB Board.</td><td colspan="3">This is an equitable outcome action (EOA) focus area
(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity
[PLACEHOLDER]</td><td>Milestone
(DHB selected milestone)</td><td>Measure
(DHBs select the most appropriate measure/s note: when measures are reported, data should be disaggregated by ethnicity and other demographic information where data allows)</td><td colspan="3">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td colspan="3"></td><td>System outcome
(please select ONE system outcome for this priority)
We have health equity for Māori and other groups
OR
We live longer in good health
OR
We have improved quality of life</td><td colspan="2">Government priority outcome
(please select ONE Government priority outcome for this priority)
Support healthier, safer and more connected communities
OR
Make New Zealand the best place in the world to be a child
OR</td></tr>
</table>

				Ensure everyone who is able to, is earning, learning, caring or volunteering

Delivery of Regional Service Plan (RSP) priorities and relevant national service plans • Identify any significant actions the DHB is undertaking to deliver on the Regional Service Plan. In addition to the above: <u>Hepatitis C</u> • DHBs are asked to identify their role in supporting the delivery of the regional hepatitis C work and objectives. Action include for example how DHBs will: ○ work in collaboration with other DHBs in the region to implement the hepatitis C clinical pathway ○ work in an integrated way to increase access to care and promote primary care prescribing of the new pangenotypic hepatitis C treatments ○ support implementation of key priorities in the National Hepatitis C Action Plan.			**This is an equitable outcomes action (EOA) focus area** (equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs). See section 2.6 *Expectations on developing the activities in your plan* for additional information.	
Activity ***[PLACEHOLDER]***	**Milestone** (DHB selected milestone)	**Measure** (DHBs select the most appropriate measure/s note: when measures are reported, data should be disaggregated by ethnicity	**Government theme:** **Improving the well-being of New Zealanders and their families**	
			System outcome (please select **ONE** system outcome for this priority) We have health equity for Māori and other groups **OR** We live longer in good health	**Government priority outcome** (please select **ONE** Government priority outcome for this priority) Support healthier, safer and more connected communities **OR**

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		and other demographic information where data allows)	**OR** We have improved quality of life	Make New Zealand the best place in the world to be a child **OR** Ensure everyone who is able to, is earning, learning, caring or volunteering

Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
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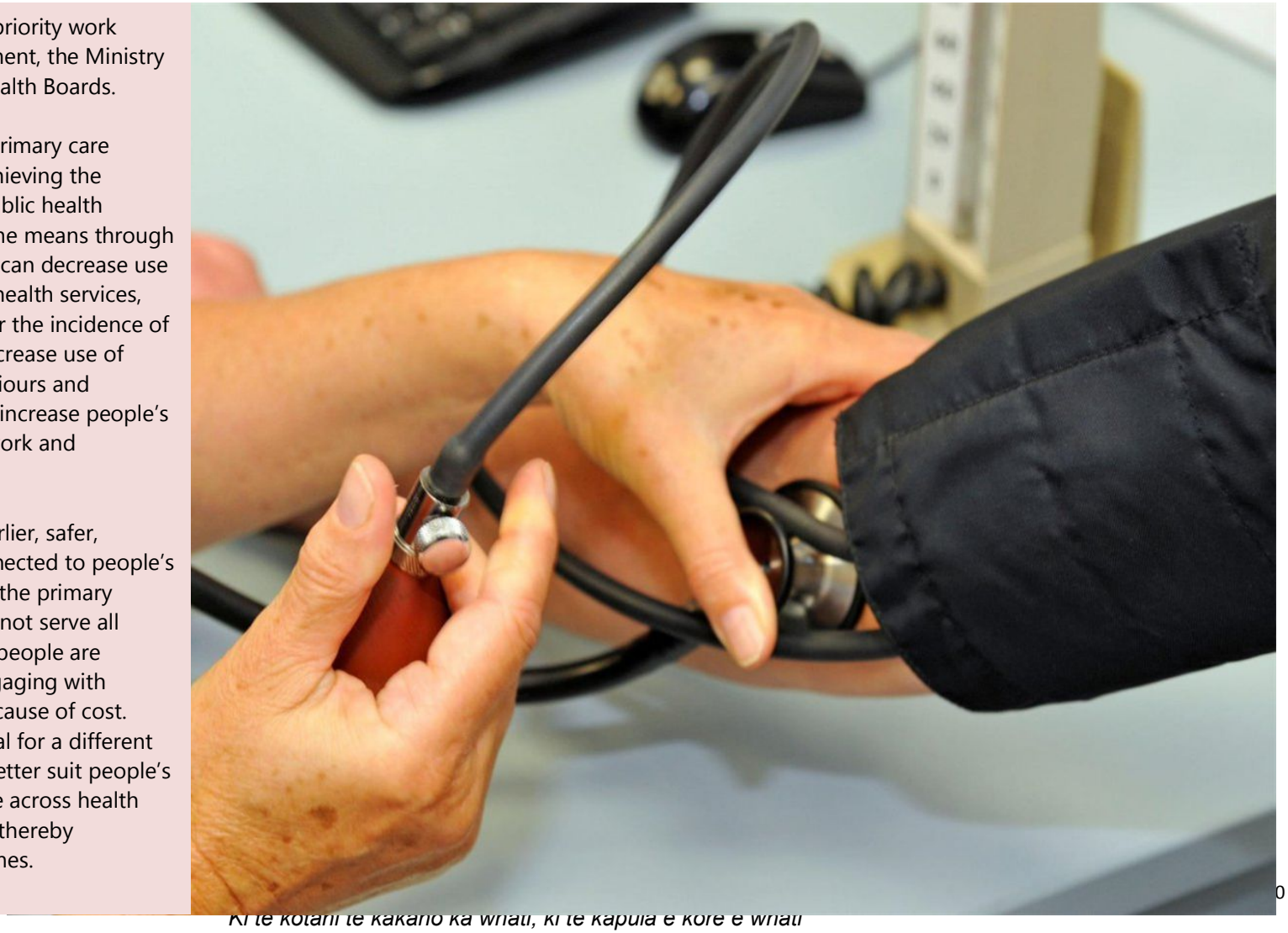
2.8.7 Better population health outcomes supported by primary health care

Primary health care is a priority work programme for Government, the Ministry of Health and District Health Boards.

An affordable effective primary care system is essential to achieving the objectives of a strong public health system. Primary care is the means through which the health system can decrease use of expensive secondary health services, better manage and lower the incidence of long-term conditions, increase use of illness-preventing behaviours and treatments, and thereby increase people's ability to participate in work and education.

Primary health care is earlier, safer, cheaper, and better connected to people's daily routines. However, the primary health care system does not serve all people equitably. Some people are avoiding or delaying engaging with primary care services because of cost. There is also the potential for a different primary care model to better suit people's lives and better integrate across health disciplines and facilities, thereby improving health outcomes.



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Primary health care integration

Integration and strong local partnerships remain important to the delivery of high-quality health services.

The Health and Disability System Review and actions developed from the Wai 2575 Hauora Report are likely to inform further support of integration.

In the meantime, DHBs are expected to continue to strengthen integration and their relationship with their primary care partners. As detail becomes available from the Review, Wai 2575 and Budget 20 this guidance may be updated.

- DHBs are expected to describe at least two actions which strengthen integration and improve access to a range of services for patients. At least one of these actions will specifically improve access for Maori, holistic and culturally responsive services. Further DHBs must demonstrate how they are working with Maori Health providers and NGOs to develop these services, eg:
  - Changes in service models such as implementing different consultation modalities (eg electronic, telephone)
  - Broadened use of the workforce (eg use of Nurse Practitioners, practice nurse consultation lists, use of physiotherapists, pharmacists and pharmacist vaccinators)
  - Development and implementation of new services based on robust analytics (eg outreach services on Marae).

Note: *Some or all of the actions in this section may form part of your System Level Measures (SLM) Improvement Plan. If this is the case it is not necessary to provide that information here but rather indicate that the assessor should refer to the SLM Improvement Plan.*

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
			System outcome	**Government priority outcome**
1. Refer system level measures plan	n/a		We live longer in good health	Ensure everyone who is able to, is earning,

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				learning, caring or volunteering

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<table>
<tr><td colspan="3">Pharmacy
Medicines related morbidity and mortality and inappropriate polypharmacy are a significant cost to the health system and contribute to poor health outcomes for New Zealanders
• Describe any significant initiatives the DHB is undertaking to implement integrated models of care that ensure older people living in the community have equitable access to the medicines optimisation expertise of pharmacists.
• Describe any significant initiatives the DHB is undertaking to implement integrated models of care that ensure people living in aged residential care facilities have equitable access to the medicines optimisation expertise of pharmacists.
• Describe any significant initiatives the DHB has commissioned locally (or intends to commission locally) this year, under the Integrated Community Pharmacy Services Agreement (ICPSA), to reduce the difference in local access and outcomes for your population. Examples might include new community pharmacy services such as gout management, or enabling pharmacists to deliver a broader range of vaccinations.
• Describe the local strategies the DHB has initiated from 1 April 2020 that support pharmacy and other immunisation providers to work together to improve influenza vaccination rates in Māori, Pacific and Asian people over 65 years of age.</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(All DHBs are to include equity focus and clear actions to improve Māori health outcomes, it is expected that the equity actions are evidence based. Pacific health outcomes are expected from the Pacific DHBs)
See section 2.6 Expectations on developing the activities in your plan for additional information.</td></tr>
<tr><td>Activity

Wairarapa DHB will:
• Survey pharmacies and other organisations employing pharmacists to determine the pharmacist skill base and the tools used for optimising pharmaceuticals in older people
• Continue to monitor the work being undertaken by the Auckland metro DHBs to develop pharmacist services for aged residential care to determine whether those initiatives could be applied in the Wairarapa
• Complete a review of community pharmacy LTC services and consider options for amending or replacing the service
• Extend funded provision of ECP from under 25s to under 30s</td><td>Milestone

Surveys completed by May 2020

LTC review completed by October 2020</td><td>Measure

Pharmacies providing flu-</td><td colspan="3">Government theme:
Improving the well-being of New Zealanders and their families
System outcome
(please select ONE system outcome for this priority)
We have health equity for Māori and other groups
OR
We live longer in good health
Government priority outcome
(please select ONE Government priority outcome for this priority)
Support healthier, safer and more connected communities
OR</td></tr>
</table>

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A reed that stands alone is easily broken, bound together – unbreakable

• Increase the provision of influenza vaccine through pharmacies in the 2020 flu season • facilitate the provision of influenza vaccine by pharmacists to over 65s through marae and Pacific churches.	LTC service options identified and consulted on by November 2020	vax increase over 2019 or maintained at 100%. Influenza vaccine provided by pharmacies to Maori and Pacific in 2020 increase by 10% over 2019.	**OR** We have improved quality of life	Make New Zealand the best place in the world to be a child **OR** Ensure everyone who is able to, is earning, learning, caring or volunteering

Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
A reed that stands alone is easily broken, bound together – unbreakable

Long-term conditions including diabetes

Identify how the DHB will:

- improve primary and community care activity to prevent, identify and support management of long-term conditions targeting those with the poorest outcomes
- offer evidenced based nutritional and physical activity advice
- monitor and use PHO/practice level data to improve equitable service provision and inform quality improvement
- improve early risk assessment and risk factor management efforts for people with high and moderate cardiovascular disease risk by supporting the spread of best practice from those producing the best and most equitable health outcomes.

Identify how the DHB is working in collaboration with their high needs population groups to identify the health promotion / protection activities that are most effective and efficient activities for that population group.

Diabetes specific actions

Identify how the DHB will ensure that all people with diabetes will:

- be effectively managed through diabetes annual reviews, retinal screening, access to specialist advice
- improve modifiable risk factors by targeting those at high-risk (including people with existing complications: foot, eye, kidney, and cardiovascular disease, see SS13 for further details)
- provide culturally appropriate diabetes self-management education (DSME) and support services and evaluate the effectiveness of the DSME
- identify health promotion and health protection activities the DHB has agreed to undertake to prevent diabetes and other long-term conditions.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear evidence-based actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs).

See section 2.6 *Expectations on developing the activities in your plan* for additional information.

Activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Support Whaiora to develop an integrated diabetes care model between the General Practice and Pae Ora Service that can be replicated in other practice during 2020/2021. 2. Work with the 7 practices to identify options for engaging with Māori who have not had HbA1c in last 12 months.	TBC	TBC	**System outcome** We live longer in good health	**Government priority outcome**

Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
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3. Undertake detailed, anonymised demographic analysis of Māori newly diagnosed with diabetes to identify trends and opportunities for improved care. 4. Develop Te Ao Māori Stanford self-management courses for Māori. 5. Undertake consultation/co-design hui to identify service gaps and options for service development.				Support healthier, safer and more connected communities

Ki te kōtahi te kākaho ka whati, ki te kāpuia e kore e whati
A reed that stands alone is easily broken, bound together – unbreakable

2.9 Financial performance summary

[TO BE INSERTED]

SECTION 3: Service Configuration

3.1 Service Coverage

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

Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups. Wairarapa DHB may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services.

Wairarapa DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2020/21.

3.2 Service Change

The table below describes all active service changes that have been approved or proposed for implementation in 2020/21.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Contract Changes for Non-Devolved Services	A number of contracts, currently funded through direct contracts with MoH / other agencies or CFA obligations, may be terminated early if funding is not approved for 2020/21.	Decisions not under Wairarapa DHB control unless DHB decides to prioritise funding to these services.	National
Ophthalmology service	Implementation of national Age-related Macular Degeneration (AMD) and glaucoma referral guidelines	• Nationally consistent acceptance criteria • Consistent timeframes for review and follow up	National
He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction	In 2018, the He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction was completed. The DHB will plan for service development which aligns with the report in partnership with our stakeholders and service providers. This may result in commissioning a different range of services to that which is currently funded. It may also result in the termination of some current agreements to allow the commissioning of best practice model-of-care services that support optimal population health outcomes. Capital & Coast, Hutt Valley and Wairarapa DHB's are working closely with MOH, PHO's and NGO providers to implement He Ara Oranga recommendations. Since the Wellbeing budget was released in 2019, the Greater Wellington Regional Collaborative forum has been established to respond to the various RFP's that	• Improved patient experience • Improved responsiveness to Māori health • Improved patient outcomes • Strengthened clinical and operational partnership	National, Sub- Regional & Local

	are being released into the MH&A sector. The access and choice initiative in primary care (Te Tumu Waiora model) is currently being implemented across the sub region and will increase access into GP clinics for those presenting in distress. The 3 DHB's will continue to work collaboratively with the GWRC partners to respond to each RFP as MOH release these.		
Change	**Description of Change**	**Benefits of Change**	**Change for local, regional or national reasons**
MHAIDS Structural Review	Bedding in of implementation of move to single DHB employment (CCDHB) for all 3DHB Mental Health, Addiction and Intellectual Disability Service (MHAIDS) staff and of revised MHAIDS leadership structure and clinical governance, starting in early part of 20/21.	• Improved governance structures • Strengthened clinical and operational partnership • Stronger locality leadership presence • Value for money • Improved health outcomes	3DHB - Hutt, Capital & Coast, and Wairarapa
Acute Care Continuum	A project to develop an acute care services has commenced. The aim of the project is to develop an improved model of integrated service delivery, focusing on a defined range of services which will together deliver an 'Acute Care Continuum'. The system design approach taken with this project aims to deliver best practice improvements to better meet the acute needs of services users including improved support for family / whanau. The outcome of this project will determine the investment approach for a range of linked acute services, including inpatient and NGO provided services. This may result in commissioning a different range of services than currently funded, with potential review and updating or termination of some existing contracts.	• Improved integration between providers of acute care services • Smother and safer care • Improved access and responsive support for at risk service users and family / whanau.	3DHB - Hutt, Capital & Coast, and Wairarapa
Inpatient mental health services models of care	Following significant issues with the physical space of the Te Whare Ahuru mental health inpatient unit at Hutt DHB, Hutt DHB has embarked on a strategic assessment and single stage business case to consider facility options. The facility is used by Wairarapa patients.	• Improved patient experience • Improved responsiveness to Māori health • Improved health outcomes	3DHB - Hutt, Capital & Coast, and Wairarapa

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Acute mental health services and alcohol and other drug treatment services	The DHBs are undertaking a review of their mental health acute services and alcohol and other drug treatment services. This may result in commissioning a different range of services that what is currently funded. It may also result in the termination of some current agreements to allow the commissioning of best practice model-of-care services that support optimal population health outcomes.	• Improved patient experience • Improved responsiveness to Māori health • Improved health outcomes	3DHB - Hutt, Capital & Coast, and Wairarapa
Community Pharmacist Services	Review and implement changes to the the Long Term Condition service provided by pharmacists, and the commissioning of pharmacist services to aged residential care.	• More integration across the primary care team • Consumer empowerment • Safe supply of medicines to the consumer • Improved support for at-risk populations • More use of pharmacists as a first point of contact	Local
		•	
Access to specialist clinical services	During 2020/21 we will review the range, mix and level of specialist services provided at Wairarapa Hospital, and how these clinical services are currently configured in order for us to maintain financial and clinical sustainability, and meet health needs more equitably. This may result in implementation of some changes during 2020/21.	• Improved health outcomes • Improved clinical sustainability • Address health inequities • Value for money • Maintain access to services for our population	Local
Radiology Services	During 2020/21 we will be reviewing the provision of radiology services including the provision of community referred radiology services. This may result in implementation of some changes during 2020/21.	• Improved health outcomes • Improved clinical sustainability • Address health inequities • Value for money • Maintain access to services for our population	Local
Access to Local Services	Description of changes- During 2020/21 we will review the range, mix and level of local services provided, and how these services are currently configured in order for us to maintain financial and clinical sustainability, and meet health needs more equitably. This may result in implementation of some changes during 2020/21.	• Improved health outcomes • Improved clinical sustainability • Address health inequities • Value for money • Maintain access to services for our population.	Local

SECTION 4: Stewardship

This section provides an outline of the arrangements and systems that Wairarapa DHB has in place to manage our core functions and to deliver our planned services.

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4.1 Managing our Business

Organisational performance management
Wairarapa DHB's performance is assessed on both financial and non-financial measures, which are measured and reported at various levels of the organisation, from unit level through to the Hospital Advisory Committee and the Board. These are reported daily, weekly, fortnightly, monthly or quarterly as appropriate.

Funding and financial management
Wairarapa DHB's key financial indicator is how we are tracking against our budget. This is reported through Wairarapa DHB's performance management process to the Executive Leadership Team and the Board. Further information about Wairarapa DHB's planned financial position for 2020/21 and out years is contained in the Financial Performance Summary section of this document in Appendix A: Statement of Performance Expectations.

Investment and asset management
Wairarapa DHB completed their first stand-alone Long Term Investment Plan (LTIP) covering at least 10 years. LTIPs are part of the new Treasury system for monitoring investments across government, the Investment Management and Asset Management Performance (IMAP) system. Work is being done to update the plan manage execution going forward.

Shared service arrangements and ownership interests
Wairarapa DHB has a 16.67% shareholding interest in Central Region's Technical Advisory Services Limited and 0.79% shareholding interest in New Zealand Health Partnerships Ltd. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management
Wairarapa DHB has a formal risk management framework and robust reporting system. Risks are recorded on the Wairarapa DHB SharePoint Risk Register and monitored by risk owners, a report is collated and escalated to FRAC and the Board as required. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality assurance and improvement
Wairarapa DHB's approach to quality assurance and improvement is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

4.2 Building Capability

4.2.1 Capital and infrastructure development

The main hospital building was built in 2006 as part of the site redevelopment. The building was designed to meet the New AS/NZS1170 Building Standards (NBS) and it has been assumed that the facility would perform in relation to its function as such.

The main hospital facility is rated an Importance Level 4 Building (IL4). In this regards the facility itself is expected to meet 100% NBS and be serviceable after a 1:500 year Earthquake (i.e. operating at normal function within minutes to an hour post event.

As part of the new legislation, requiring Local Territorial Authorities to quantify the seismic compliance ratings of all priority buildings Wairarapa commissioned two separate engineering surveys of the main hospital facility in relation to the primary structure and the contained services of the hospital building. LGE Engineering Ltd and Clendon Burns Park Ltd undertook these reviews respectively.

The reports received by the DHB identified the main hospital building as requiring seismic remediation to meet its service and function requirements as an IL4 building rated overall at 34% NBS. It also identified significant issues specifically in relation to restraint of in ceiling services rated provisionally at 15%. A further recommendation to undertake detailed seismic assessment of connected structures was also made. The DHB has completed, over the 2018/19 and 2019/20 year, restraint remediation for in ceiling services to address the safety issues identified as well as commissioning a detailed structural engineering assessment of connected structures and an assessment to provide the level of remediation required to meet the service and function requirements of an IL4 building. These further reviews will inform the full scale of remediation required and will be made available over the course of this year 2020/21.

The Training Centre has been subject to a seismic engineering review and a scheme developed for strengthening. The funding has not been approved in the 2020/21 Capex budget.

Engineering reviews of the Clinical and Support Services Building (main administrative building) have been undertaken and these reviews have demonstrated that considerable refurbishment to the fabric of the building is required to maintain a 25 year life expectancy. The strategy is to evaluate options for alternative accommodation over the next five years.

4.2.2 Training and development

High quality training and supervision of interns and RMOs is a strategic priority at Wairarapa DHB. Trainee Intern training (PGY1, PGY2 and RMO) will be offered and supported in 2019/20 as will Community Based Attachments (CBAs) given the DHB's regional setting and our close relationship with Primary Care Providers.

The Wairarapa DHB continues to support the development and placement of students and new graduates within the DHB in conjunction with supporting the wider community where possible. Initiatives include:

Nursing

- MOU in place with UCOL to support nursing student placement
- Employment of nursing students in Healthcare Assistant positions
- Dedicated unit to support new graduate nursing development
- New graduates employed in the community invited to DHB provided study days
- Diversity of new graduate workforce consider as part of new graduate in take

Allied, Scientific and Technical

- Provide placements for Allied, Scientific and Technical students
- Development of graduate program/orientation where applicable (i.e sterile services and speech language)
- Ongoing Implementation of the Calderdale Framework
- Continued implementation of 3DHB Allied Health Career Framework

General support to encourage working in health is achieved by offering information at local school careers sessions.

4.2.3 Co-operative developments

Wairarapa DHB works and collaborates with a number of external organisations and entities on delivery of programmes and initiatives contributing to the Wairarapa health system. These organisations and entities have a role in delivering the priority action areas noted in Wairarapa DHB's Annual Plan.

4.3 Workforce

The five key areas outlined in 19/20 for Workforce still continue into the 20/21 period. These are:

1. Leadership Development
    a) Leading with Values-providing all leaders with the tools around DHB expectations.
    b) Identifying and implementing relevant leadership programs.
    c) Accelerating capability and skill.
2. Values & Recognition
    a) Embedding our values in everything we do
3. Wellbeing & Safety
    a) Developing a wellbeing focus and program within the organisation.
    b) Ensuring our values and culture support a safe work environment.
4. Culture and Behaviours
    a) Integrating our values into performance frameworks.
    b) Building constructive relationships.
    c) Including the voice of our patients in what we do.
5. Environment and Systems
    a) Making it easier to work at our DHB.
    b) Ensuring a quality start.
    c) Development of the payroll system to support data management and easier processes.

As an organisation we have also now landed on our key Values, these being:

1. Wellness
2. Equity
3. Respect
4. Innovation
5. Relationships

These values integrate and underpin with the five areas of focus from a Workforce perspective. The challenge we have over the next 12 to 24 months is establishing a health service model that is successful in in attracting people to our DHB and region from a workforce perspective and then retaining them for the long term. As a DHB we need to be engaging with our regional peers and local businesses to be able to offer opportunities not only based in the DHB setting but also the wider local health sector and with those outside the health sector.

The DHB is continuing its journey to challenge how we do things as an organisation and support each other in the work environment. For transformation to occur everyone within the organisation needs to be engaged and invested in the work that is occurring. A key component of this is ensuring we focus on the diversity of our workforce and continue to build strong linkages with the work that is occurring via the Kia Ora Hauora Programme.

Training and development
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- Ongoing Implementation of the Calderdale Framework
- Continued implementation of 3DHB Allied Health Career Framework

General support to encourage working in health is achieved by offering information at local school careers sessions.

4.4 Information technology

3DHBICT is developing a new digital and data strategy that will describe the six key core digital and data themes that we will use to prioritise our portfolio of work across the 3DHBs. These themes will support the achievement of the Capital Coast, Hutt Valley, and Wairarapa DHB priorities. The draft themes of our strategy are:

1. Place-based and virtual health options in our communities
2. Patients as Partners
3. Desire for Regional View of Services
4. Equity Across Māori, Pacific, Socio-economically Deprived
5. Use of technology and analytics to support investment decisions
6. Empowering our workforce to deliver high quality, efficient specialist care

These six themes inform our operating model change towards a modern ICT business unit that lifts portfolio management, a move to product & service management, and an effective support model of operation. This business change journey commenced in 2019 and is not planned to be completed until 2021. The newly established Digital and Data Intelligence Governance Group (DDIG) allows us to obtain support across the three DHBs for organisational change at executive level, a single point of decision making for Wellington regional ICT strategic decisions, and a way to engage on significant initiatives that enable achievement of DHB, Ministry, and Ministerial goals.

As our operating model evolves and we deliver critical foundational capability, we are investigating how digital and data can enable better community health. Technology is an enabler but will not of itself deliver new services. There needs to be a corresponding change to how people in health work. In early 2020 we

commenced the first step towards a digital health system for the Wellington region by developing a set of personas of health workers to use as a reference for building a digital workplace.

We work with our regional partners and at a national level to ensure that we leverage good thinking and existing solutions to reduce the national complexity and variety of Heath ICT solutions. This is done by attending National CIO's meetings, meeting monthly with the Ministry of Health on the progress of our plans, and inclusion of regional participants in our architecture governance board where we ensure sound architectural decisions and consistency of solutions across the region. A critical success factor will be the development of national health data interoperability standards. These standards will enable sharing of information across all DHBs thus achieving a virtual national health record.

In early 2020 we completed the HIMMS digital maturity assessment for our three regional DHBs. This assessment in which we engaged with the key players such as representatives from community health, provides us with an independent moderated benchmark to compare the current state of our ICT compared to other DHB's and a reference to measure improvements against until the next assessment in three years.

We have legacy technology debt to overcome as we shift towards enabling better health care for our region. This means improving the resiliency of our supporting infrastructure in the advent of a disaster, shifting away obsolete voice technology towards unified communications, addressing gaps in cyber security to protect our systems and information as well as increasing awareness of cyber security risks.

We are embarking on a programme of consolidation of disparate bespoke solutions across the Wellington regional DHBs. Key initiatives such patient administration systems (WebPAS) consolidation which will enable centralised and consistent patient management. We are also consolidating the clinical portals (Concerto) that will enable better patient care and cost efficiencies. There has to be increased focus on the corporate systems and the tools needed to run an effective Health service. We are working with the corporate functions across the three DHBs to standardise the tools and systems.

3DHBICT has selected its four critical initiatives for inclusion into the 2020/21 annual plan. These initiatives are focused on achieving stability of existing critical clinical and corporate systems, bringing significant improvements to operational efficiency, improving patient care, transforming services to be fully digital, and Ministry / Minister Directives.

There are other supporting initiatives in our capital plans across the three DHBs we support which are not included here. We have not included our BAU support activity which underpins existing health services provided by the three DHB's.

What this plan does not allow for is the significant increase of ICT resources to support a modern health service and the change programme required to achieve the aspirations of the Minister and Ministry of Health.

SECTION 5: Performance Measures

5.1 2020/21 Performance Measures

The health and disability system has been asked to focus on the following priorities:

- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention.
- Better population health outcomes supported by strong and equitable public health services
- Better population health outcomes supported by primary health care.

The DHB monitoring framework and accountability measures have been updated for 2020/21 to provide a line of sight between DHB activity and the health system priorities that will support delivery of the Government's priority goals for New Zealand and the health system vision and outcomes, within a system that has a foundation of financial, clinical and service sustainability and strong governance.

Performance measure		Expectation		
CW01	Children caries free at 5 years of age	Year 1	TBC (MoH)	
		Year 2	TBC (MoH)	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	TBC (MoH)	
		Year 2	TBC (MoH)	
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled	Year 1	TBC
			Year 2	TBC
		Children (0-12)not examined according to planned recall	Year 1	TBC
			Year 2	TBC
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Year 1	TBC	
		Year 2	TBC	
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month-olds olds fully immunised.		
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five year of age.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with General Practice	The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age and by 3 months of age and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.		
CW08	Increased immunisation at two years	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years,		
CW09	Better help for smokers to quit (maternity)	90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.		

CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile one to four (and decile five after January 2020) secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.	
		Initiative 3: Youth Primary Mental Health.	
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliane team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.	
CW13	Reducing rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever to XX per 100,000	
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Maori, other & total	TBC
		Age (20-64) Maori, other & total	TBC
		Age (65+) Maori, other &total	TBC
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.	
		95% of audited files meet accepted good practice.	
MH03	Shorter waits for non-urgent mental health and addiction services	Mental health provider arm	80% of people seen within 3 weeks.
			95% of people seen within 8 weeks.
		Addictions (Provider Arm and NGO)	80% of people seen within 3 weeks.
			95% of people seen within 8 weeks.
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified	
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	
MH07 (tbc)	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	TBC (MOH)	
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.	
PV02	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.	
SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	
SS02	Ensuring delivery of Regional Service Plans	Provide reports as specified	

SS03	Ensuring delivery of Service Coverage	Provide reports as specified		
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	TBC		
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.		Only applies to specified DHBs
SS07	Planned Care Measures	Planned Care Measure 1: *Planned Care Interventions*		TBC
		Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
			ESPI 2	0% – no patients are waiting over four months for FSA
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
			ESPI 5	0% - zero patients are waiting over 120 days for treatment
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool
		Planned Care Measure 3: *Diagnostics waiting times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are

				reported, within 6 weeks (42 days).
		Planned Care Measure 4: *Ophthalmology Follow-up Waiting Times*	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
		Planned Care Measure 5: *Cardiac Urgency Waiting Times*	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency.	
	(Only the Five Cardiac units are required to report for this measure)	Planned Care Measure 6: *Acute Readmissions*	TBC	
SS08	Planned care three year plan	Provide reports as specified		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	TBC
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	TBC (MOH)
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than95 %
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5 %
			Assessment of data reported to the NMDS	Greater than or equal to 75%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified

SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.	
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified	
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions to: Support people with LTC to self-manage and build health literacy.
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care*.
			Count of enrolled people aged 15-74 in the PHO who have completed a DAR in the previous 12 months.
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity
		Focus Area 3: Cardiovascular health	Provide reports as specified
		Focus Area 4: Acute heart service	**Indicator 1: Door to cath** - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram**.**
			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and **Indicator 2b:** ≥ 99% within 3 months.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance ≥85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - Aspirin*, a 2nd anti-platelet agent*, and an statin (3 classes)

			- ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), - Beta-blocker if LVEF<40% (5-classes). • * An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.
			Indicator 5: Device registry completion ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure.
			Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.
		Focus Area 5: Stroke services	**Indicator 1** ASU: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway
			Indicator 2 Thrombolysis: 10% of potentially eligible stroke patients thrombolysed 24/7
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation: 60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.	
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.	
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.	
		95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system.	
SS17	Delivery of Whānau ora	Appropriate progress identified in all areas of the measure deliverable.	
SS18	Financial outyear planning & savings plan	Provide reports as specified	

SS19	Workforce outyear planning	Provide reports as specified
PH01	Delivery of actions to improve SLMs	Provide reports as specified
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90 percent.
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95 percent or above
PH04	Primary health care: Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
Annual plan actions – status update reports		Provide reports as specified

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Wairarapa District Health Board

Statement of Performance Expectations 2020/21

Presented to the House of Representatives pursuant to section 149(L) of the Crown Entities Act 2004.

2020/21 Statement of Performance Expectations including Financial Performance

This Statement of Performance Expectations (SPE) is a requirement of the Crown Entities Act 2013 and serves three purposes:

1. To allow the responsible Minister to participate in setting the annual performance expectations of the Wairarapa DHB
2. To provide parliament with information on these expectations, and
3. To provide a base against which actual performance can be assessed. The actual results of service performance against what was forecast here will be published in our 2020/21 Annual Report.

Board Statement

In signing this statement, we acknowledge that we are responsible for the information contained in the Statement of Performance Expectations (SPE) for the Wairarapa District Health Board.

This information has been prepared in accordance with the requirements of the Crown Entities Act 2004. The SPE sets out our performance expectations for the period from 1 July 2020 to 30 June 2021.

Signed on behalf of the Board

Sir Paul Collins
Board Chair

Date:

Dr Tony Becker
Deputy Chair

Date:

Output class measures

Four Output Classes are used by (all) DHBs to reflect the nature of services provided. These are as follows:

1. **Prevention services:** publicly funded services that protect and promote health in the whole population.
2. **Early detection and management:** services delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings including general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.
3. **Intensive assessment and treatment:** generally hospital services including Emergency Departments, ambulatory services (outpatients, district nursing and day procedures) and inpatient services (acute and planned care).
4. **Rehabilitation and support:** services delivered following a 'needs assessment' process and co-ordination input by NASC Services including palliative care, home-based support and residential care services.

The aim of selecting output measures within each class for inclusion in the SPE is to ensure that the SPE meaningfully supports the key strategic priorities of the Wairarapa DHB's planned activities as outlined in the earlier Sections of this Annual Plan, and provides representative information about the vast scope of business as usual services we provide in support of our strategic goals.

In identifying appropriate output measures[4] within each output class we have included, in addition to volume measures, a mix of measures that help us evaluate different aspects of our performance. These measures indicate performance against service coverage (encompassing health equity) quality, volume (quantity) and timeliness. The intervention logic is depicted in Figure 1.

Some performance measures are demand-based and are included to provide a picture of the services funded and/or provided by the Wairarapa DHB. For such measures, there are no assumptions about whether an increase or decrease is desirable. As such, the "target" represents an estimation of the service delivery for 2020/21 based on historical and population trends.

The following tables provide baselines, forecasts and targets for each output area.

Reference key			
HT	(National) Health Target*	C	Coverage
SLM	System Level Measure*	V	Volume (quantity) measure
PP	Policy priority measure*	Q	Quality measure
SI	System Integration measure*	T	Timeliness measure
OP	Output measure*		
OS	Ownership measure*		*These measures are part of the National non-financial performance monitoring framework.
DV	Development measure*		
WPI	Wairarapa DHB performance indicator		
3DHB[5]	3DHB performance indicator (Capital & Coast DHB, Hutt Valley DHB, Wairarapa DHB)		

[4] Some performance measures show health indicators by locality, i.e. the people who live in the Wairarapa DHB's catchment, while other measures show performance of the services provided by Wairarapa DHB regardless of the service user's home district.

[5] Some measures show combined data for all 3 DHBs; Wairarapa, Hutt Valley and Capital & Coast, most often where services are provided on a sub-regional basis and data is not disaggregated by DHB. These measures are indicated in the tables as (3DHB).

Figure 1 – Intervention logic map for Wairarapa DHB SPE Output classes.

National	**NZ Health System intended outcomes: New Zealanders live longer, healthier and more independent lives.**						
Central Region Triple Aim	In the Central region we aim to achieve: • Improved health & equity for all populations • Improved quality, safety & experience of care • Best value for public health system resources						
DHB vision	**Better health for all**						
System level health outcome measures	**For the Wairarapa success will mean:** • Improved health equity - reduced outcome disparity in system level measures • Reduction in Ambulatory sensitive hospital (ASH) admissions 0-4 yr olds and age 45-64 • Reduction in amenable mortality rates • Reduction in Acute Hospital bed days per capita • Improved scores across domains of the patient experience survey • Increase in number of babies in smoke-free homes at 6 weeks • Improved youth health – reduced hospitalisations for self-harm and increased chlamydia testing						
Impacts How we measure our progress.	• Increased and more equitable number of babies who live in smoke-free households. • More babies breastfed. • More adults and pregnant women offered help to quit smoking. • High proportion 8-month old immunised equitably across ethnicities. • Improved and more equitable oral health for children. • More women screened for breast and cervical cancers equitably across ethnicities.	• More adults referred to Green Prescription program. • Increased and more equitable number of patients enrolled in PHOs. • More people assessed for CVD risk equitably across ethnicities. • Improved access to mental health and addiction services. • Reduced Rheumatic Fever (first) hospitalisation rates. • More patients attend planned appointments equitably across ethnicities.	• Shorter stays in our Emergency Department. • Shorter and equitable waiting time for cancer diagnosis and treatment. • Timely access to planned elective services. • Proportion of older people receiving long term support that are comprehensively clinically assessed (inter RAI). • Number of people registered with Disability Alert.				
DHB intended outcomes	• Environmental and disease hazards minimized • Lifestyle factors affecting health well managed • Children have a healthy start in life • Long term conditions well managed • Improved health, wellbeing & independence of our older people		• Responsive services for people with disabilities • People receive high quality hospital and specialist health services when needed • People receive high quality mental health services when needed • Reduced health disparities				
Outputs Services provided	**Prevention** • Health protection & regulatory services • Health promotion & education • Pop-In health screening • Immunisation • Smoking cessation	**Early Detection & Management** • Primary health care • Oral health • Community care • Pharmacy services • Diagnostics	**Intensive Assessment & Treatment** • Mental Health & Addictions services • Elective and acute medical and surgical services • Cancer services • Maternity	**Rehabilitation & support** • Disability services • Health of older people • Age-related residential care • Needs assessment • Home based care • Palliative care			
Inputs	People & knowledge	Collaborative partnerships	Quality systems & processes	Technology	Facilities	Funding	Risk management

Output class 1: Prevention Services

Prevention services

- Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.
- Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.
- Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services.
- On a continuum of care these services are public wide preventative services.

Outputs measured by	Note		Target/Est. 2020/21	Baseline	Baseline data date
Health promotion and education					
Number of adult referrals to the Green Prescription program.	V	WPI	≥ 224	212	2019/20 Q2
Smoking cessation					
Percentage of PHO enrolled patients who smoke and have been offered help to quit smoking by a health care practitioner in last 15 months.	C	PH04	≥90%	90.5%	2019/20 Q2
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or LMC being offered brief advice and support to quit smoking.	Q	CW09	≥90%	100%	2019/20 Q2
Babies living in Smokefree Homes at 6 weeks post-natal	Q	PHO4	Total ≥37.5% Māori ≥18.5% Other ≥48.3%	Total 37.5% Māori 18.5% Other 48.3%	2018/19 Q2
Immunisation					
Percentage of 2-year olds fully immunised.	C	CW05	≥95%	Total 91.4% Māori 94.1% Pacific 85.7% Other 100%	2019/20 Q2
Percentage of 8-month olds fully vaccinated	C	W08	≥95%	Total 94.4% Māori 95.7% Pacific 100% Other 76.9%	2019/20 Q2

Outputs measured by	Note		Target/Est. 2020/21	Baseline	Baseline data date
Percentage of 5-year olds fully immunised	C	CW05	≥95%	Total 97.0% Māori 100 % Pacific 100% Other 90.9%	2019/20 Q2
Percentage of year 7 children provided Boostrix vaccination in Wairarapa district.	C	WPI	≥92%	Total 92%, Māori 94%, Pacific 113%, Other 90%	2018/19 Q2
Percentage of year 8 girls and boys vaccinated against HPV (final dose) in Wairarapa district.	C	CW05	≥89%	Total 89% Māori 118% Pacific 75% Other 85%	2018/19 Q2
Percentage of people aged 65+yrs who have completed their annual influenza immunisation.	C	CW05	≥75%	Total 68% Māori 53% Other 67%	2019/20 Q1
Breastfeeding					
Percentage of infants fully or exclusively breastfed at 3-months.[6]	Q	CW06	≥70%	TBC	2018/19 Q1
Population based screening services					
Percentage of eligible children receiving a B4 School Check.	C	CW10	≥90%	Total 100%	2019/20 Q2
Percentage of eligible women (25-69 years) having cervical screening in last 3 years.	C	SS08	>80%	Total 74.3% Māori 73.8% Pacific 79.3% Other 74.3%	2019/20 Q1
Percentage of eligible women (50-69 years) having breast screening in the last 2 years.	C	SS07	>70%	Total 79.6% Māori 70.4% Pacific 59.7% Other 80.9%	2019/20 Q1

[6] This measure is based on all WCTO providers (not just Plunket).

Output class 2: Early detection and management

Early detection and management

1. Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.
2. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.
3. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Outputs measured by	Note		Target/Est. 2020/21	Baseline	Baseline data date
Primary Care services / Long term conditions management					
Newborn enrolment with General Practice	SI18	CW07[7]	≥80%	Total 93.6% Māori 85.2% Pacific NA Other 105%	December 2019
Percentage of DHB-domiciled population enrolled in a PHO.	C	PH03	All ethnicities ≥99%	Total 99%, Māori 103% Pacific 107% Asian 76% Other 100%	2019/20 Q2
ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000)	PP22	PH018	Total ≤ 6,300 Māori ≤ 9,000 Pacific NA Other ≤5,000	Total 6,679 Māori 5,169, Pacific NA Other 4,490	12 months to Sep 2019
ASH Rates (avoidable hospitalisations) for 45-64 years	SI1	SS	Total ≤ 3,500 Māori ≤ 5,500 Pacific NA Other ≤3,400	Total 3,009 Māori 8,148 Pacific 9,231 Other 3,883	12 months to Sep 2019
Percentage of DHB-domiciled population (15-74 yrs) enrolled in a PHO with well managed diabetes (HbA1c ≤ 64 mmol/mol)	PP20	SS13 FA2	≥70%	Total 67% Māori 58% Pacific 58% Other 71%	Dec 2019
Oral health					
Percentage of children under 5 years enrolled in DHB-funded dental services.	C	CW04	≥91%	Total 88% Māori 82% Pacific 73% Other 92%	2018/19 Q2
Percentage of children Carries Free at 5 years	Q	CW02	Total ≥68% Māori≥52% Pacific ≥60% Other≥76%	Total 68% Māori 53% Pacific 50% Other 75%	2018/19 Q2
Percentage of children with Decayed, Missing, Filled Teeth-DMFT in year 8 kids	Q	CW01	Total ≤76% Māori≤72% Pacific ≤80% Other≤78%	Total 77% Māori 61% Pacific 75% Other 83%	2018/19 Q2

[7] Also a Well Child/Tamariki Ora Quality Improvement Framework Indicator (number 11) - with a national target of ≥90%.
8 Also a HQSC Health System Quality Indicator (EFCT-15)

Output class 3: Intensive assessment and treatment

Intensive Assessment and Treatment services

- Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together.
- They include:
  - Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
  - Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
  - Emergency Department services including triage, diagnostic, therapeutic and disposition services
- On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

Outputs measured by	Note		Target/Est. 2020/21	Baseline	Baseline data date
Mental Health and Addiction services					
Percentage of patients 0-19 yrs referred to non-urgent child & adolescent mental health services & seen within 8 weeks.	T	MH03	≥95%	84.6%	2019/20 Q2
Percentage of patients 0-19 years referred to non-urgent child & adolescent Addiction services & seen within 8 weeks.	T	MH03	≥95%	87.1%	2019/20 Q2
Percentage of clients with transition (discharge) plan	3DHB	MH02	≥95%	67%	2019/20 Q2
Percentage of people discharged from an acute mental health inpatient service that were seen by the mental health community team in the 7 days following discharge.	Q	WPI	≥90% (Nat'l ≥90%)	78.6%	2018/19 Q2
Elective and Acute (Emergency Dept.) inpatient/outpatient					
Number of surgical elective discharges.	V	HT2	≥2,417	2,541	2018/19 Q2
Percentage of patients admitted, discharged or transferred from ED within 6 hours.	T	SS10	≥90%	90.4%	2018/19 Q2
Standardised inpatient average length of stay ALOS (Acute).	T	OS3 (SS)	≤2.35	2.61	Year to March 19
Standardised inpatient average length of stay ALOS (Elective).	T	OS3 (SS)	≤1.55	1.47	Year to March 19
Standardised Acute Readmissions	Q	OS8 (SS)	Total ≤11%	Total 10.6% Māori 10.8% 75+Total 11.3% 75+Māori 8.1%	2019/20 Q2
Rate of inpatient falls causing harm per 1,000 bed days.	Q	WPI	≤0.50	0.18	2019/20
Rate of hospital acquired pressure injuries per 1,000 bed days.	Q	WPI	≤1.40	0.18	2019/20

Outputs measured by	Note		Target/Est. 2020/21	Baseline	Baseline data date
Rate of identified medication errors causing harm per 1,000 bed days.	Q	WPI	≤0.85	0.18	2019/20
Weighted average score in Patient Experience Survey	Q	SI8	≥8.3	Comms: 8.4 Co-ord: 8.3 P/ship: 8.3 Physical and emotional needs: 8.4	2019/20 Q2
Percentage Did Not Attend (DNA) appointments for outpatient First Specialist assessments.	Q	WPI	≤8%	8.2%	2019/20
Percentage DNA appointment for follow-up Specialist appointments.	Q	WPI	≤8%	6.5%	2019/20
Cancer services					
Percentage of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	T	SS01	≥85%	94.1%	2019/20 Q1
Percentage of patients with a high suspicion of cancer and a need to be seen within 2 weeks that received their first cancer treatment (or other management) within 62 days of being referred.	T	SS11	≥90%	94.7%	2019/20 Q2

Output class 4: Rehabilitation and Support

Rehabilitation and Support services

- Rehabilitation and support services are delivered following a 'needs assessment' process and co-ordination input by NASC Services for a range of services including palliative care, home-based support and residential care services.
- On a continuum of care these services will provide support for individuals

The second implementation phase of the Ageing Well Strategy (2016), covering 2019 - 2022, prioritises achieving greater equity, measuring and monitoring progress. One of the priority actions is the "the development of an outcomes and measurement framework for this purpose". Readmissions and length of stay are two system measures which appear will be included in this monitoring framework.

Outputs measured by	Note		Target/Est 2020/21	Baseline	Baseline data date
% People > 75 living in their own home	C	SS04	≥ 91.75%	91.26%	30/06/2019
			≥93.75%	93.66%	30/06/2019
Acute average length of stay in hospital for people >75 years of age	C	SS04	≤5.5	5.6	30/06/2019
			≤4.5	4.1	30/06/2019
Standardised acute readmission rate for people >75 years of age	C	SS04	≤11%	12%	30/06/2019
			≤11%	11.2%	30/06/2019
Rate of hip (neck of femur) fractures due to an out of hospital fall per 1,000 people >50 years of age	C	WPI	≤0.7500	0.8675 per 1,000 population	30/06/2019

Outputs measured by	Note		Target/Est 2020/21	Baseline	Baseline data date
% of residential care providers being awarded 3-year (or more) certification in the planned year	Q	WPI	100%	100%	30/06/2019

Note:
Where actual numbers are less than 30, target group data has not been used or converted to percentages.

SECTION 4: Financial Performance

{TO BE INSERTED]

APPENDIX 1: System Level Measures Improvement Plan 2020/21

Wairarapa District Health Board
System Level Measures Improvement Plan 2020/2021

V2 21 Feb 2020

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

Regional Public Health
HAUORA Ā IWI KI TE ŪPOKO O TE IKA A MĀUI
Better health for the greater Wellington region

Tū Ora
COMPASS HEALTH

WHAIORA

Signatories

The members of Tihei Wairarapa - the Wairarapa Alliance Leadership Team

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Chair
Tihei Wairarapa

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Wairarapa and Hutt Valley District Health Boards

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Wairarapa District Health Board

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Introduction

Background

In 2016, the Ministry of Health introduced the System Level Measures Framework, which was developed with a system-wide view of performance and built on the previous Integrated Performance Incentives Framework. Leading up to its introduction, the Ministry of Health worked with health sector stakeholders to co-develop a suite of system level measures to support this whole-of-system view of performance.

In response to this, Tihei Wairarapa, an Alliance between Wairarapa DHB and Tū Ora Compass Health, submitted a System Level Improvement Plan which was approved by the Ministry of Health in November 2016. Tihei Wairarapa's plan was recognised by the Ministry as being an action-focused plan that made good use of data.

In 2018/19 the Tihei Wairarapa Alliance was refreshed and the membership widened to reflect the importance of working with a wider range of partners. The new Alliance Leadership Team (ALT) committed to work in partnership to refresh and further develop the plan. The 2020/21 Improvement Plan continues to build on progress made during 2019/20. This updated plan includes the following:

- Improvement Milestones for six System Level Measures (SLMs),
- Activities to meet the SLM milestones,
- A set of contributory measures aligned to the activities and milestones, and
- District ALT agreement to the planned activities, milestones and measures.

In addition, the DHB has a local reporting and accountability framework.

There are activities underway in Wairarapa that will lead to improvements in a number of SLM areas. Not all of these have been replicated across each SLM in this plan. The plan is focused on priority areas, to ensure on-going manageability. Where contributory measures are available in the Health Quality Measures New Zealand, they have been prioritised for use. Non-availability of contributory measures in this library has not precluded the use of other local contributory measures, as per Ministry guidance. Tihei Wairarapa is committed to including such measures in the library in future.

Māori health

Māori health is a key strategic priority for the Wairarapa DHB and its alliance partners. Along with Te Oranga O Te Iwi Kainga, the Wairarapa DHB is committed to making practical and effective changes to the system to achieve positive outcomes for Māori. It is important that this document be read in conjunction with the DHB's Annual Plan and Tū Ora Compass Health's Māori Health Plan, where more specific activities that focus on positive outcomes for Māori are recorded.

All contributory measures will be monitored by Māori, Pacific and Total populations. Where this data is not currently collected, the Wairarapa DHB will ensure that steps are put in place to start collecting this data by ethnicity.

Wairarapa DHB SLM Plan Development 2020/21

Collaborative Development

Wairarapa DHB hosted a workshop attended by a range of relevant community agencies (including DHB clinical and senior management staff and Board members, Tū Ora Compass Health, Aged Residential Care providers, Hospice, Regional Public Health, Wellington Free Ambulance, Iwi Kainga, and Pharmacists) to inform the development of the 2020/21 Annual Plan, and SLM Improvement Plan.

The development of the SLM Improvement Plan specifically has been led by a collaborative SLM Development Group comprising Executives and Clinical Leads in the PHO and DHB.
Other Groups that have been engaged with and/or provided with progress updates:

- Te Iwi Kainga
- Tū Ora Compass Health Clinical Quality Management Committee
- Tū Ora Compass Health Board
- Wairarapa DHB Executive Leadership Team
- Executive Leader Māori Health, WrDHB
- Director of Pacific Health, WrDHB

Links with Strategic Priorities

The SLM development team agreed that the milestones for the SLMs should consider and align with strategic priorities across the sector, should focus on reducing inequity, and should be attainable while supporting the current performance of Wairarapa DHB. These principles remain appropriate and relevant for the 2020/21 Plan. The milestones are also aligned with the National Health Strategy, and DHB performance measures as reflected in the DHBs 2020/21 Annual Plan.

2020/21 System Level Measures

From 1 July 2020 the System Level Measures remain:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Amenable mortality rates under 75 years
- Youth access to and utilisation of youth-appropriate health services
- Proportion of babies who live in a smoke-free household at six weeks postnatal

In 2020/21, 25% of PHO incentive pool funding will be paid on Quarter 4 achievement of the following three SLM improvement milestones and two primary care targets (to be confirmed):

- Acute hospital bed days per capita
- ASH rates for 0-4 year olds
- Patient experience of care
- Primary Care Target: Better help for smokers to quit
- Primary Care Target: Increased immunisation for eight month olds.

The 25% incentive funding is equally weighted across all five incentivised measures.

The context of our 2020/21 Plan

Wairarapa DHB recognises that we remain in a consolidating phase following the rebuilding of relationships with the local community and health providers after dissolution of the 3DHB planning and funding unit and the 2DHB management structure (including establishing a consumer council). During the 2019/20 year key appointments have been made which include the Chief Executive, Executive Leader Planning &Performance, Chief Medical Officer and Chief Financial Officer. These changes, combined with recent Tu Ora Compass Health local management change and the inception of new WDHB Board members means that 2020/2021 provides an exciting opportunity for taking the Alliance forward from its challenges over the past few years and improving effectiveness.

Our 2019/20 plan outlined several key actions that we believed were required to lay the foundation for future service development. Collectively we committed to renewing the Alliance Leadership Team and establishing local Service Level Alliances to replace previous sub regional arrangements. This was intended to provide us with an operational framework to effectively monitor and evaluate our performance, and agree priorities and service improvement actions.

We also recognised the need to modernise and free-up capacity in primary care to improve the management of patients in the community. The implementation of the Health Care Home Model (HCH) across all seven Wairarapa practices was the major commitment for the PHO and practices over the next three years, and the DHB acknowledged that this would limit the extent to which other service developments might be possible.

The challenges we recognised a year ago have intensified. The rapid population growth we experienced in recent years as people relocated from the major cities has continued during 2019/20. Many of these immigrants to the Wairarapa are retirees, adding to our already relatively old population. There is also an increasing percentage of the population who are young and Māori, and a first intake of refugees arriving to settles in Masterton in June 2020. These changes have increased the disparity between population sub-groups, with significant proportions of our population, particularly in Masterton, living in relative deprivation. In both the hospital and primary care there has been significant growth in acute demand. Primary Healthcare (PHC) continues to have workforce challenges including GP recruitment and skill mix, and this is an ongoing focus.

In this context it has been crucial that we focus on those activities which will provide the quickest wins in meeting immediate demand. We have made significant progress in some areas, including:

- The DHB is refreshing its strategic direction, and undertaking planning for clinical services and population health
- The ALT has been revitalised, with membership widened
- Implementation of the Health Care Home model is progressing across all Wairarapa practices
- Our Child and Youth Service Level Alliance is progressing a number of child and youth priority projects
- We have developed an implementation plan for an integrated palliative care service
- We have implemented a falls prevention programme
- We are participating in the ongoing development of Health Pathways and a new smart e-referral system

There are some priorities that we have been less able to progress due to pressure on our health system and clinicians. This includes the development of better models of long term condition management, revised urgent/acute care arrangements and the development of an integrated maternity model. Combined reviews between PHC and Adult inpatient surveys are challenging to triangulate easily due to different questions. A new inpatient survey that the new provider IPSOS is commencing, due for release in July 2020 may enable this to be done in a more meaningful way. These remain priorities for 2020/21. The implementation of Health Care Homes provides a platform for both planned LTC and urgent care developments.

Table 1 below summarises the headline actions that have been agreed as priorities for the 2020/21 year, and the intervention logic behind them.

Our 2020/21 Priority Projects

Table 1: Our priority projects and the milestones they will impact on

	ASH 0-4	Acute bed days	Patient Experience	Amenable mortality	Youth access to service	Babies in smoke free households
The Alliance Leadership Team (ALT) will continue to be responsible for the development and implementation of the system level measures and will be accountable to the Board and to Te Iwi Kainga for the SLM Programme of work.	✓	✓	✓	✓	✓	✓
The Health Care Home (HCH) model has been implemented in all seven Wairarapa practices. In 2020/21 there will be a focus on embedding the new model to achieve: • Improvements in patient experience of healthcare • Improved satisfaction and sustainability of the workforce • Improved quality of care through improved access and a focus on prevention and early intervention • A reduction in the downstream impacts on the broader health system such as hospitalisation, emergency presentations and amenable mortality.	✓	✓	✓	✓		
The ALT will monitor LTC quality indicators, and identify opportunities to work collaboratively to improve outcomes. This activity will include reviewing: • the SLM contributory measures, • the Atlas of Healthcare Variation, • Health Roundtable data and • the Tū Ora Compass Health quality indicator data, System improvements to improve population health outcomes will be prioritised by equity. The ALT will use palliative care as a model for improvement for long term conditions services. MDT activity in this space will focus on diabetes and cardiac conditions. The ALT will have primary responsibility for the implementation of the acute bed days and amenable mortality measure improvement plans.	✓	✓	✓	✓		✓

	ASH 0-4	Acute bed days	Patient Experience	Amenable mortality	Youth access to service	Babies in smoke free households
A Service Level Alliance will identify and monitor system improvement in child and youth health services. The SLA will monitor quality indicators including: • the WCTO quality framework • the SLM contributory measures, and • the Tū Ora Compass youth health quality indicator data and will make recommendations to the ALT on system improvements to improve child and youth health outcomes including increasing equity. The SLA will continue to focus on respiratory health for Māori under 5s, developing culturally appropriate antenatal and postnatal options for Māori, reconfiguring services to provide more support for high needs families and improving access to youth health services (in particular mental health support). The SLA continues to have primary responsibility for the implementation of the ASH 0-4, babies in smoke-free households and youth measure improvement plans. The SLA will also focus specifically on the development of youth services including the Youth clinic, services in South Wairarapa and school-based services.	✓		✓	✓	✓	✓
The Alliance believes there are opportunities to improve the patient experience of the health system as a whole by sharing PES results and NZ health survey results and combining quality improvement initiatives. We will continue to conduct quarterly combined reviews of survey results and commit to an integrated quality improvement approach.			✓			

The Wairarapa DHB/Tihei Wairarapa agreed Improvement Milestones for 2020/21 are:

System Level Measure	Key Improvement Milestones	Date	2019/20 Target and latest results	2020/21 Improvement Milestone
ASH rates for 0-4 year olds	Wairarapa Māori 0-4 years non-standardised ASH rate per 100,000	End of Q4	Reduce non-standardised Māori 0-4 years ASH rate from 9,318 to <9,000 per 100,000 population Target - Māori 0-4yrs <9,000 Baseline: Sep 2019 Māori 0-4yrs = 8,136 Other 0-4yrs = 5,276	Reduce non-standardised Māori 0-4 years ASH rate from 8,136 to <8,000 per 100,000 population
Acute bed days per capita	Wairarapa acute bed day rate per 1,000	End of Q4	Reduce standardised Māori acute bed days for DHB of domicile by 10% from 553 to 500 per 1,000 population Baseline: June 2019 381 per 1,000 population	Reduce standardised Māori acute bed days for DHB of Domicile by 8% from 381 to 350 per 1,000 population
Patient Experience Survey	Wairarapa primary care and inpatients composite score (note national definition currently unavailable in library)	End of Q4	**Primary Care:** New target for 2020/21 We have 100% of practices transitioned and participating in the new PES and will maintain or improve on current domain composite scores (assuming that domain scores will remain in the new survey format and are comparable). Baseline: Q4 2019 Communication: 8.0 Coordination: 8.3 Partnership: 7.0 Physical & emotional needs: 7.9 **Inpatient:** Increase participation rates in the inpatient PES to the national average (currently 24%) Increase inpatient PES communications domain score to the national average (currently 8.3) Baseline: Sept 2019 Participation rate = 26% Inpatient PES communications domain score = 8.2	**Primary Care:** We have 100% of practices transitioned and participating in the new PES and will maintain or improve on current domain composite scores (assuming that domain scores will remain in the new survey format and are comparable). **Inpatient:** Maintain or increase participation rates in the inpatient PES to the national average to ensure validity of results. Maintain or increase the inpatient PES communications domain score to the national average.
Amenable mortality rates	Wairarapa total 0-74 standardised AM rate per 100,000	End of Q4	Reduce AM rate to at or below 105 per 100,000 (5 year average) Baseline:2012-2016 5 year average Māori = 188.0 Total = 94.7	Reduce 0-74 years age standardised AM rate for Māori from 188 to at or below 165 per 100,000 (5 year average)

Youth access to and utilisation of youth-appropriate health services	**Access to preventative services:** Increase Māori and Pacific adolescent dental coverage **Intentional self-harm hospitalisations** (including short-stay hospital admissions through ED) for 15 - 19 year olds	End of Q4	**Access to preventative services:** Increase Māori and Pacific adolescent dental coverage from 45% /40% to 55% by 30 June 2020 Baseline: June 2018 Maori = 45% Pacific = 40% (2019 data not yet available) **Mental Health and Wellbeing:** Decrease rate of self- harm hospitalisations for 10-24 year olds to 50 per 10,000 population (standardised) Baseline: Year to Sept 2019 44.9 per 10,000 Māori rate = 80.4 Other rate = 30.9	**Access to preventative services:** Increase Māori and Pacific adolescent dental coverage from 45% /40% to 55% by 30 June 2020 **Mental Health and Wellbeing**: Decrease rate of self- harm hospitalisations for Māori 10-24 year olds to 60 per 10,000 population (standardised)
Babies in smoke-free households	Percentage of babies that are six weeks old, who live in a household with no smoker present	End of Q4	Increase the total % of babies living in smoke free homes to 40% and Māori babies to 25% by 30 June 2020 Baseline: June 2019 Total babies = 57.2% Māori babies = 41.4%	Increase the % of all babies living in smoke-free homes to 60% and Māori babies to 45% by 30 June 2021.

Ambulatory Sensitive Hospitalisations 0-4yo

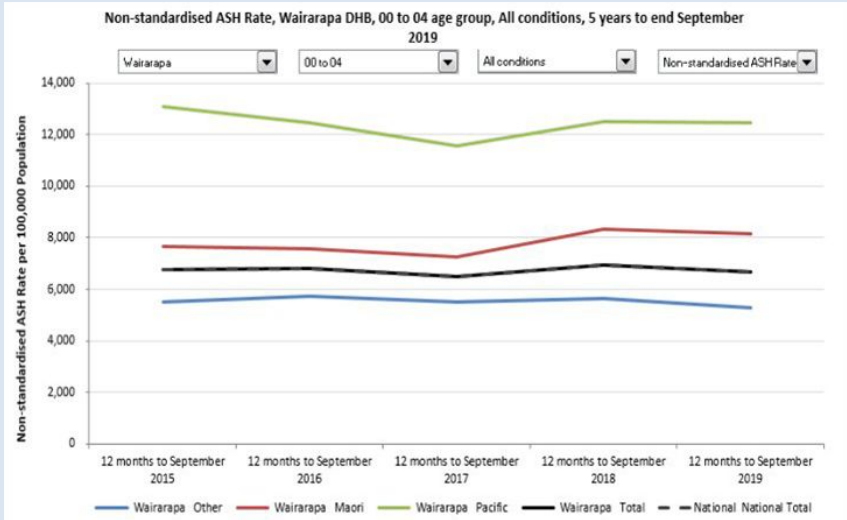
As a Wairarapa DHB system we want all our children to have a healthy start in life. One of the DHBs strategic goals is to improve child health and child health services in the Wairarapa Region. Our system will support all families to maximise their child's health and potential. In 2019/20 WrDHB we achieved our goal of reducing the Māori ASH rates (non-standardised) for 0 – 4 year olds to under 9,000 per 100,000. We aim for a further reduction from the Sept 2019 rate of 8,136, with a new target of under 8,000 per 100,000.

SI 1: Ambulatory Sensitive Hospitalisations (ASH)

ASH Top 10 Conditions over last 6 years to 30 September 2019 (split by Maori and Other) - Actual admissions

Condition	12 months to December 2014		12 months to December 2015		12 months to December 2016		12 months to December 2017		12 months to December 2018		12 months to September 2019	
	Maori	Other	Maori	Other	Maori	Other	Maori	Other	Maori	Other	Maori	Other
Upper and ENT respiratory infections	16	19	18	40	21	31	15	36	25	25	10	14
Gastroenteritis/dehydration	16	22	3	16	10	14	7	26	15	14	8	14
Asthma	17	16	24	20	17	15	16	9	12	16	9	18
Dental conditions	11	19	16	13	13	12	13	10	8	8	3	8
Lower respiratory infections	3	2	3	2	3	6	3	6	8	5	2	5
Pneumonia	5	6	6	4	3	6	12	9	4	6	5	6
Cellulitis	7	5	12	5	2	4	6	5	4	3	2	4
GORD	1	1	0	0	0	2	1	0	1	6	0	0
Dermatitis and eczema	6	4	4	1	7	1	1	2	4	1	3	3
Constipation	0	3	1	2	3	2	3	3	1	2	3	4
TOTAL	82	97	87	103	79	93	77	106	82	86	45	76
TOTAL POPULATION 0-4 Year Olds	810	1930	840	1860	840	1830	860	1775	880	1755	890	1715
% of Total Population 0-4 Year Olds	10%	5%	10%	6%	9%	5%	9%	6%	9%	5%	5%	4%

Inequity for Māori children has reduced over the past year. Comparative data is not available for Pacific children due to the small population, but we intend to monitor hospitalisations for Pacific children at an individual level. Upper and ENT respiratory infections, Asthma, Gastroenteritis/dehydration are the three largest drivers of admissions, especially for Māori children.



DHB	Ethnic Group	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018	12 months to September 2019
Wairarapa	Other	5,510	5,721	5,507	5,630	5,276
Wairarapa	Maori	7,666	7,559	7,249	8,322	8,136
Wairarapa	Pacific	13,097	12,457	11,552	12,498	12,458
Wairarapa	Total	6,761	6,807	6,503	6,955	6,679

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significant swings

Milestone	Actions	Contributory Measures All contributory measures will be monitored by Māori, Pacific & Total Population where data allows
Reduce Māori ASH rate for 0-4year olds from 8,136 to <8,000 per 100,000 population	• Embed enhanced whānau Ora services for families of children identified through LMC/WCTO needs assessments, those booked for dental treatment on the surgical bus and those with repeat respiratory admissions • Scope opportunities for increasing Whanau Ora Navigation to include dental with high needs children 0-8yrs.	• % preschool children enrolled with oral health service • Hospital admissions for children under 5 years with dental as primary diagnosis
	Implement a comprehensive child health coordination services for 0-4 year olds establish in Q1	• Increased performance in WCTO QI framework indicators (including Māori specific)
	Implement an enhanced model of care that increases the number of children proactively having fluoride applied biannually by the dental service. Prioritising high needs children	• Number of children who have had fluoride application • 5yr old dmf • Yr 8 DMF - measures
	To provide practices with lists of children who are potentially eligible for Fluvax. Scope and investigate auto referral process to outreach for Maori.	• Fluvax 6 months to 4 years (Māori and other)
	Refresh and renew the pathways for children with repeat childhood respiratory presentations, including a referral to Ha Ngawiri program and healthy homes assessment.	• 0-4 ASH Rate with a primary diagnosis of respiratory disease (Māori and other)
	Implement the National Hauora collation program 'Equity generation 2040'	• The number of early pregnancy assessments completed.

Patient Experience of Care

The Wairarapa health system encourages patients to provide feedback about their experience of care through our complaints and compliments process and by participating in the Adult Inpatient and Primary Care Patient Experience Surveys (PES). One of our priorities is to monitor results and feedback and use them to inform initiatives that will lead to improved patient experience and outcomes.

Combined reviews between Primary Care and Adult Inpatient has been difficult and hard to triangulate easily due to different questions – we believe the new survey that the new provider IPSOS is commencing in July will enable this to be done in a more meaningful way for the 2020-21 year.

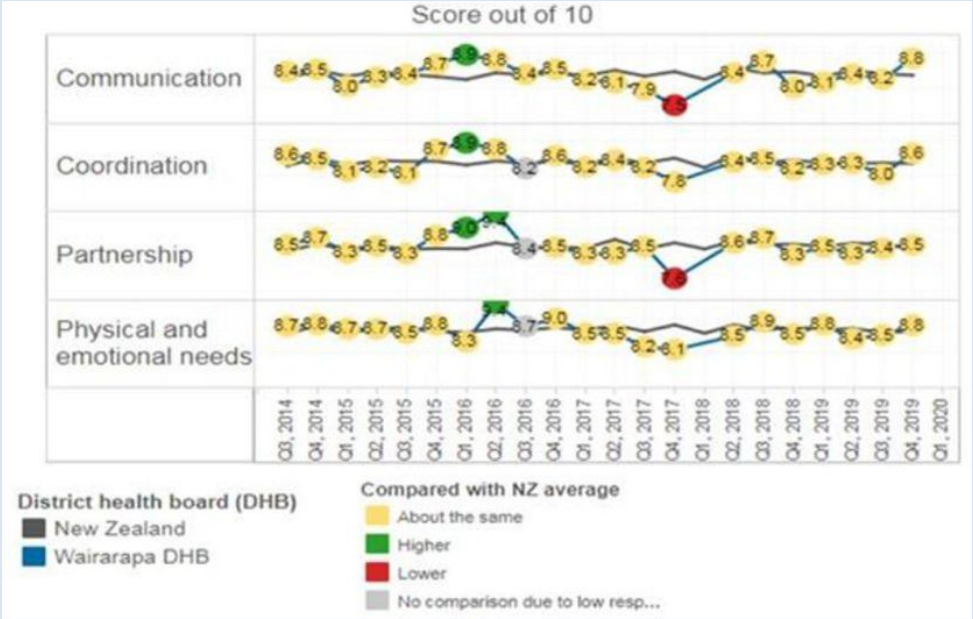
The Primary Care PES will provide improvement opportunities for practices implementing the Health Care Home model. We aim to have 100% of practices transition and participating in the new PES and will aim to maintain or improve on current domain composite scores (assuming that domain scores will remain in the new survey format and are comparable).

As at Q4 2019, the WrDHB inpatient survey is at or above the NZ average for all domains (see graph). At the same time, the participation rate in the WrDHB inpatient survey was 23%, which is in line with the national average of 24%. Our target for the communication domain score in 2019-20 was achieved.

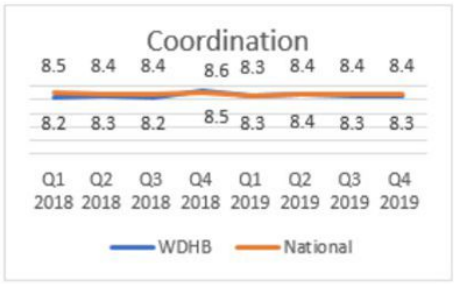
Maori participation numbers (6 people in Q4 2019) for hospital health services are insufficient to provide any meaningful data on consumer experience and we are hopeful that the new format and provider will improve this.

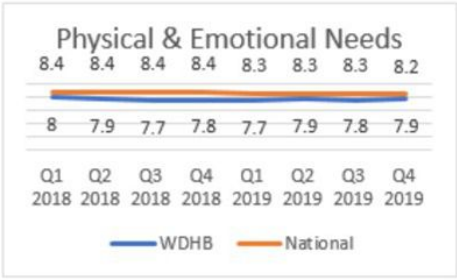
During 2020-21 we will familiarise ourselves with the new survey, its format and reporting structure and review results as they come in. If we then identify that our participation rates are lower than the national average, we will review and consider options as to how to realistically increase them – we are however hoping that the new provider has identified ways to improve this by the format.

Hospital Patient Experience Survey Scores (score out of 10), Wairarapa DHB (2014-2019)



Primary Care Patient Experience Survey Scores (score out of 10), Wairarapa DHB (2018/19)





Milestone	Actions	Contributory Measures All contributory measures will be monitored by Māori, Pacific & Total Population where data allows
Primary Care Milestone: We have 100% of practices transitioned and participating in the new PES and will maintain or improve on current domain composite scores (assuming that domain scores will remain in the new survey format and are comparable).	Embed the Health Care Home model across Wairarapa practices with expectations for year of care planning and appointment availability	• Number of people activated in the healthcare portal • The time to third next available appointment (TNAA)
	Familiarise ourselves with the new survey, its format and reporting structure	• % patients with email addresses recorded in the Patient Management System
	Following the July 2020 rollout of the new 'Inpatient survey', continue quarterly review of combined inpatient and primary care survey results to identify focus for continuous quality improvement	• 2 combined quarterly reviews completed 2020.
Adult Inpatient Milestone: Maintain or increase participation rates in the inpatient PES to the national	Review and embed new Inpatient survey that the new provider (IPSOS) is commencing in July 2020-21 year. Review both the PHC and new Inpatient survey questions to set up a new Triangulation process	• PES Participation rates • Correlated data that indicates clear themes for improvement

average to ensure validity of results.	between Primary Care and Adult Inpatient surveys.	
	Identify interventions that best impact participation and completion rates e.g. pre-survey reminders, increased collection of email addresses on admission	
	Concurrently consider other methods to collect good patient experience data from inpatients as well as other service areas such as outpatients and community services	
Maintain or increase the inpatient PES communications domain score to the national average	Increase sharing of results across the organisation to ensure visibility of results to patient-facing staff	• Communication domain score
	Continue “Voice, Vision, Values” project which focuses on impact of communication on patient experience	
	Investigate the use of “relationship centred care” learning modules to form part of mandatory training programme for DHB staff	

Acute Bed Days

Better health for all is the WrDHB vision. We want our population to be well in the community and to receive appropriate care when they are not well. Our aim is to maintain acute bed days (standardised by DHB of Domicile) under 370 per 1,000, in 2020/21. A short-term goal for 20/21 is to better manage respiratory conditions in primary care, and for general practices, through the Health Care Home model of care which all 7 practices have adopted, to use stratification tools to identify populations at risk of admission and implement year of care planning.

Over all, the Wairarapa standardised rate of acute bed days has continued to decrease with the latest results the lowest yet. Our rate has consistently been below the national average for the past three years

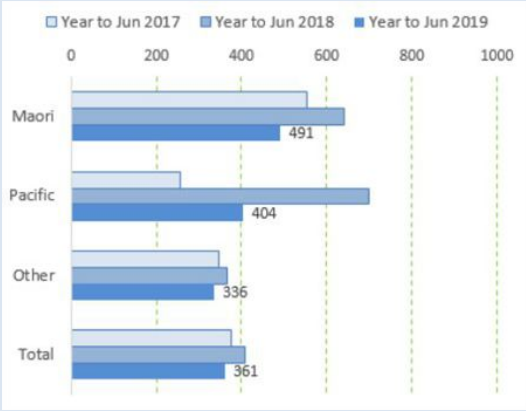
Respiratory conditions, especially in the very young, elderly and Māori, cerebrovascular disorders and fractures especially in the elderly are the largest drivers of acute bed day usage.

Maori rates have improved with a drop from 553 to 491 per 1,000 from Dec 2018 to June 2019.

Acute Standardised Bed Days per 1,000 population by DHB of Domicile by age group for the year to June 2017 to 2019

DHB of Domicile	Estimated Popn Year to Jun 2019	Acute Stays Year to Jun 2019	Acute Bed Days Year to Jun 2019	Standardised Acute Bed Days per 1,000 Popn Year to Jun 2017	Year to Jun 2018	Year to Jun 2019
Auckland	542,240	62,109	192,160	429.6	434.0	403.4
Bay of Plenty	239,360	33,851	112,273	428.3	425.6	393.0
Canterbury	568,500	60,686	233,522	408.4	404.5	382.1
Capital and Coast	319,870	34,833	101,545	371.7	345.3	324.6
Counties Manukau	563,730	66,696	232,310	478.5	500.4	462.7
Hawke's Bay	166,400	25,350	77,824	415.8	439.8	409.6
Hutt	150,320	20,346	54,489	408.7	380.7	350.6
Lakes	110,180	15,425	50,128	418.2	432.8	435.7
Midcentral	180,410	24,359	79,223	466.3	413.2	388.2
Nelson Marlborough	151,320	16,928	48,271	269.2	269.1	253.5
Northland	180,690	25,308	84,723	411.4	427.4	410.0
South Canterbury	60,090	8,325	34,320	436.8	429.6	441.9
Southern	332,020	36,673	125,592	385.5	389.6	343.1
Tairawhiti	49,285	6,875	24,922	456.3	479.3	497.2
Taranaki	120,455	18,729	61,212	408.8	466.8	449.9
Waikato	419,850	60,628	220,859	478.4	497.4	495.4
Wairarapa	45,880	5,743	20,418	375.1	407.2	360.6
Waitemata	626,990	78,341	256,414	453.8	437.6	404.3
West Coast	32,475	4,113	15,217	420.1	453.9	403.1
Whanganui	65,130	11,051	28,890	485.8	429.7	372.8
National	4,925,195	616,369	2,054,314	423.4	424.3	397.9

Wairarapa DHB of Domicile – Ethnic Group Comparison – Standardised Acute Bed Days per Capita Rates 2017-19



Milestone	Actions	Contributory Measures All contributory measures will be monitored by Māori, Pacific & Total Population where data allows
Maintain or Reduce standardised acute bed days for DHB of Domicile from under 370 per 1,000 population including an equitable rate for Māori	Continue the falls programme and specifically embed the Fragility Fracture Protocol for targeted management of bone health	• Number of people 55+ years with low impact fragility fractures who have been referred to their GP service for bone health and falls risk assessment
	Implement trial of post discharge navigation with people identified at risk of readmission and their whānau to increase health literacy, self-management and resilience.	• 75yr + readmission rate
	Continue to embed the Health Care Home model across the seven general practices Implement the Community Service Integration component of Health Care Home for patients identified as being at risk of hospitalisation	• All practices showing progress in model maturity using the HCH maturity matrix • Number of people with Year of Care Plan compare to HCH goal for the 12 months

	Develop a clear COPD identification, assessment and management pathway to support consistency and continuity of care in primary care.	• COPD hospital admission rate

Amenable Mortality

We want to have an effective WrDHB health system, for individuals and the population as a whole. Wairarapa DHB aims to maintain its 5 year average amenable mortality rate at less than 105 per 100,000. Our focus in 2020/21 and beyond continues to be on reducing the Māori amenable mortality rate. Suicide continues to have a large relative impact on the rate at WrDHB. We are continuing to develop an improved understanding (including by age and ethnicity), so effective solutions can be developed and implemented in future years.

Wairarapa DHBs amenable deaths for 0-74 year olds between 2000 and 2016 has continued to drop steadily year on year from 155.9 in 2000 to 94.7 in 2016.

Inequities remain with the Māori population continuing to have the highest AM rates (188 per 100,000 compared to non-Māori 85.0).

At Wairarapa DHB between 2010 and 2016, the most prevalent conditions for AM were coronary disease, suicide, COPD and land transport accidents (excluding trains) followed by diabetes and female breast cancer.

Amenable mortality, ages 0-74, 2012-2016
Calculated using 2014 population data
With 99% confidence intervals

DHB of domicile	Māori				non-Māori, non-Pacific				Total			
	Deaths	Rate	LCB	UCB	Deaths	Rate	LCB	UCB	Deaths	Rate	LCB	UCB
Northland	632	231.4	207.7	255.1	832	85.4	77.8	93.0	1484	121.7	113.5	129.8
Waitemata	323	147.5	126.4	168.6	1854	58.0	54.5	61.4	2415	67.5	63.9	71.0
Auckland	297	176.9	150.5	203.3	1342	59.4	55.2	63.6	2055	76.9	72.6	81.3
Counties Manukau	707	220.4	199.0	241.7	1430	66.2	61.7	70.7	3040	102.7	97.9	107.5
Waikato	791	214.9	195.2	234.5	1716	82.1	77.0	87.2	2600	104.2	98.9	109.4
Lakes	393	241.7	210.3	273.1	442	86.1	75.5	96.6	852	123.4	112.5	134.3
Bay of Plenty	559	217.4	193.7	241.1	984	77.3	70.9	83.6	1577	104.8	98.0	111.6
Tairawhiti	264	233.1	196.1	270.0	160	86.7	69.0	104.3	434	139.6	122.4	156.9
Hawkes Bay	358	203.5	175.8	231.2	744	80.3	72.7	87.9	1149	103.7	95.8	111.5
Taranaki	163	185.8	148.3	223.3	596	85.7	76.6	94.7	775	97.6	88.6	106.6
Midcentral	262	192.0	161.5	222.6	943	91.9	84.2	99.6	1240	106.6	98.8	114.4
Whanganui	168	225.0	180.3	269.7	386	107.0	93.0	121.1	562	125.4	111.7	139.0
Capital & Coast	193	147.0	119.7	174.2	988	62.0	56.9	67.1	1357	74.3	69.1	79.5
Hutt Valley	169	174.8	140.2	209.4	638	80.6	72.4	88.8	884	94.3	86.1	102.4
Wairarapa	59	188.0	124.9	251.0	252	85.0	71.3	98.8	315	94.7	81.0	108.4
Nelson Marlborough	78	123.0	87.1	158.8	781	73.7	66.9	80.5	874	77.4	70.6	84.1
West Coast	30	181.4	96.1	266.7	232	108.0	89.7	126.3	269	117.2	98.8	135.6
Canterbury	298	160.4	136.5	184.4	2503	77.1	73.2	81.1	2886	83.7	79.6	87.7
South Canterbury	23	...	...	...	380	94.1	81.7	106.5	408	94.7	82.6	106.8
Southern	192	158.9	129.4	188.5	1729	86.1	80.8	91.4	1953	91.0	85.7	96.3
Overseas and undefined	13	...	...	...	249	...	...	...	315	...	...	...
Total New Zealand	5972	197.4	...	...	19181	75.1	...	...	27444	92.6	...	...

Rates per 100,000 age standardised to WHO world standard population
Rates are suppressed where there are less than 30 deaths

Milestone	Actions	Contributory Measures All contributory measures will be monitored by Māori, Pacific & Total Population where data allows
Reduce 0-74 years age standardised AM rate for Māori to at or below 165 per 100,000 (5 year average)	Continue to influence policy to improve healthy lifestyles through submissions to local councils and relevant national bodies eg supporting RPH submissions by co-signing or co-presenting	• Numbers of submissions
	Continue to provide More Heart and Diabetes Checks to eligible people with a priority Māori, Pacific and South East Asian Work with young men to understand how best to engage them in the CVRA process, trialling initiatives and new ways of working	• % PHO enrolled eligible population who have had a CVD risk assessment recorded in last 10years • % of Māori 30-44 year old men with CVRA completed
	Leverage of the new community based mental health collaborative arrangements to better connected mental health and other wellbeing services in the Wairarapa	• Suicide screening rates for at risk populations
	Facilitate smoking referrals from non-traditional locations i.e. Work with Māori to develop new ways to support Māori Whānau to quit smoking	• Number of referrals to SSS • Smoking Quit Rates by ethnicity
	Review current pilot kaupapa Māori self-management programmes with the view to implementing a sustainable model Monitor Primary Care performance against Diabetes Clinical Guidelines	• % PHO enrolled eligible population with a record of a diabetes annual review during the reporting period whose HbA1c <64 mmol/mol and prescribed insulin by ethnicity • % of people with diabetes that are meeting clinical guidelines

	Proactively engage Māori and Pacific women who are under-screened or unscreened to combined breast and cervical screening sessions provided collaboratively between the Primary Care, Regional Screening Services and DHB	• Māori and PI breast screening rates (SS07) • Māori and PI cervical screening rates (SS08)

Youth access to and utilisation of youth appropriate health services

As a Wairarapa DHB system we want all our youth to have access to, and to utilise, appropriate services that meet their age-specific health needs. One of the DHBs priorities is to engage young people with health services where they are comfortable and receive youth friendly health care. During 2019/20 we reviewed our youth health services and determined priorities for future action. In 2020/21 we intend to develop and better coordinate our youth services so they are more accessible to a wider range of youth, especially rangatahi Māori.

Self-Harm

In the past three years there has been considerable variation in the rate of hospitalisation for intentional self-harm among 10 – 24 year olds, however as the population is relatively small some variation is expected. In the year to September 2019, we had reached our goal of reducing the rate to 50 per 10,000 for the total population, however Maori young people were hospitalized much more often than non-Maori. For the 12 months to September 2019, the Maori rate for 10-24 year olds was 80.4 per 10,000 compared to 30.9 for "other". 19 Maori young people and 15 non-Maori, non-Pacific were hospitalised in this 12 month period. The Maori rate was higher than the national average and the "other" rate was lower.

Youth Oral Health

Between 2010 and 2017 adolescent oral health utilisation dropped from 82% to 64%. While there was a slight increase overall in 2018, to 67%, the equity gap has grown larger. In 2018, coverage was 45% for Māori, 40% for Pacific and 77% for other ethnic groups.

Milestone	Actions	Contributory Measures All contributory measures will be monitored by Māori, Pacific & Total Population where data allows
Decrease intentional self-harm ED presentations /	Refresh the DHB Youth Health Strategy to guide the development of youth health services 2020 - 2025	• Strategy completed

hospitalisations of Maori 10-24 year olds to a rate of 60 per 10,000 population (standardised) Increase Māori and Pacific oral health utilisation to 55% by 30 June 2021	Enhance youth primary mental health services across youth settings, including school based services and the youth clinic: 1. Implement year 2 of the Piki programme pilot for 18-25 year olds 2. Implement kaupapa Maori primary youth mental health service (subject to Ministry of Health RFP funding) 3. Complete implementation of Public Health Nurse HEADDSSS assessments for 10-13 year old primary school children, where requested by the school. 4. Align youth primary mental health service models to ensure equitable access and best practice model of care	• Intentional self-harm presentations 10-14 and 15-19 years (Māori /Other) • number of referrals to youth mental health programmes (Maori /Pacific/Other)
	Work with intersectoral partners to develop options for increasing access to youth specific health and social services	• Consult rates at youth clinics
	The oral health co-ordinator to continue to work with local dentists to identify Youth DNA to oral health services and follow-up.	• Year 9 transfers to community based dentists (Māori /Pacific /Other)

Babies in smoke-free households

As a Wairarapa DHB system we want all our children to have a healthy start in life. Babies and children who have a smoke-free home have better outcomes. One of our priorities is to reduce the rate of infant exposure to cigarette smoke. Maternal smoking is associated with a range of poor child health outcomes such as sudden unexpected death in infancy (SUDI) and low birth weight. This measure seeks to go beyond maternal smoking, focusing on the home and family/whānau environment. In addition to the benefits to babies of no smoke exposure, other members of the population would benefit from a change in the households' smoking behavior. There is also potential for positive impact at a broader system level, due to the integrated approach required between maternity, community and primary care services.

As at June 2019, 41.4% of Māori babies and 57.2% of all babies were recorded as living in smoke-free homes in the Wairarapa. As at January 2020 1/5 of the total population of Wairarapa are living at the highest deprivation level of 9-10. While this is a significant increase on 2018/19

Milestone	Actions	Contributory Measures All contributory measures will be monitored by Māori, Pacific & Total Population where data allows
Increase the proportion of all babies living in smoke free homes to 40% (total) and 25% (Māori).	First 1,000 Days Professional education day for clinicians with contact with Māori whānau with focus on motivational interviewing.	• Number of clinicians attending First 1,000 Days Professional education day
	Implement 'Hapūtanga *first thousand days'* programme 2019/20 and 2020/21	• Programme referrals, enrolments, and quit rates • Pregnant women who identify as smokers upon registration with an LMC
	Contract local Māori heath provider to deliver wahakura [traditional Māori sleeping devices] and traditional baby rearing training to whānau	• Number distributed, number attending training
	Implement the DHB's 'Tapu te Hā' [*Tobacco Control Plan 2019/20*] including implementing processes for increasing referrals to cessation support services from LMCs and WCTO providers.	• Number of mothers smoke free at first core contact • PHO rate of babies in households with smokers
	Contract Māori health provider to deliver a programme of work dedicated to working with hapū mama and babies utilising a whānau ora approach.	• Programme referrals, enrolments, and quit rates
	Investigate opportunities to grow the Healthy Homes Project and target twenty [20] whānau with home assessment and remedies package.	• Programme referrals, enrolments, and quit rates

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Sir Paul Collins
Chair
Wairarapa District Health Board
paul@aehl.co.nz

Tēnā koe Paul

Letter of Expectations for district health boards and subsidiary entities for 2020/21

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2020/21.

DHBs make positive differences in the lives of New Zealanders and I look forward to working with you and your new Board to deliver the wider changes we need to improve outcomes. Strong and sustained leadership provides a foundation for high-performing DHBs and is critical to overall sector performance.

The Government intends to deliver long term, sustainable change to support improved wellbeing for New Zealanders. In the coming months we will receive the final report from the New Zealand Health and Disability System Review. Many of you have contributed to the review, and I thank you for that. The interim report aligned strongly with our Government's priorities and the changes we have underway to deliver better outcomes for Māori and improving equity and wellbeing. I expect you to be prepared and ready to implement Government decisions resulting from the review.

Wellbeing and equity underpin my priorities. Appendix one details expectations for the five system priorities:

- improving child wellbeing
- improving mental wellbeing
- improving wellbeing through prevention;
- better population outcomes supported by a strong and equitable public health and disability system
- better population health and outcomes supported by primary health care.

This letter will outline my expectations for a range of matters that contribute to performance across these priority outcomes.

Governance

The DHB Board sets the direction for the DHB and rigorously monitors the DHB's financial and non-financial performance and delivery on the Government's priorities.

I expect you to hold your Chief Executive (CE) and senior leadership team to account for their financial performance and on the delivery of equitable health outcomes for your population.

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As Chair, you will need to provide leadership and direction to the Board, providing guidance and support to members to ensure they effectively govern the DHB. Please ensure that you have a process in place to review the performance of the Board on a regular basis.

Sustainability

Every DHB must clearly demonstrate how strategic and service planning will support improved system sustainability, including models of care and the scope of practice of the workforce. You should address how your DHB will work with sector partners to deliver the Government's priorities and outcomes for the health and disability system while reducing cost increases and deficit levels.

Please ensure that your 2020/21 planning documents clearly identify your DHB's approach to financial and clinical sustainability at both a strategic level and operationally across each of my priority areas.

Service performance

I expect you to challenge and support your CE and senior leadership team to identify ways to respond to the challenges the DHB faces, including timely, high quality delivery of planned care, reducing the length of emergency department stays and increasing immunisation coverage. You will oversee progress on the plans they develop to address these issues.

You need to ensure that workforce and delivery plans support innovative models of care and don't merely add FTE to maintain existing approaches. I expect this to be supplemented with other activities, such as managing annual leave liabilities and maximising productivity in theatres and wards.

Achieving equity

Achieving equity in health outcomes and ensuring fairness in access to and experience of care is essential. I will always expect you to consider equity as you develop plans across priority areas and to prioritise resources to achieve equity across population groups. This will include improving health outcomes for Maori and Pasifika, and an explicit focus on addressing racism and discrimination in all of its forms across all aspects of your operations.

Embedding Te Tiriti o Waitangi and achieving pae ora (healthy futures) for Māori

Māori-Crown relations are a priority for this Government, and I expect your DHB to meet your Te Tiriti o Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I expect you to develop your plans in partnership with your iwi/Māori partnership boards and include a statement from the Chair of the partnership board in your annual plan alongside statements from yourself and your CE.

Achieving pae ora (healthy futures) for Māori is an important goal for the entire health and disability system. While this includes achieving equity in health outcomes for Māori, responding to our obligations under the Treaty of Waitangi goes beyond that. A critical aspect is enabling iwi, hapū, whānau and Māori communities to exercise their authority to improve their health and wellbeing. I expect your plan to specify how you will work with iwi and Māori communities in your district to achieve this goal.

Financial performance and responsibility

The 2018/19 and 2019/20 budgets have provided the largest increases in funding that DHBs have ever had. To improve service and financial performance, you must focus on good

decision-making within your sphere of control and influence. Most of the issues driving costs are within the control of the DHB, including the number and mix of full-time equivalent staff.

A central challenge in the public health system is to deliver a wide range of quality health services to New Zealanders while remaining within budget. You will be aware of your DHB's financial position and my expectation is that you and your Board will deliver improved financial management and performance; this is especially true for those DHBs that have struggled in recent years.

The In-Between Travel (IBT) appropriation will be devolved from 1 July 2020. I expect you to work with the Ministry of Health (the Ministry) to ensure a seamless transition of responsibilities. The Ministry has an ongoing stewardship responsibility to ensure that all IBT obligations are met.

Capital investment

Timely delivery of the business cases prioritised for investment from the Budget appropriation should be a strong focus. You must comply with financial performance expectations for capital investments requiring Crown equity. You will also be expected to deliver a business case within the budget parameters set, and ensure all investments are procured in a timely manner.

Business cases for high priority projects should continue to be developed irrespective of their immediate investment status and I will seek your assurance that this work is progressing.

I expect all DHBs to follow the guidelines for construction procurement developed by the Ministry of Business, Innovation and Employment. I also expect DHBs to support the initiatives being developed under the Construction Accord. Information on these initiatives will be provided as the work develops.

The Government is supporting a range of capital infrastructure initiatives. The wider public good from our capital projects must be realised, which requires adherence to certain principles. An example is the NZ Green Building Council (NZGBC) Green Star rating for new building developments. Capital builds ought to meet a 5-star standard in the absence of any other mature standard, and this aim should be written into design thinking from the outset. This should result in longer term efficiencies, both financial and environmental. During 2020/21, you will need to engage with the Ministry and other partners as we continue to evolve approaches to sustainable facility design.

National Asset Management Plan

I would like to thank your DHB for supporting the first iteration of the National Asset Management Plan (NAMP) and ask that you continue to engage with the NAMP work as we develop and implement the next phases. Please continue to strengthen your DHB's asset management approach, including focusing on critical service assets, embedding asset management practices and ensuring you appropriately govern service improvement and asset performance.

Service user councils

Service user/consumer councils are key mechanisms through which service users can give feedback on how health and disability services are delivered in different communities. The Health Quality and Safety Commission (the Commission) has provided guidance to support an effective approach – 'Engaging with consumers: A guide for district health boards' and 'Progressing consumer engagement in primary care'. I am aware that many DHBs already

have strong service user councils and I want to strengthen this across all districts and regions.

The Commission, in partnership with the sector, has developed quality and safety markers for service user engagement and I encourage your DHB to participate in this.

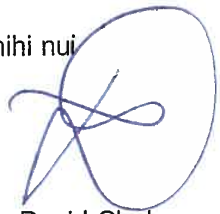
My priority areas

I have clearly communicated my priorities for the health system. I expect your annual plans to address these priorities to meet the needs of all population groups, especially those groups that experience the most significant inequities. The actions you commit to in your plan must contribute to lasting equity and outcome improvements for Māori and for your Pacific population, including a strong focus on prevention. Appendix one details expectations for the five system priorities, which will be further described in the planning guidance your DHB receives from the Ministry.

I look forward to engaging with you on your planning intentions, receiving your planning documents for 2020/21 and working with you as your DHB delivers on your commitments. I appreciate you are receiving this letter at a time when our system is facing emerging pressures from COVID-19. I am pleased to see the way the sector has worked together during the early response phase and I know DHBs will continue to support our collective system response.

Thank you for your continued dedication and efforts to provide high quality and equitable health care and outcomes for New Zealanders.

Ngā mihi nui



Hon Dr David Clark
Minister of Health

Appendix one: Ministerial planning priority areas

Improving child wellbeing

The Child and Youth Wellbeing Strategy and Programme of Action (the Strategy) launched in August 2019 provides a clear pathway to ensuring New Zealand is the best place in the world for children and young people to live. I expect your annual plans to reflect how you are working to improve the health and wellbeing of infants, children, young people and their whanau. Your plans should focus on improving equity of outcomes (especially for Māori); on children and young people of interest to Oranga Tamariki; and children with greater need, including children and young people with disabilities.

I expect DHBs to increase childhood immunisation rates, especially for Māori. The recent measles outbreaks remind us of the impact of communicable diseases on our communities and the health sector and the importance of achieving full immunisation. I expect DHBs to work closely with their primary care providers to prioritise immunisation, including a renewed focus on robust pre-call and recall processes and immunisation outreach services.

I expect DHBs to focus on family and sexual violence screening, early intervention and prevention to ensure victims and families receive effective and timely health care and perpetrators are supported to break the cycle of family and sexual violence.

High quality maternity care is fundamental to ensure children get the best possible start in life. As part of their commitment to the Midwifery Accord signed in April 2019, I expect DHBs to implement a plan to improve recruitment and retention of midwives. You should use Care Capacity Demand Management (CCDM) work to ensure optimal staffing in maternity facilities.

Working with a full range of stakeholders, the Ministry has developed a comprehensive Maternity Action Plan to support a flexible, innovative and sustainable maternity system. I expect DHBs to work with all elements of the maternity system to ensure responsiveness to Māori and equitable access to quality maternity care, including maternal and infant mental health services.

Improving mental wellbeing

He Ara Oranga: Report on the Government Inquiry into Mental Health and Addiction and the Government's response, has set a clear direction for mental wellbeing in New Zealand. Supported by the investments announced in the 2019 Wellbeing Budget, we have a unique opportunity to improve the mental health and wellbeing of New Zealanders. Your leadership will drive system transformation in the mental health and addiction sector.

Collective action is needed to achieve equity of outcomes, in particular for Māori, as well as for other population groups who experience disproportionately poorer outcomes, including Pacific peoples, youth and Rainbow communities. You will work with the Ministry, the Initial Mental Health and Wellbeing Commission and the Suicide Prevention Office to support system transformation and the rollout of the Government's priority initiatives.

The mental health and addiction system must respond to people at different life stages and levels of need. I expect DHBs to work individually and collectively on mental health and addiction promotion, prevention and early intervention at the primary and community level. At the specialist end of the continuum you should ensure those with the most need have access to sustainable quality mental health and addiction services.

Improving New Zealanders' mental wellbeing will require collaboration with communities and non-government organisations (NGOs). I consider that DHBs have a social responsibility to

support the sustainability of NGOs and to empower communities to engage in the transformation of New Zealand's approach to mental health and addiction. This includes offering your expertise at no charge to NGOs and community organisations to support participation in new service delivery, particularly for communities who experience disproportionately poorer outcomes.

I expect you to contribute to the development of a sustainable and skilled workforce. You must invest to diversify, train and expand both the existing and new workforces. You should focus on training workforces to support the Government's primary mental health and addiction initiatives and communicate proactively with the Ministry about opportunities to expand coverage to reach underserved populations.

Improving wellbeing through prevention

Environmental sustainability

Ensure that you continue to contribute to our Government's priority of environmental sustainability, including green and sustainable facility design as noted above in the section on Capital Investment. I expect your annual plan to reflect your work to progress actions to mitigate and adapt to the impacts of climate change and enhance the co-benefits to health from these actions.

Antimicrobial resistance

I am concerned about the increasing threat of antimicrobial resistance (AMR) to our health security. DHBs have a key role in minimising this threat. The issues are systemic and require long-term planning and sustained actions.

I expect your annual plan to reflect actions that align with the objectives of the New Zealand Antimicrobial Resistance Action Plan and demonstrate you are working towards a sustainable approach to containing AMR.

Smokefree 2025

Smoking remains a major preventable cause of premature death, morbidity and health inequities. My expectation is that you work towards achieving Smokefree 2025. I expect to see effective community-based wrap-around interventions to support people who want to stop smoking, with a focus on Māori, Pacific people, pregnant women and those on a low income. The interventions should reflect your regional and programme provider collaborative efforts.

Bowel Screening

The National Bowel Screening Programme remains a priority for this Government. DHBs are expected to achieve national bowel screening targets (where applicable) and consistently meet diagnostic colonoscopy wait times. It is crucial that symptomatic patients are not negatively impacted by screening demand. DHBs must work individually and collectively to develop a sustainable endoscopy workforce, including support of training positions for nursing and medical trainees to meet growing demand in this area.

Better population health outcomes supported by a strong and equitable public health and disability system

National Cancer Action Plan

On 1 September 2019 the Prime Minister, Rt Hon Jacinda Ardern and I launched the National Cancer Action Plan and its four key outcomes. DHBs have an important responsibility to drive the necessary changes and deliver of these outcomes.

I have established a National Cancer Control Agency, which will report to me on the implementation of the Cancer Action Plan. You will work with and take direction from the Agency to reach national standards of care and improve quality.

Disability

Disabled people experience significant health inequalities and they should be able to access the same range of health services as the general population. Your DHB should look for opportunities to increase its employment of disabled people to improve the competency and awareness of your workforce in matters regarding disabled people and to advance social inclusion more generally.

Accessibility means that your DHB provides a barrier-free environment, including information and communications for the independence, convenience and safety of a diverse range of people. This includes people who may have access needs, including disabled people, older people, parents and carers of young children and travellers.

Enabling disabled people to access health services includes ensuring that all key public health information and alerts are translated into New Zealand Sign Language. It means consulting disabled patients (including people with sensory, intellectual or physical impairments) on their preferred means of communication for appointment notifications and the like.

As with previous years, your DHB must make progress towards, or fully implement, the United Nations Convention on the Rights of Persons with Disabilities. DHBs also need to implement policies and procedures to collect information about disabled people within your patient population. DHBs should also ensure contracts with providers reflect the requirement to either ensure accessibility or put in place plans to transition to a more accessible service.

Healthy ageing

If our ageing population continues to grow as current trends suggest, the number of people with dementia, and the associated financial and social consequences, will grow commensurately. This Government is determined to make a positive difference in the lives of people with dementia, their families, whānau, friends and communities. I expect your DHB to work with your region to implement the regional dementia priorities.

Please ensure the DHB develops models of care to identify frail and vulnerable older people in community settings, in particular Māori and Pacific peoples, and provides supports to restore function and prevent the need for acute care.

Workforce

I expect DHBs to develop bargaining strategies that progress the Government Expectations on Employment Relations in the State Sector.

I expect bargaining strategies to progress consistent employment arrangements and support agile, innovative workforces to deliver services. Employment arrangements should encourage people to grow, develop and thrive in a work environment that supports transdisciplinary teams and innovative models of care. I expect commitments made in bargaining to be met, including working party commitments, Accords or programmes, such as the CCDM programme.

DHBs have an essential role in training our future workforce and providing learning and development opportunities for current workforces. I expect you to continue to utilise current workforces to support innovative and transdisciplinary practice across models of care and enable people to work to their full scope of practice.

DHBs must create environments in which all health and disability workforces thrive. DHBs should facilitate healthy and culturally reinforcing working environments that support health equity outcomes for all.

Workplace violence

I am concerned about what appears to be increased levels of violence in the health workplace. In accordance with the Health and Safety Act 2016, DHBs are responsible for the health and safety of their staff, patients and visitors. I expect DHBs to keep staff, patients and visitors safe by implementing appropriate policies, procedures and training to maintain public trust and confidence in the health and disability sector.

Health Research Strategy implementation

Research and innovation, analytics and technology are all crucial to achieving an equitable, sustainable health system and better patient outcomes.

The New Zealand Health Research Strategy (2017-2027) is the key platform for us all and it is important to implement the strategic priorities. In the next year, we should focus on developing a flourishing research and innovation culture in our DHBs in both primary and secondary care.

I have asked the Ministry to work with you and other stakeholders to build up DHB people and resources to support and enhance research, innovation and analytics so the system can make better use of the evidence and innovation and contribute to the Health Research Strategy objectives. Please work with the Ministry to design and invest in the programme of work with a focus on creating regional research and analytics networks that support staff engaged with research and innovation.

National Health Information Platform (nHIP/Hira)

Digital health services are important to me and to all New Zealanders and I expect DHBs to ensure the digital services you use are safe, secure, integrated, reliable and provide appropriate access to data and information.

I also expect you to support the Ministry in developing and designing nHIP/Hira services and to prioritise nHIP/Hira implementation activities in your annual plan.

Planned care

The refreshed approach to deliver elective and arranged services, under a broader planned care programme, will build on the development of the three-year plan you started in 2019/20. Timely access to planned care remains a priority. I urge you to take advantage of the increased flexibility in where and how you deliver these services; to ensure improved equity

of access and sustainability of service delivery; and to provide services that meet your population's health care needs, support timely care and make the best use or your workforce and resources.

I am particularly concerned, across many DHBs, about the number of people waiting beyond expectations for first specialist assessments, planned care interventions, ophthalmology follow-ups and diagnostic radiology services. Please ensure you have appropriate plans in place to support timely care.

Measuring Health System Performance

The System Level Measures (SLM) programme provides a framework for continuous quality improvement and integration across the health system. I intend to build upon the SLM framework by publicising local progress in responding to my national priorities from quarter one 2020/21. I expect DHBs to work with all health system partners to agree local actions and the contributory measures needed to make a tangible impact on health system performance. This will require broadening of alliances to include partners beyond the primary health organisations (PHOs). Equity gaps are evident in all SLMs and in nearly all districts. Where equity gaps exist, I expect local actions and contributory measures to focus on addressing these gaps.

Care Capacity Demand Management

I continue to expect significant progress on implementing all components of the CCDM programme this year, including detailed plans for full implementation in all units in nursing and midwifery by June 2021. Full implementation includes annual FTE calculations and agreed budgeted FTE in place. I expect timely reporting, including your assessment on progress towards meeting the June 2021 deadline for full implementation of CCDM. It is vital that nurses and midwives see the impact of CCDM FTE increases and effective variance response management on safe staffing levels and that the core data set drives quality improvement. It remains my expectation that CE performance expectations include delivering CCDM expectations within agreed timelines.

Better population health outcomes supported by primary health care

Primary care

Primary care makes a significant contribution to improving health outcomes and reducing demand on hospital services. Continuing to improve primary health care remains a priority for this Government.

DHBs must work with their primary care partners and lead their alliance(s) to develop and implement models of care that improve equity for Māori and other high needs populations through services that target the needs of these populations. I expect these new models of care to use broader multi-disciplinary teams, strengthened inter-professional collaboration and improved integration between secondary, primary and community care. I expect high-quality information and data to be shared through formal agreements and used to support decision-making, particularly in improving outcomes for Māori.

Long-term conditions

As I have previously advised, I expect DHBs to explicitly require improvements in performance and reporting on long-term conditions in their contracts with PHOs. DHBs should incentivise PHOs to improve equity, reduce the burden of long-term conditions, demonstrate improvements in primary care settings and increase accountability for effectively managing long-term conditions, especially diabetes.

Pharmacy

Progress has been made on the strategic vision of the Pharmacy Action Plan 2016. I expect this progress to accelerate as you work with the pharmacy sector to develop funding models and models of care that are equity focused and centred on service users. Please ensure your DHB enables pharmacist vaccinators to deliver a broader range of vaccinations to improve access.

Rural workforce

DHBs with rural communities should build on 2019/20 and improve access to services for rural people. I expect you and your rural alliance partners, including rural hospitals, to explore the opportunities to use the Ministry's rural workforce initiatives to strengthen your rural workforce and improve the sustainability of rural services.

Supporting delivery of the Māori health action plan

The sector has recently engaged in the development of a Māori Health Action Plan to further implement He Korowai Oranga: the Māori Health Strategy and improve Māori health outcomes. I expect all DHBs to demonstrate delivery and implementation of this plan in 2020/21 planning documents.

Improving wellbeing through public health service delivery

Public Health Units (PHUs) are key to protecting and improving health and you should ensure that your DHB has strong and sustainable public health capability and capacity. I expect to see PHU plans integrated with DHB Annual Plans where appropriate in 2020/21.

Over the next year, a programme is underway to develop criteria and to confirm the accountability arrangements for public health service delivery. I encourage your PHU and DHB to get involved in this process and support the programme.

PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**CPHAC DISCUSSION PAPER**
	Date: 11th March 2020

Author	Joanne Edwards, Planning and Performance Advisor
Endorsed By	Sandra Williams, Executive Leader, Planning and Performance
Subject	Wairarapa Palliative Care Update

RECOMMENDATION

It is recommended that the Community and Public Health Advisory Committee (CPHAC):

Notes this summary of the Wairarapa Palliative care Service and its implementation.

ADDENDUMS

1. Gold Standards Framework
2. interRAI Palliative Care (PC)
3. Monitoring framework Report Oct – Dec 2019
4. Characteristics assessed

1 PURPOSE

The purpose of this paper is to inform CPHAC about how the Sub-regional Palliative Care strategy, "Living Well, Dying Well" is being implemented in Wairarapa.

2 SUMMARY

The Wairarapa Palliative Care Service is targeted at patients with life limiting cancer or non-cancer illness with little or no prospect of cure. These people are usually well known to their general practice and other services and are entering a new phase of their life. The service aims to ensure that patients receive quality, coordinated health care and support services based on a palliative approach whereby primary care is supported by palliative care specialist services.

The Wairarapa Palliative Care Service is a network of a number of agencies each with a specific role who work together across the sector. Some components of the Wairarapa Palliative Care Service are more visible than others and achieve more public recognition, but each component is essential.

The Wairarapa Palliative Care Service can be likened to a service alliance rather than a singular service. The service fabric is woven from a variety of strands to create a stronger, more integrated service than any one of those strands can provide alone. Strengths of this model include a broad reach for people who need palliative support, not just the few who are under the specialist service. However, by not being a singular specialist service, this approach also presents a challenge in 'visibility' and identification of the Palliative Care Service being more related to a person's journey through a range of services than specific to just one.

Since July 2019, implementation of the living Well, Dying Well strategy in Wairarapa has targeted a number of service developments and it is recognised that further implementation and a focus on quality improvement will continue to drive progress.

PUBLIC

3 BACKGROUND

The sub-regional palliative care strategy, "living well, dying well", was endorsed by the Wairarapa DHB in 2016. Its vision is that -

'ALL PEOPLE WHO REQUIRE A PALLIATIVE APPROACH LIVE WELL AND DIE WELL IRRESPECTIVE OF THEIR CONDITION OR CARE SETTING'. **THIS VISION IS INTENDED TO BE ACHIEVED THROUGH THE PRINCIPLES:**

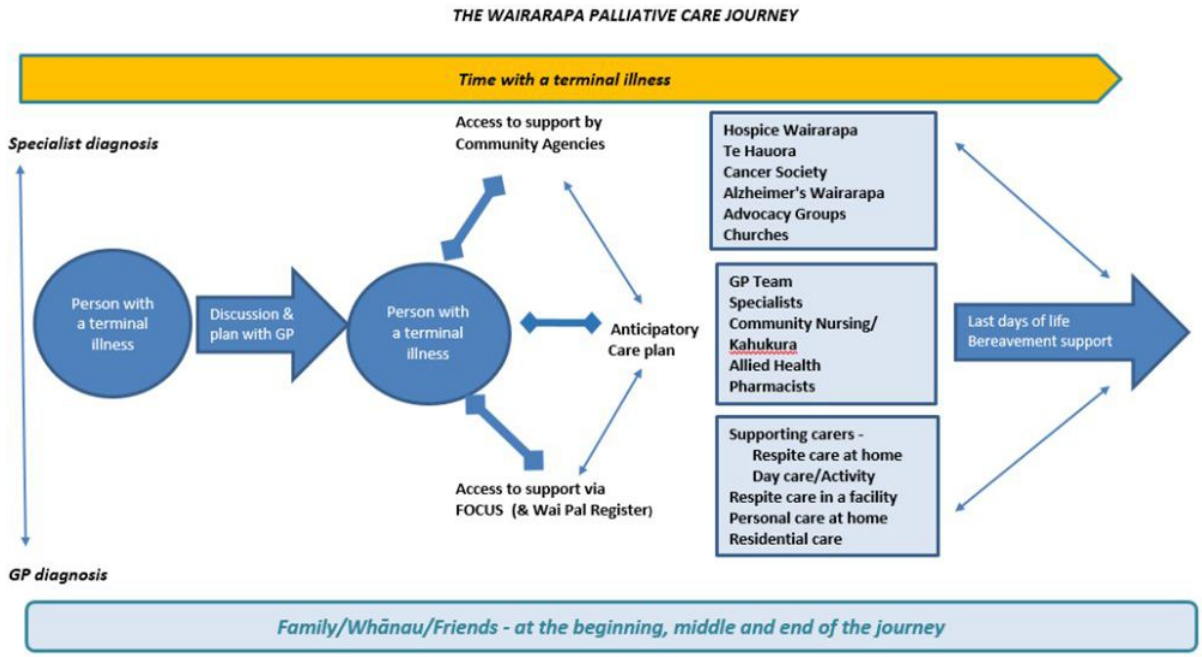
- Seamless and holistic patient care
- Service provision is based on need
- One integrated care team
- Led by primary care
- Supported by specialists in palliative care
- Clearly defined roles and responsibilities

Since 2016 a number of actions have assisted towards implementing this strategy. This document describes how the Wairarapa palliative care model is being implemented. Both capability and capacity have improved for Wairarapa over recent years, but it is recognised that there are still improvements which need to take place, including service review based on feedback from families and increased access for people with non-cancer diagnoses.

1 PALLIATIVE CARE IN WAIRARAPA

1.1 The Journey

The journey of a person with a terminal illness and those important to them is a very personal one and one which needs different services at different stages of the journey. Palliative Care in Wairarapa is not a singular service, but rather a range of services offering a palliative approach, with primary care taking the lead. The diagram below illustrates the main components of the Wairarapa system for the palliative journey.



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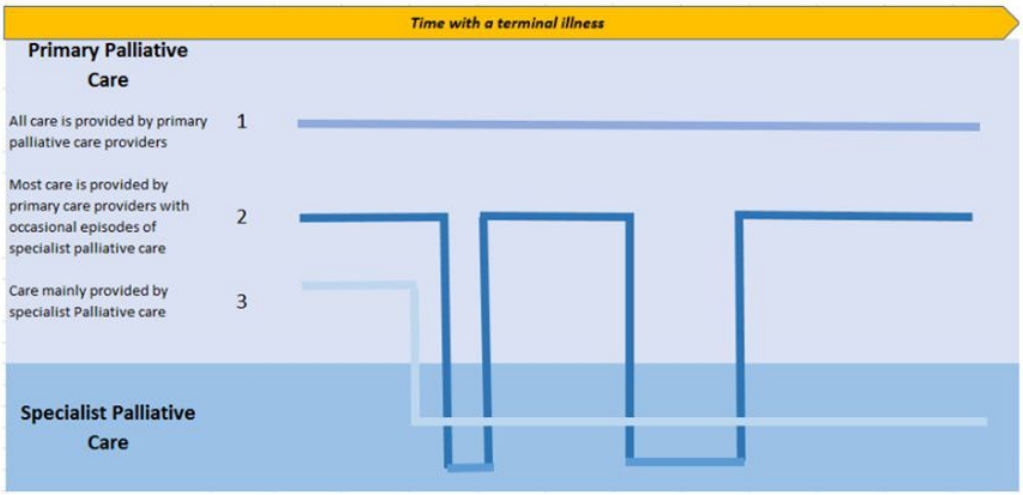
Specialist palliative services (assessment, clinical advice/ management and education) provide support to primary care and people may need more intensive and specialist palliative services at different times in their journey.

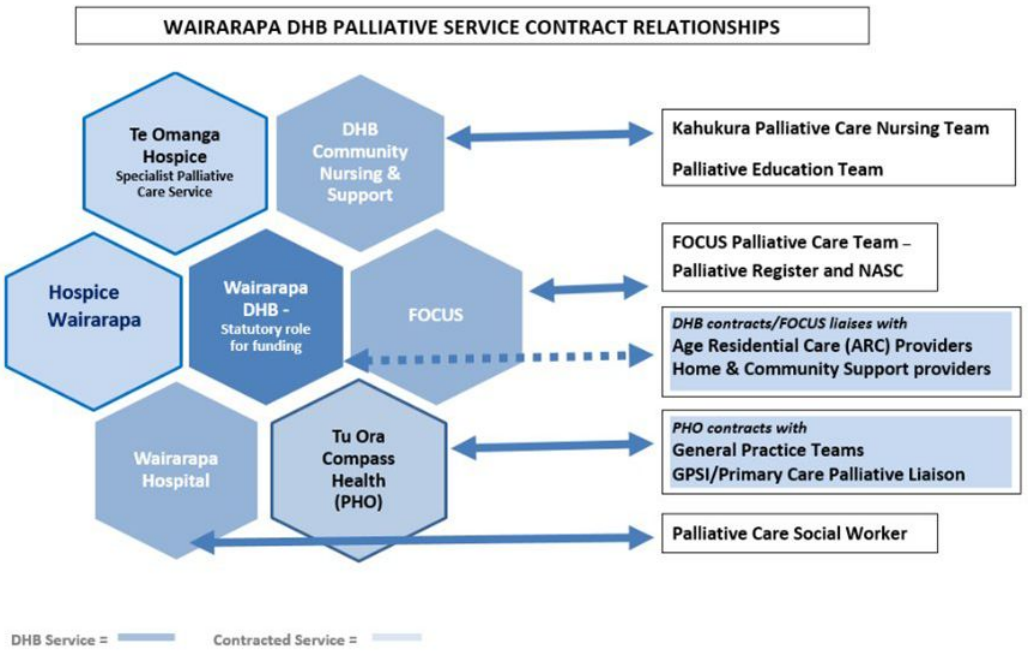
The Wairarapa Palliative Care Journey – The Relationship Between Primary and Specialist Palliative Care[1]



[1] Adapted from the *Living Well, Dying Well Strategy, The relationships between primary palliative care and specialist palliative care*
Source: Ministry of Health (2015a)

1.2 The Services

The Wairarapa Palliative Service is provided by a range of organisations; The DHB itself provides components of the service other components are provided through contracts with non-government organisations (NGOs), while other supports are provided through community agencies.



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1.3 Implementation

The implementation plan was endorsed by the Board in June 2019. This plan is building on past developments and acting as a springboard for future actions. The key principles underpinning the implementation plan are:

- GP led - All referrals for specialist palliative care to go through GP
  - MDT review & planning using the Gold Standard Framework (GSF) 'traffic light system' (Appendix 1)
  - Anticipatory care planning.
- Supported by specialist palliative care service (Te Omanga & Kahukura nursing service) – assessment, advice & education.
- Wairarapa wide – All people needing a palliative approach (FOCUS register & support service coordination).
- Provided by a network of agencies – Hospice Wairarapa, ARC providers, Allied Health, Community Nursing, HCSS, Pharmacies, Wellington Free, hospital.
- 'Ownership' - PC Management Group (provides collective leadership for system-wide implementation) and wider PC Reference Group (stakeholders).

Since July 2019, actions have included:

- Finalisation of the Wairarapa Palliative Care Health Pathway (a web based system to guide health professionals in their management of patients).
- Multidisciplinary approach – Planned Care Team established by Masterton Medical practice.
- Revised FOCUS referral form and Wairarapa-wide Palliative Care Register.
- Implementation of interRAI Palliative Care assessment to ensure timely access to appropriate supports (Appendix 2).
- Implementation of short term in-home respite primarily intended to be for in-home night support to enable a carer to sleep, but can provide additional support at other times of carer stress.
- Implementation of a carer support programme by Hospice Wairarapa.
- Education and mentoring for professional development of health professionals.
- Te Ara Whakapiri: Principles and guidance for the last days of life guidance tool being introduced in ARC.
- Wellington Free Ambulance – in process of establishing access to Medimap (electronic medication system) for Kahukura patients.
- Governance groups and reporting framework established.

Anticipated developments for 2020/21 include:

- Establish a position for primary care palliative liaison. This GP role will support their peers and generalist health professionals across the Wairarapa to achieve optimum outcomes for their patients and quality improvement through education, mentoring and clinical governance.
- Extending number of primary care practices implementing the palliative care health pathway, including using gold standards framework for interdisciplinary anticipatory care planning.
- Wellington free Ambulance – Embed Medimap and communication systems for Kahukura patients in the community
  - Stage 1 – 'Read only' access to medimap to access patient's current medication record
  - Stage 2 – 'write' access so that medications which have been given can be recorded on the shared electronic system.
- Establish a palliative care 'clinical coach' role to support arc providers to strengthen knowledge and skill of the workforce and endorse their role in the Wairarapa integrated palliative care model.
- Extend rural reach for supporting family carers through community based programmes.
- Embed processes for follow-up conversations.

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1.4 Management of the Wairarapa Palliative Care Service

Although much has been achieved since 1 July 2019, there are still actions to be addressed. It is expected that the Wairarapa Palliative care service will continue to develop and grow within a quality improvement framework. The Wairarapa Palliative Care Management Group is responsible for driving the acheivement of the Wairarapa Palliative Care Plan and Living Well, Dying Well strategy. It supports the Tū Ora Compass Health Programme Manager to monitor progress in implementing the plan, monitoring service inputs, outputs and outcomes and driving service development. This group reports to the Alliance Leadership Team.

The purpose of the Group is to collectively evaluate service delivery, functionality and effectiveness of the service. The Group will:

- Provide system-level oversight and evaluation of all aspects of the service.
- Ensure connectedness and a whole of system approach to service delivery.
- Highlight issues to the funder as well as advice on potential improvements.

Beyond the Palliative Care Management Group is the wider reference Group which is comprised of a wide range of interested parties. Together, they provide collective leadership across all settings of the health sector within Wairarapa. Through their experience, observations, opinions and preferences they inform and influence the Palliative Care Management Group.

1.5 Monitoring and Quality improvement

The monitoring framework is a high level regular summary of indicators – some inputs, outputs and outcomes. This enables the Management group to ensure that implementation is on track and identify service development needed. The indicators which are included reflect a range of aspects of the Wairarapa Palliative Care approach and are informed by more specific detail which can be 'drilled down' as needed.

Appendix 3 presents the latest quarterly report.

At a high level, the characteristics of older people assessed by interRAI in Central Region (July 2018 – June 2019) is presented in Appendix 4. This data is presented regionally because at the DHB level, the data sets for these measures are too small to be meaningful. Nevertheless, it is interesting to note ethnic differences which should in turn prompt further service development.

5 PALLIATIVE CARE INVESTMENT IN WAIRARAPA

The Wairarapa DHB invests in Palliative care through a range of services which together provide the Wairarapa Palliative Care Service. Investment in these services for 2019-20 are described in the table below and total $1,397,182:

NGO Providers

NGO Provider Name	Service	2019/20
Compass Health -Primary Care Local Services Agreement	Primary Health Palliative Care Service	$ 94,201.00
Compass Health -Primary Care Local Services Agreement	Primary Care Palliative Liaison	$ 36,500.00
Hospice Wairarapa	Carer Support programme and funding for overnight care, bereavement support	$ 10,733.00
Te Omanga Hospice Trust	Specialist Palliative Care Medical Services	$ 89,575.00
TOTAL		**$ 231,009**

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Wairarapa DHB Provider Arm

DHB Provider Service	Service	2019/20
FOCUS	Palliative care Assessment & Service Coordination	$ 92,810.00
FOCUS	Palliative Care – Community Service (night respite)	$ 15,000.00
Community Nursing and Support	District Nursing – palliative care	$ 683,071.00
Community Nursing and Support	Kahukura & Social worker	$ 286,582.00
Community Nursing and Support	Specialist Palliative Education and Liaison service	$ 88,710.00
TOTAL		**$ 1,166,173.00**

Support is also provided in the community and age residential care for people with palliative care support needs. However, these clients are part of a larger cohort in each funding stream and are not reported as a separate group. Funding lines include:

Long term Support- Chronic Health conditions (LTS-CHC) *– people under 65 years with palliative care support needs, with a longer prognosis -likely to be over 6 months*

CMI funding *– People under 65 years with palliative care support needs, with a shorter prognosis – weeks to months, up to 6 months*

Home & Community Support services (HCSS) *– People in both age groups with palliative care support needs*

Age Residential Care (ARC) *– People over 65 years with palliative care support needs*

- Palliative respite may be provided through any of the above funding lines depending on the clients funding category.

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Appendix 1

Gold Standards framework

The palliative care Gold Standards Framework (GSF) needs-based coding system informs needs-based prioritisation and anticipatory planning. It will guide referral urgency, anticipatory interdisciplinary planning and determination of 'no charge' status.

Appendix 2

interRAI Palliative Care (PC)

interRAI is a suite of web based assessment tools which has been adopted across New Zealand. A number of assessment tools sit within this system and all of them are internationally validated with amendment for a New Zealand cultural context. In Wairarapa, FOCUS assessors are trained in using the interRAI assessments which inform their discussion with a person and their family/ whānau about how their support needs may be met. Other health providers and agencies involved with individuals are able to access this assessment to prevent the person being subject to duplicate assessments.

The interRAI Palliative Care (PC) Assessment tool was developed to provide a comprehensive assessment of the strengths, preferences, and needs of adults in both hospice and palliative care. Following testing in Canada, Czech Republic, Iceland, Netherlands, Sweden, Spain, and the U.S., the first version was released in 2003. The system has since been updated as part of interRAI's restructuring initiative to ensure that all of our instruments contain common items and definitions for overlapping clinical content.

The Palliative Care assessment offers an alternative for Home Care assessors to be used with clients living in the community and with a terminal condition or prognosis. The assessment focuses on items like, for example, managing pain and fatigue, and preparing for the need for increased support. Palliative Care assessments are also shorter than the standard Home Care assessments.

Appendix 3

Monitoring framework Report Oct – Dec 2019

The monitoring framework includes selected measures to represent monitoring of service quality, provision, and development. The reporting template is attached and is used for a quarterly report to the Palliative Management Group on a quarterly basis, from 1 October onwards.

Measure	Comment
Interview - significant other's response - was the death a 'good death' - or not? (& reason) (Approx 12 – 16 weeks after death)	FOCUS will be providing this service for all palliative patients who die. Deferred over the end of year period.
Total number on register on last day of the Quarter	**1 October to 31 December Q2:** 83 on register - 10 Māori; 67 NZ Euro; 1 Pacific Island; 20 other

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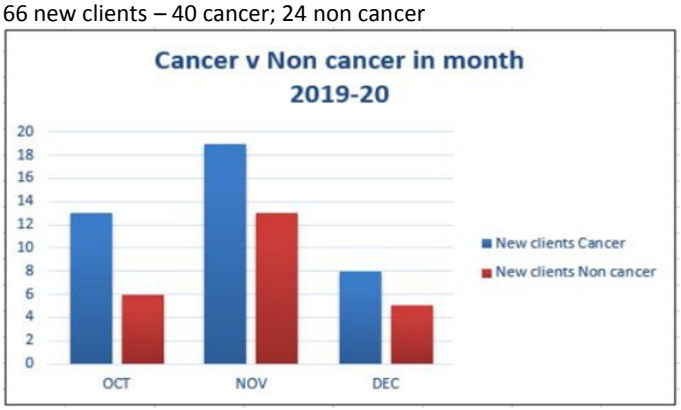
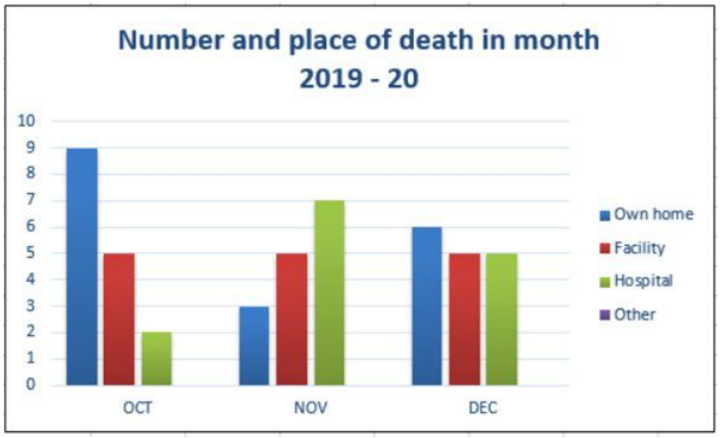
<table>
<tr><td>New clients on register during this quarter</td><td>1 October to 31 December Q2:
66 new clients – 40 cancer; 24 non cancer
 
</td></tr>
<tr><td>Number of deaths on register & Place of death</td><td>1 October to 31 December Q2:
<table><tr><th>No. of deaths</th><th>Own home</th><th>Facility</th><th>Hospital</th><th>Other</th></tr><tr><td>47</td><td>18</td><td>15</td><td>14</td><td>0</td></tr></table> 

Because Wairarapa does not have in-patient hospice beds, data relating to “dying in a facility” masks two distict groups of people – those who live there long term and those who have transferred there for palliative care.

The Management Team is keen to identify those groups of people to gain a clearer picture of those who die in their ‘own home” .</td></tr>
<tr><td>Calls for specialist advice – nursing and medical</td><td>1 October to 31 December Q2
15 calls
Relationship with Te Omanga specialists seems to be key to using this service to the maximum advantage.</td></tr>
<tr><td>Specialist palliative care support for the Wairarapa Palliative Care Service</td><td>Case based teaching at Kahukura MDT on Wednesday afternoon – various topics which arise from patients seen on that day

12 clinics
The Clinical medical education (CME) at Wairarapa Hospital will start in Feb 2020.</td></tr>
<tr><td>Clinical issues/trends identified through patient reviews</td><td>The Te Omanga report notes that the formation of the ‘clinical governance’ group is an important improvement (yet to be established through the role of Primary Care Palliative Liaison).</td></tr>
</table>

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Palliative Education report

Education Provided	No. Attendees	No. Sessions
Palliative Care Education Trust lectures	18	3
Fundamentals RNs-3 sessions	18	2
Fundamentals HCAs	24	2
Syringe Driver	19	4
Volunteers	15	1
Carer support	8	1
Te Ara Whakapiri	17	2
ACP-community	16	1
De-briefing-various facilities	15	2
End stage Dementia (trial)	Nil till Feb	
In-Services (various facilities)	27	4
Primary care presentations	11	1

Education is changing with more "on site" education being requested. Discussion with ARC providers has led to

- planning 1.5-3hour sessions on various subjects for individual facilities on subjects such as communication, loss and grief, building resilience, de-briefing, end of life care and support.
- notifying all ARC and community service providers about "other" short sessions that may be available.

Education contact for primary care (as in G.P. practices) has increased.

A new facility is yet to commence provision for palliative respite. Palliative Care Training for their staff is commencing in February.

AIM for 2020 is to implement Te Ara Whakapiri across the Inpatient units in Wairarapa Hospital.

Innovations funding has been transferred to the Palliative Care Education Services and used to appoint 0.3 FTE Palliative Care Clinical Coach for supporting ARC.

Supporting patients, family carers and whānau

The Caregivers Programme
Evaluation comments from participants continue to describe the value of this programme in terms of understanding, practical support and sharing feelings with peers/hospice.

During this quarter23 Services delivered (8 different people attended). Ethnicity European/Pakeha 7, Māori 1

Night Support

	Month October	Month November
Nights - Support Worker	23/10/10, 24/10/19 29/10/19	14/10/19
Other Hours - RN		
Other Hours - Support Worker		
Maori clients		
Other clients	1	1

* December data not yet available
Bereavement Support
[Residential care facility] in October

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	Hospice Wairarapa is visiting all ARCs in February to reinforce that this care is available.
Implementation comments	GP practices are now better informed about the recent changes to the palliative service and are using the revised forms/processes. Feedback from families of patients who have been palliative are very complimentary about the clinical care and support they receive, but have been confused about who is leading the care (e.g. GP, MML team, Kahukura or District Nursing). It is likely that this risk arises from the palliative care service being a network of providers rather than one single identifiable palliative care provider and further work is needed to clarify this journey for patients and their families. Two families have offered to share their experience with the Management team. Shawn Sturland, the DHB CMO, has undertaken to clarify the referral pathways into the palliative care service with Wairarapa DHB medical staff and out-of-area consultants. MML have established a planned care team, who are focusing on the management of patients with long term conditions including palliative patients.

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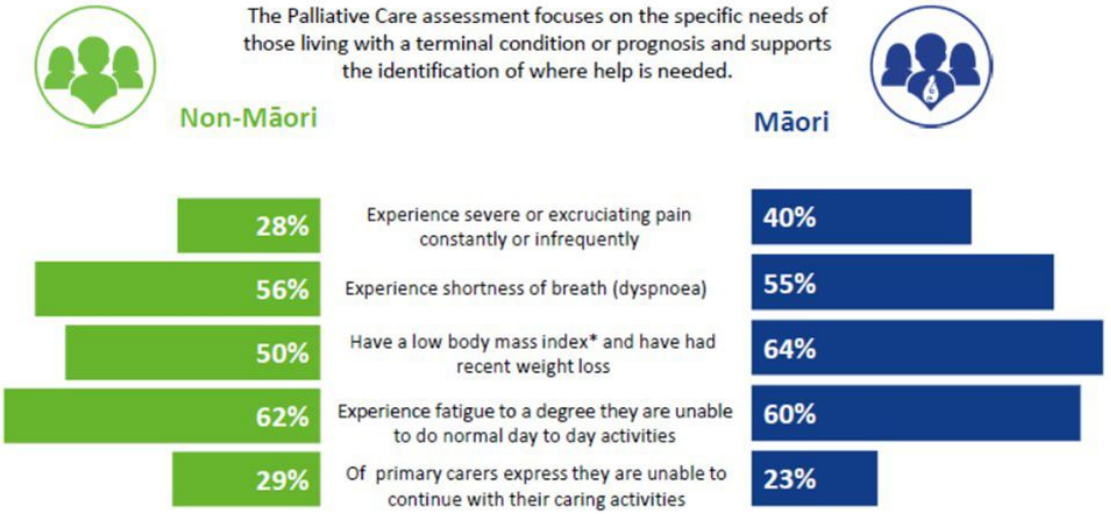
Appendix 4

The characteristics of older people assessed by interRAI, Central Region 1 July 2018 to 30 June 2019

The Palliative Care assessment focuses on the specific needs of those living with a terminal condition or prognosis and supports the identification of where help is needed.



One of the ways DHBs help older people get the right support at the right time, is to have a health professional complete an assessment of a person's health and wellbeing. One assessment is the interRAI Palliative Care Assessment, for people living at home in the community with a terminal condition or prognosis.

The Palliative Care Assessment has been phased in across the Central Region DHBs over the last couple of years and may be used in place of the interRAI HomeCare assessment.

Notes: 608 interRAI Palliative Care assessments were completed between 1 July 2018 and 30 June 2019. Of those assessed, 10% identified themselves as Māori and the latest population estimates distributed by Stats NZ, shows 7% of the population aged 65 plus, identify as Māori.

* In the Palliative Care Assessment, low Body Mass Index (BMI) is defined as 20 or lower.

interRAI New Zealand · Capital & Coast District Health Board · Hutt Valley DHB · Hawke's Bay District Health Board · MidCentral District Health Board · Wairarapa DHB · Whanganui

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**CPHAC DISCUSSION PAPER** **Date: 9 March 2020**

From	Sandra Williams, Executive Leader, Planning and Performance
Author	Keith Fraser, Planning and Performance Advisor
Endorsed By	Dale Oliff, Chief Executive
Subject	Pharmacy services in the Wairarapa

RECOMMENDATION

It is recommended that the Community and Public Health Advisory Committee (CPHAC):

1. **Notes** the contents of this report
2. **Notes** Wairarapa DHB forecasts it will invest $12.6m in local providers in 2019/20 for community pharmaceuticals and services for 2019/20 to be
3. **Notes** the opportunities for pharmacists -practising at top of scope; pharmacists as part of the Healthcare Team (Integration), improving the quality of medication use, locally commissioned pharmacy services, recognising quality in pharmacist services, and working with intersectoral partners to remove cost access barriers.

APPENDIX

1. Top 20 pharmaceuticals by cost and volume

1. PURPOSE

The purpose of this paper is to update the Community and Public Health Advisory Committee (CPHAC) on the performance of services provided for the Wairarapa population under the nationally negotiated Integrated Community Pharmacy Services Agreement (ICPSA). This paper includes information to the pharmaceuticals and pharmacy services that comprise 7% of health system expenditure and 10% of DHB expenditure. It focuses on the 9% of DHB expenditure that community services account for, and the particular challenges for that sector.

2. RELATIONSHIP WITH PHARMAC AND PRESCRIBERS

PHARMAC is responsible for managing the supply and cost of medicines. DHBs agree the national pharmaceutical budget with PHARMAC each year. As a major area of expenditure for the DHB, we have a strong interest in understanding the utilisation of medications including growth, geographic and equity based perspectives.

At a local level, community pharmacies purchase pharmaceuticals from regional wholesalers, which in turn purchase them from the drug companies.

The prescribers of medications are principally GPs and specialists, but also dentists and there is an emerging group of prescribing nurse practitioners and prescribing pharmacists. For Wairarapa DHB, a significant amount of the overall cost of medication is prescribed by specialists outside the DHB region, especially by rheumatology and cancer specialists.

3. INTEGRATED COMMUNITY PHARMACY SERVICES AGREEMENT

Wairarapa DHB forecasts investing $12.6million in 2019/20 in agreements for community pharmacy services with 6 pharmacies in our district. The agreements cover dispensing and other services provided by community pharmacies and the costs of the pharmaceuticals dispensed. While pharmaceuticals are also provided to patients in both inpatient and outpatient settings in both local and other hospitals, around 90% of pharmaceuticals by cost are provided through community pharmacies.

The Integrated Community Pharmacy Services Agreement (ICPSA) is an evergreen contract between DHBs and community pharmacies, like the contracts between DHBs and Aged Residential Care and Primary Health Organisations. There is an annual process of review to agree changes to price and services. The ICPSA provides for DHBs to reimburse community pharmacies for:

- the gross cost of pharmaceuticals
- plus pharmacy service fees for supply and advice
- less any patient contribution (usually $5 per item up to 20 items).

Some services don't fit the usual pattern of pharmaceutical supply and advice and require a different level of service. Examples are monitored therapy medicine services (Clozapine and Warfarin), long term conditions (an adherence support service), and flu vaccination (a public health prevention service).

The ICPSA has two main levels of services;

- Nationally commissioned services that are determined through the national process

Service	Description
Long Term Conditions	For people with chronic conditions and adherence issues. The DHB funds the pharmacist $21 per month for every registered LTC user.
Aged Residential Care services	Community Pharmacies supply medications to aged care facilities.
Funded influenza vaccinations	Vaccination of pregnant women and those aged 65 and above.
Special medicines	Includes Clozapine, (an atypical anti-psychotic with potential effects on white cell count), opioid substitution medicines and the supply of sterile medications
CPAMS	Warfarin patients where the blood tests are done in the pharmacy. The dose can be adjusted by the pharmacist based on the result. The DHB funds five Pharmacies $540 per year per enrolled patient

- Locally commissioned services that are determined at the local level.

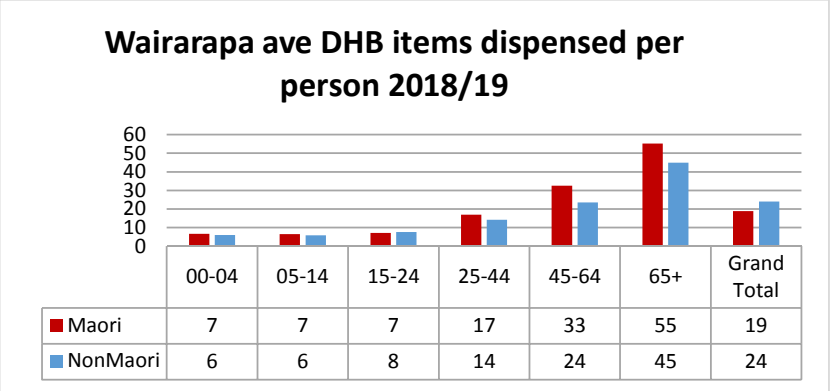
4. SERVICE PROVIDERS

Wairarapa has contracts with eight community pharmacies, four in Masterton and one in each of the towns, Carterton, Greytown, Featherston and Martinborough. They vary significantly in size from those employing as few as one pharmacist and one technician up to those with 5

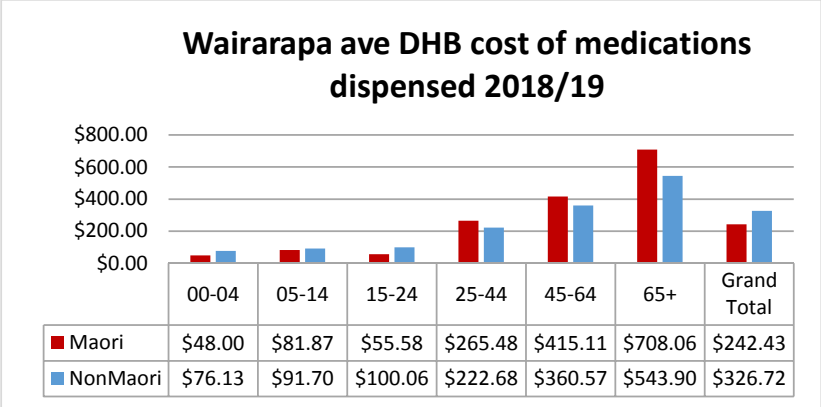
pharmacists and 6 pharmacy technicians. Wairarapa has larger pharmacies on average at 5800 people per pharmacy compared with 4600 for NZ.

5. PEOPLE RECEIVING SERVICES

There is variation in the use of medications across DHBs due to different prescribing patterns, age structures and the incidence of disease.
The amount and cost of medication prescribed follows closely the age structure of the population, as the following two graphs show.

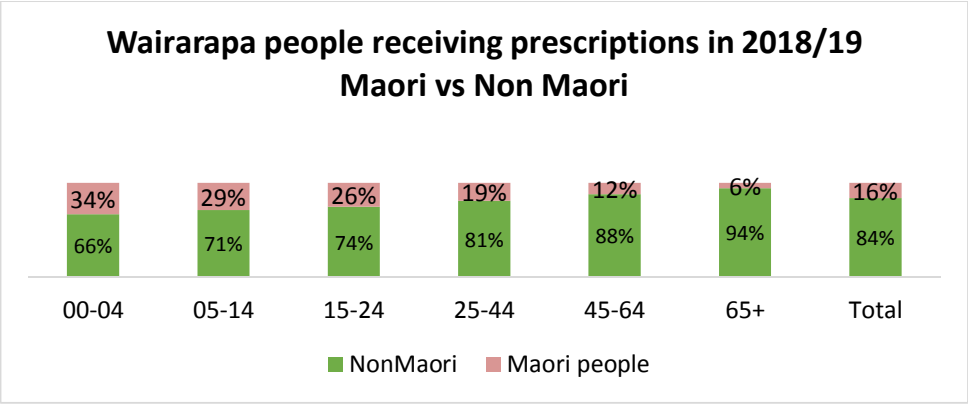


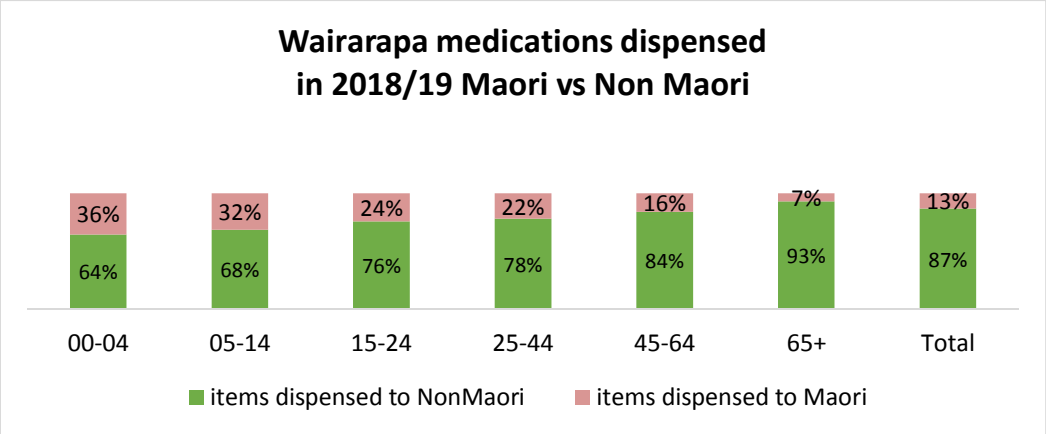
	00-04	05-14	15-24	25-44	45-64	65+	Grand Total
Maori	7	7	7	17	33	55	19
NonMaori	6	6	8	14	24	45	24



	00-04	05-14	15-24	25-44	45-64	65+	Grand Total
Maori	$48.00	$81.87	$55.58	$265.48	$415.11	$708.06	$242.43
NonMaori	$76.13	$91.70	$100.06	$222.68	$360.57	$543.90	$326.72

In general, Maori appear to be receiving less medication than we might expect, given the burden of disease. The greatest disparity appears to be in the 15-24 age group where 31% are Maori but only 24% of dispensed items are for Maori. This may reflect the HQSC survey that found that cost of medications is more of a barrier for younger people than for over 65s.





6. OTHER DRUG EXPENDITURE PATTERNS

There are **676** different medications (chemical names) that were dispensed in 18/19. The most commonly prescribed medicine is paracetamol but our most expense drug is Adalimumab (marketed as Humira) is a monoclonal antibody drug that inhibits inflammation in joints.

The top 20 pharmaceuticals by cost and volume are listed in Appendix 1.

Variation at a DHB level reflect local patterns of prescribing and incidence of disease – eg cancer and rheumatology. The list above excludes Hepatitis C since the drugs are provided directly to pharmacies for named patients and costs do not appear in the claims database.

Variation on a monthly basis can reflect pace of uptake of new drugs from DHB to DHB and the timing of new drugs becoming available during the financial year. Most new drugs now are high cost and low volume and often have rebates attached to them (sometime very large rebates). This can mean monthly pharmaceutical costs can be very lumpy from month to month, due to the uptake of expensive new drugs at particular points in the year.

7. SUMMARY

Pharmaceuticals and pharmacy services are around 10% of DHB expenditure.

There is considerable opportunity to improve the quality use of medications, particularly for Maori and older people, that will require a collective response from DHBs, prescribers, pharmacies and other social sector agencies, such as income support.

8. OPPORTUNITIES

- Pharmacists Practising At Top of Scope
- Pharmacists as Part of the Healthcare Team (Integration)
- Improving the Quality of Medication Use
- Locally Commissioned Pharmacy Services - LTC
- Recognising Quality in Pharmacist Services
- Co-payments and Co-payment Support
- Pharmacy Contracting Policies

4.1 Pharmacists Practising at top of scope

The principal challenge for the pharmacy sector is evolving from a transaction (medicines supply) focussed service model to one where the patient is at the centre and the cognitive services

(advice to patients) are more highly valued. We will need to change the current funding system of paying a fixed amount per item dispensed. Pharmacies are almost entirely funded this way. The funding system needs to be more patient based, to more closely reflect the large proportion of activity dedicated to serving the core group of patients (20%) with long term medication needs. This should be set so it more fairly reflect equity challenges (serving higher needs populations), and also to de-emphasise dispensing frequency as a determinant of revenue and more fairly be a matter of professional judgement.

Pharmacies will need to respond by re-engineering their dispensaries to have technicians with automated technology undertaking the medication supply function to allow pharmacists to spend most of their time face-to-face with patients. DHBs, prescribers and others in the system will also need to play their part by enabling better access to information, to reduce the amount of time chasing relevant information such as the medication list (what has been prescribed), the diagnoses (what is the medication being used for) and laboratory test results (is the medication working or even being taken). Accessing the hospital patient management system to clarify medication information is invaluable and enhanced patient safety in those DHB regions where this has been enabled. In some DHBs, patient privacy concerns and lack of sufficient priority continue to slow information access for pharmacists as health professionals with a legitimate interest and involvement in patient care.

Information systems improvement can also be used to drive prescription quality improvement and free up time by pharmacists spent addressing incorrect scripts.

4.2 Pharmacists as Part of the Healthcare Team (Integration)

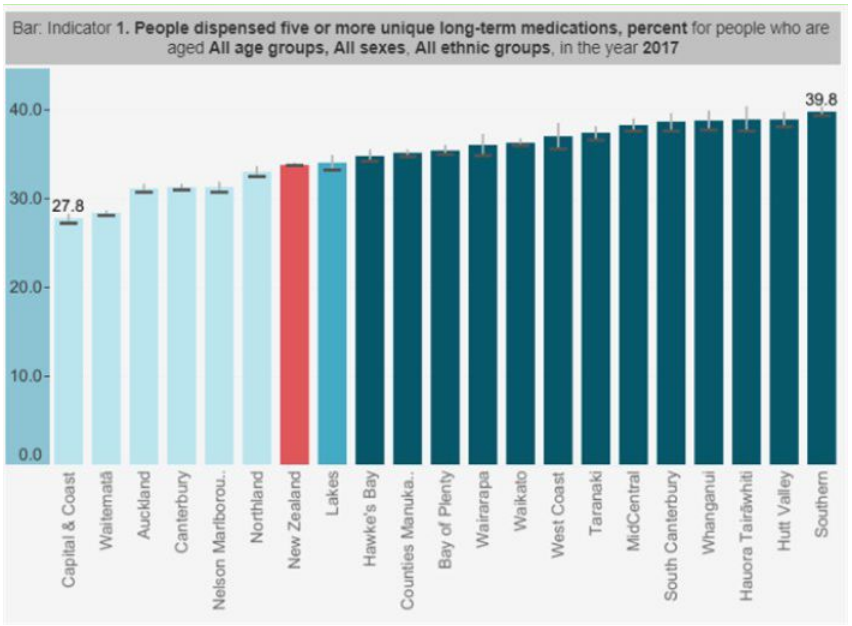
Pharmacists need to be connected to the team involved in patient care by being able to interact efficiently through mechanisms such as multi-disciplinary team meetings and shared plans of care. PHOs in the greater Wellington Region and elsewhere have agreed to support and recommend that general practices adopt Indici as a patient management system. Indici has the functionality to enable interaction with other information systems and provide access to a shared plan of care that health professionals involved in a patient's care can view and contribute to. At present, while many discussions between pharmacies and general practice are over patient health issues, many of the interactions are about (incorrect) prescriptions but, with better information systems, could be more productive and focussed on better patient health plans.

4.3 Improving the Quality of Medication Use

As part of the review of locally commissioned services, Wairarapa DHB wants to consider how well medication resources are used at a population level and how to respond to those. Gout management is a prime example of an equity issue. Gout is a long term condition that disproportionately affects Maori and Pacific but where several parts of the health and other social sectors could come together to ensure preventative therapy is not underused. People afflicted by gout may lurch through a series of acute episodes and be prescribed medications to manage a flare-up that are have a detrimental effect over time. To stay well, a regular medication is required to avoid the painful build-up of uric acid crystals in joints. That may need health education, income support, and a joined up secondary care, general practice and community pharmacy approach. Some DHBs are funding gout programmes at a DHB level that target inequality.

The pattern of largely reflects the younger age structure of the Maori population. Most medication is provided to larger group of people of Other ethnicity in the older age groups.

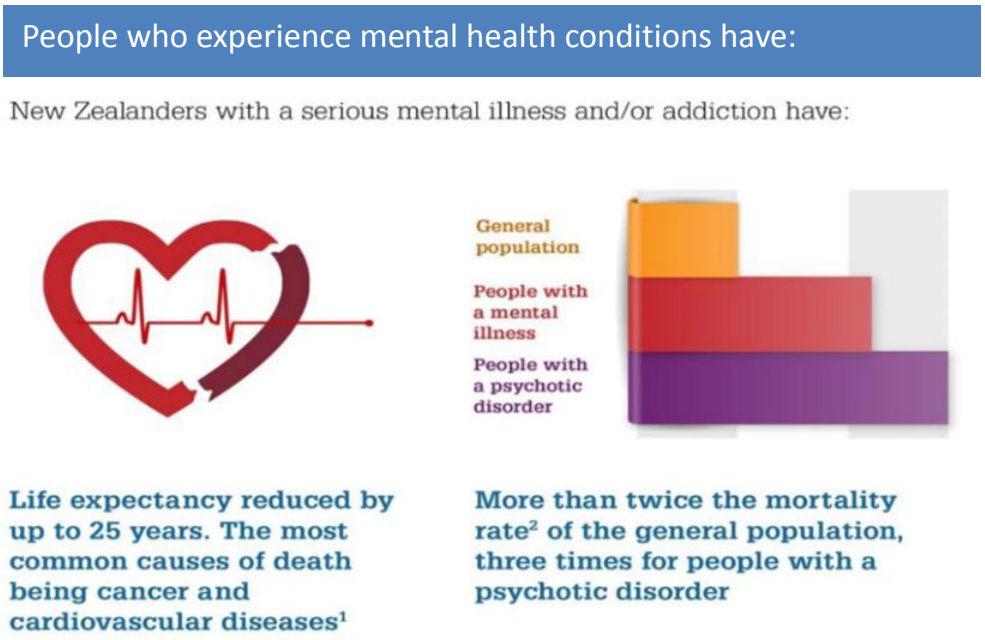
Pharmacists based in general practices and operating independently of a community pharmacy are being used in some DHBs to support the quality use of medication by providing advice at a population and individual prescribing practice level. Aside from equity/unmet need issues such as gout, they may, for example also provide advice on polypharmacy (use of multiple medications), an example of a quality use of medication issues that DHBs are being asked to respond to in their annual planning. The HQSC provides Atlas of Variation analysis at a DHB level and shows for example that polypharmacy is greater in the Wairarapa for over 65s than for NZ on average (All age groups = 65-74, 75-84, 85+).



4.4 Locally Commissioned Pharmacy Services - LTC

One pharmacy service that was introduced nationally in 2012 but now falls within the group of services that can be locally commissioned is the Long Term Conditions (adherence support) service. DHBs are generally concerned at the variability in the provision of the service from pharmacy to pharmacy, and consequently, the way in which the service is funded. Some Wairarapa pharmacies have embraced the service to the extent the Wairarapa's enrolment in the service at a DHB level has been around 60-70% higher than the national average. The variation in the proportion of people registered at a pharmacy level varies from 3.5 to 22.7%. The NZ average is around 5%.

A weakness of the LTC services is its strong focus on the number of medicines and hence older people. The high health need of people with mental health conditions may not be reflected in the number of medications they collect.



Wairarapa DHB intends to undertake a review of these services in 2020 with the objectives of reviewing whether patients are getting the services they need, whether the services are making a difference, and whether they are being funded appropriately.

4.5 Recognising Quality in Pharmacist Services

There's no clear consensus on how to recognise good quality pharmacist services. There are tangible measures of quality for pharmacies such as opening hours, waiting times, range of services, and privacy arrangements. It is less obvious how to recognise good quality pharmacist services, where the quality of the service and the patient health outcomes are the product of the care team as a whole. Part of the answer may lie in empowering patients by prompting them to ask the questions they are likely to have or to volunteer what is most important to them and getting feedback on their level of satisfaction.

4.6 Co-payments and Co-payment Support?

Co-payments for subsidised pharmaceuticals are up to $5/item for up to 20 items. For more than 20 items, households are eligible for a subsidy card that means further items are free of charge. For items prescribed by a private specialist, or a prescriber not contracted to provide publicly funded services, the co-payment is $15 per item.

In many parts of NZ there are some corporate pharmacies that are discounting the co-payment to $0. This has created some angst for pharmacies that are nearby a discounting pharmacy as they are concerned about losing market share, in a way they feel unable to match, and because they feel those pharmacies do not provide the full service. Co-payments comprise around 21% of pharmacy fees so the loss of income is material.

Wairarapa DHB does not have any discounting pharmacies, but it does have the benefit of Tu Ora Compass allocating some Service to Improve Access (SIA) funding to pharmacies to assist people

who are struggling with co-payment costs. When surveyed recently, the community pharmacies generally noted that they had sufficient funding to provide support.

4.7 Pharmacy Contracting Policies

Some DHBs, concerned about a growing number of small pharmacies have recently adopted policies to manage the number of pharmacies that have DHB contracts. Those policies are based on principles of improving patient services and improving integration with other care providers, especially general practice. Adopting such policies is consistent with DHB statutory obligations to

> *seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local…needs* (section 22(1)(ba))

Wairarapa DHB has not yet adopted such a policy and as noted above, has pharmacies that are greater than the average size for NZ.

Appendix 1

rank	Chemical name	Sum of No of items	% of total items
1	Paracetamol	43495	4.7%
2	Omeprazole	31602	3.4%
3	Atorvastatin	29003	3.2%
4	Methadone hydrochloride	27240	3.0%
5	Aspirin as anticoagulant	25523	2.8%
	Aspirin as analgesic	356	0.0%
6	Metoprolol succinate	23324	2.5%
7	Salbutamol	17150	1.9%
8	Cilazapril	17030	1.9%
9	Zopiclone	16312	1.8%
10	Buprenorphine with naloxone	14766	1.6%
11	Levothyroxine	13971	1.5%
12	Amlodipine	13447	1.5%
13	Ibuprofen	12909	1.4%
14	Metformin hydrochloride	12450	1.4%
15	Colecalciferol	11738	1.3%
16	Furosemide [Frusemide]	11588	1.3%
17	Quinapril	10665	1.2%
18	Docusate sodium with sennosides	10241	1.1%
19	Prednisone	10143	1.1%
20	Simvastatin	10033	1.1%
	Total for Top 20 medications	362986	39.5%
	Total all dispensed medications	919512	

rank	Chemical name	Total DHB cost 2018/19	% of total cost
1	Adalimumab	$ 1,315,471.72	10%
2	Dabigatran	$ 621,848.63	5%
3	Insulin glargine	$ 421,807.66	3%
4	Abiraterone acetate	$ 355,807.83	3%
5	Etanercept	$ 352,722.56	3%
6	Lenalidomide	$ 344,225.46	3%
7	Budesonide with eformoterol	$ 338,466.71	3%
8	Fluticasone with salmeterol	$ 279,729.59	2%
9	Buprenorphine with naloxone	$ 257,283.23	2%
10	Methadone hydrochloride	$ 210,215.01	2%
11	Tiotropium bromide	$ 202,038.03	2%
12	Octreotide LAR (somatostatin analogue)	$ 160,180.12	1%
13	Rivaroxaban	$ 152,155.44	1%
14	Blood glucose diagnostic test strip	$ 145,807.97	1%
15	Infliximab	$ 139,471.24	1%
16	Epoetin alfa	$ 129,978.67	1%
17	Dolutegravir	$ 126,548.96	1%
18	Sodium valproate	$ 122,272.94	1%
19	Imatinib mesilate	$ 112,176.08	1%
20	Morphine sulphate	$ 110,300.30	1%
	Total for Top 20 medications	$ 5,898,508	47%
	Total all dispensed medications	$ 12,564,581	