Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**AGENDA** Held on Thursday 17 June 2021 Lecture room, CSSB, Wairarapa DHB 9.00am
COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE	**PUBLIC SESSION**

	Item	Action	Presenter	Min	Time
1. PROCEDURAL BUSINESS					
	Karakia				9.00am
1.1	Apologies	ACCEPT		10mins	
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	NOTE		"	
1.4.1	Work Programme	NOTE		"	
2. DISCUSSION					
2.1	Wairarapa DHB: Health System plan (Draft)	DISCUSS	Tom Love, Director, Sapere	40mins	9.10am
2.2	Regional Public Health Update	DISCUSS	Peter Gush, General Manager, Regional Public Health	20mins	9.50am
2.3.	Immunisation Programme update	DISCUSS	Fiona Chamberlain, Service Development Manager, Planning & Performance	10mins	10:10am
3. OTHER					
3.1	General Business			5mins	10:20am

Wairarapa Community and Public Health Advisory Committee (CPHAC)
Disclosure of Interests Register - as at 21 April 2021

Name	Appointment Date	Health Sector Interests Disclosed	Other Interests Disclosed
Committee members			
Dr Tony Becker *Deputy Board Chair*	December 2019	• Shareholder and Director (Clinical) Masterton Medical Limited • Shareholder and Director Wairarapa Skin Clinic • Wife contracts to Wairarapa District Health Board • Sister-in-law is Associate Director of Nursing at Surgery, Womens and Childrens Directorate, Capital & Coast DHB • Wairarapa GP Trustee Tu Ora Compass Health	• Trustee, Hau Kainga
Helen Pocknall *Board Member*	December 2019	• Contractor with Ministry of Health	-
Joy Cooper *Board Member*	December 2019	• Nil to declare	• Chairperson Wharekaka Trust Board Incorporated
Jill Stringer *Board Member*	December 2019	• Member of 3DHB Disability Services Advisory Committee (DSAC)	• Director, Touchwood Services Limited • Husband employed by Rigg-Zschokke Ltd • Trustee, Wellington Welfare Guardianship Trust
Yvette Grace *Board Member*	December 2019	• 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 • Member concurrent FRAC Hutt Valley and Capital and Coast DHBs • Member 3DHB Disability Services Advisory Committee (DSAC) for Hutt Valley DHB	• Trustee, House of Science Wairarapa • Trustee, Equippers Church and Oasis Trust
Dr Stephen Palmer *Regional Public Health Clinical representative*	April 2020	• Employee of Hutt Valley DHB as Medical Office of Health in Regional Public Health • Member of the Policy Committee of NZ College of Public Health Medicine	-
Limoe Kelly *Pacific representative*	February 2020	• Nil to declare.	• Works at Lyndale Rest Home
Justine Thorpe *Primary Care*	February 2020	• Tū Ora Compass Health, Deputy CEO, General Manager Corporate Services and Wairarapa	• Member of Papakanui Iwi Land Trust • Member of South Waiarapa District Council Water Race Management Committee)

representative			
Name	**Appointment Date**	**Health Sector Interests Disclosed**	**Other Interests Disclosed**
Committee members continued			
Sophronia Smith *Māori representative*	October 2020	• Member of Te Oranga o Te Iwi Kainga	-
Holly Jackson *Māori representative*	October 2020	• Member of Te Oranga o Te Iwi Kainga • Employed as Practice Manager, Whaiora	• Board volunteered member at ArrowFM (Access Radio)
Wairarapa DHB Management			
Dale Oliff *Chief Executive*		• Daughter is an employee of Ministry of Health for planned care funding	-
Sandra Williams *Executive Leader Planning & Performance*		• Nil to declare	-
Jason Kerehi *Director Maori Health*		• Partner is employed as a school nurse by Compass	• Negotiator – Rangitane Settlement Negotiations Trust

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE **PUBLIC**

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**MINUTES** Held on Thursday 13 May 2021 Lecture room, CSSB Wairarapa District Health Board 9.00am
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE	**PUBLIC SECTION**

PRESENT

Dr Tony Becker	Chair
Helen Pocknall	Member (Deputy Chair)
Joy Cooper	Member
Jill Stringer	Member
Yvette Grace	Member
Justine Thorpe	Member (Primary Care Representative)
Limoe Kelly	Member (Pacific Peoples representative)
Holly Jackson	(Maori representative)
Dr Stephen Palmer	Member (Regional Public Health (RPH) Clinical Representative)

ATTENDANCE

Sandra Williams	Executive Leader Planning & Performance (ELP&P)
Jason Kerehi	Executive Leader, Māori Health
Daniel Kawana	Service Development Manager, Planning & Performance
Fiona Chamberlain	Service Development Manager, Planning & Performance
Jen Bergantino	Minute taker, Planning & Performance

Ron Karaitana (Board member) was in attendance.

1.0 PROCEDURAL BUSINESS

1.1 APOLOGIES

Apologies were received from Dale Oliff and Sophronia Mete-Smith.

1.2 CONTINUOUS DISCLOSURE

1.2.1 Interest Register

Justine Thorpe declared a conflict of interest in regards to agenda *Items 2.3 Immunisation Programme* and *2.6 Primary Care* Update - Tu Ora Compass Health provided the information for the reports.

1.3 CONFIRMATION OF MINUTES

RESOLVED
MOVED Limoe Kelly **SECONDED** Joy Cooper
CARRIED

2.0 DISCUSSION

2.1 WAIRARAPA HEALTH SYSTEM PLAN

Presentation by Tom Love, Sapere

Tom Love tabled a draft outline of Wairarapa DHB's Health Systems Plan and provided a brief overview of what he had included in the plan.

Helen Pocknall arrived at 9.08am

He was seeking any comments / feedback from the committee.

Holly Jackson arrived at 9.10am

Discussion and feedback was provided by the Committee members. Points noted were:

- Community – look at a whole integrated approach (intersectoral)
- Investigate the wider detriments of health
- Making sure that families are connected in with the correct organisations and are receiving the benefits they should be receiving
- Connect with schools
- Need to sort out Primary and health integration first
- Hard to recruit GPs into practices. Don't necessarily have to be seen by a GP – use Health Practitioners more if available
- Important to invest in child health – DHB and Ministry of Social Development (MSD) should be working together
- Access – investigate whether DNAs using Red Cross for transport to appointments isn't a case of transport being fully booked.
- There will be learnings from the COVID-19 vaccination rollout to rural communities.

Sapere are currently populating the document and anticipate that in 2-3 weeks there will be a completed plan which could then be used for consultation with the community.

2.2 MĀORI HEALTH PLAN UPDATE

The DHB is currently negotiating with a preferred provider that will draft the plan. Once the draft plan has been prepared it will then be available for consultation.

The timeframe for completing the draft plan will be approximately 24 weeks though the writer is aiming to have a draft version of the plan completed in 18 weeks.

Part of the analysis that has been completed for this plan will be used when compiling the Wellbeing plan which focuses on prevention.

2.3 IMMUNISATION PROGRAMME UPDATE

The timeframe for Measles, Mumps & Rubella (MMR) catchup vaccinations has been pushed out because of the rollout of the COVID-19 vaccination. A recent MMR clinic held at Pacific churches was particularly successful.

2.4 SMOKEFREE AND MATERNAL CARE

Presentation by Linda Spence, Tu Ora Compass Health and Sarah Taylor-Waitere, RPH

The Pēpe Ora presentation summarised what support was currently available for mums and babies which is key for maternity care in the first 1000 days. The website provides information to help mums find the right services for themselves and their baby in the Wairarapa, from pregnancy to before school. There are four key areas of focus available on the website:
Taha Tinana – Physical health
Taha Wairua – Spiritual health
Taha Hinengaro – Mental health
Taha Whanau – Family health

The team are currently working with Capital & Coast DHB on an online platform. They would like to have continuity across the Wellington region for those mums who give birth on the otherside of the Remutaka Hill making sure that they will receive the same messaging for when they return to Wairarapa.

The second part of the presentation focussed on smokefree and the current work and activities that are underway. This also included babies in smokefree homes.

Yvette Grace left the meeting

2.4 ADVANCED CARE PLANNING (ACP)

Presentation by Sean Thompson: 3DHB Advance Care Planning Facilitator & Systems Development Manager

ACP is the process of discussing and documenting what your wishes are for your future health and personal care. The presentation covered what is an ACP, why do we have them, and why is it important.

Justine Thorpe left the meeting

2.4 PRIMARY CARE UPDATE

The Committee were advised that since writing the report Kuripuni and Greytown practices have since closed their books for new enrolments. This is a common theme seen throughout the country. 50% of GPs working in rural practices have been employed from overseas.

The Committee recommended that this report be forwarded to the Board for discussion. The CPHAC committee requested that a letter should be written by the Board outlining the difficulties and barriers practices are experiencing in recruiting GPs from overseas. Who the letter should be written to was one of the questions the Committee required the Board to discuss.

MEETING CLOSED AT: 11.40AM

Date of next meeting: 17 June 2021

CONFIRMED that these minutes constitute a true and accurate record of the proceedings of the meeting.
DATED this day of 2021

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

DRAFT

WAIRARAPA DISTRICT HEALTH BOARD PUBLIC CPHAC

Schedule of Actions

Meeting Date	Action	Person Responsible	Status
18 June 2020	The Implementation plan, for the Pacific Health and Wellbeing Strategic Plan, will be available at the time of the launch.	Director, Pacific Health	Seeking clarity on when this will be available
15 October 2020	Work with Tū Ora Compass Health and GP Liaison, to find what data on e-prescribing is available and whether this information could be helpful with the Health Care Homes programme.	Executive Leader, Planning & Performance	July 2021

Community and Public Health Advisory Committee Work Programme

This programme will continue to be updated as we move through the year

	February	March	April	May	June	July	August	September	October	November
System and service planning	-Annual Plan -WrDHB Health System Plan (CSP) - Immunisation Planning	-Māori Health Plan update	-Annual Plan Update -Update on Health System Plan (CSP)	- Annual plan update -Update Māori Health Plan -Draft Health Plan(CSP)	-Annual Plan update -Health System Plan (CSP)	-Wellbeing – Plan update Suicide Prevention and postvention plan -Maori Health Inquiry	-Youth Health -Māori Health -Refugees - Services -Planned Care -Mental Health & Addiction	--Pacific Health -Cancer services -Palliative Care District Nursing	-Healthy Ageing	-Annual Plan Process -Youth Health
System & provider performance	-Regional Public Health -Immunisation	-Alliance and SLM report -Immunisation -Healthy Ageing	-Child Health -Immunisation	-Immunisation -Smoking and maternity -Primary Care Update -Advanced Care Plan	- Regional Public Health Immunisation	-Immunisation -Alliance & SLM reporting -Consumer engagement survey	- Health of Older People dashboard Immunisation	Immunisation - Alliance and SLM reporting	-Immunisation -Health of Older People dashboard -Regional Public Health	-Primary and Community -Regional Public Health -Immunisation
Investment and prioritisation					-Investment & Prioritisation					-Investment & prioritisation

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**CPHAC DISCUSSION PAPER** **Date: June 2021**
Author	Sandra Williams, Executive Leader Planning & Performance
Endorsed By	Dale Oliff, Chief Executive
Subject	**Wairarapa DHB Health System Plan (Clinical Services Plan)**

RECOMMENDATION It is recommended that the Community and Public Health Advisory Committee:

1. **NOTES** the draft Health System Plan document
2. **DISCUSSES** the Health System Plan and provides final input into the plan prior to the final draft going to the Board.

APPENDIX:

Draft Wairarapa DHB: Health System Plan

1. PURPOSE

The purpose of the paper is to present the draft Wairarapa DHB Health System Plan to CPHAC for discussion and to input into the final version of the plan.

2. BACKGROUND

In 2019, Wairarapa DHB undertook a process to develop a common sense of purpose and direction for health services in Wairarapa. Hauora Mō Tātou | Strategic Direction 2020–2030. The Strategic Direction is now complete and was launched in April 2021.

Clinical services planning was selected to be the next level of more detailed planning to deliver on the key areas identified in Hauora Mō Tātou, and determine the clinical services and models of care required and to guide investment over the coming years.

In particular the planning work objective was to develop a clinical services plan that deliberately focused on three pressing issues:

1. The future configuration of hospital services and the model for how services will be delivered at Masterton Hospital
2. Access to urgent care across the Wairarapa district
3. Delivery of services with better geographical reach and community focus across the Wairarapa district

It was acknowledged that we can't do everything at once and the intention of the targeted nature of the plan was to give us the best chance to make measurable progress in high priority clinical service areas.

Health system planning is a continuous process and the intention was to progress on to other areas of planning to support the action plans required to deliver Hauora Mō Tātou.

3. THE WAIRARAPA DHB HEALTH SYSTEM PLAN

Far reaching changes to our health system have been announced and there will be change ahead for our services. This draft plan sets out preferred directions to meet the needs of our population given the current state of services. The draft plan is attached as the appendix.

This paper identifies a number of models that we could look to follow that have been successful for other communities including integrated home based nursing services, community based pediatric services and opportunities to collaborate with neighboring District Health Boards to deliver hospital based specialist services.

It also identifies opportunities to enhance current services such as through telehealth and investing in multidisciplinary community health teams.

Enablers identified include continued engagement with our communities, clinical governance and information technology.

4. NEXT STEPS

The next step is to include feedback from CPHAC into the final draft and to present the plan to the Board for endorsement.

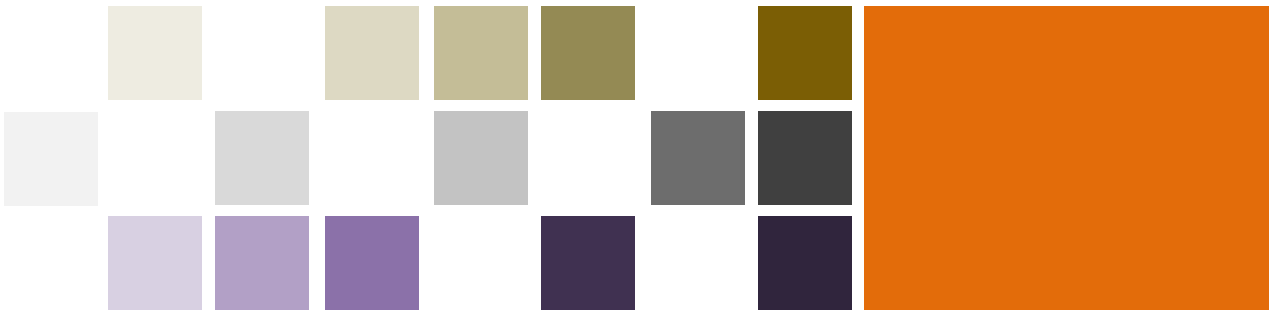
DRAFT: Wairarapa DHB: Health Systems Plan

Scope: Strengthening access, and the future configuration of hospital services

Tom Love, Rebecca Rippon

8 June 2021

DRAFT



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Executive summary

Wairarapa DHB has released its strategic direction for the year 2030: *Hauora Ma Tatou*. That plan identified a large number of focus areas for the DHB to develop. This Health System Plan has a limited scope. It aims to consider two specific areas that were identified in Hauora Ma Tatou, recognising that continued planning will be needed for a range of other areas of the health system.

The areas that this plan specifically addresses are:

- Strengthening Primary Care. This area also addresses some aspects of the Improving Access to Health and Disability Services stream from the strategy, since the strategy identifies issues of access to primary and community care as important for the Wairarapa. In particular, this plan considers issues around geographic access and extended hours access.
- A fit for purpose hospital. A number of immediate actions were identified within this stream, and considerable activity has been undertaken to review the immediate effectiveness of hospital processes. This plan sets out the longer term direction for how hospital services can be delivered in the Wairarapa, considering the range of services and how they can be fitted within the wider context of hospital activity in neighbouring districts.

Strengthening primary care – services across the District

A range of services have limited accessibility for people across the Wairarapa, and there is scope to provide community services in a more joined up fashion. The three keystones of the direction that we will use to improve access across the district are:

1. Telemedicine specialist support. We will use hospital based specialists to support primary care teams with expert advice and support. This will support primary care teams to manage more complex patients in the community.

2. Investment in multidisciplinary community health teams, providing packages of care in the community. There are a number of models in existence across Aotearoa, and these can be adapted to the local population. This approach will require specific investment in clinical workforce. We expect that this will better support people in their homes, better support discharge from hospital, and improve access to services that are currently likely underprovided in the Wairarapa.

3. Developing more school based services. Building upon some success in working with schools, we expect that this will provide improved access to care for some of our more remote communities, and will build deeper links with communities, potentially improving engagement with health services. This approach has the potential to involve wider cross sectoral services from other government agencies and NGOs.

Strengthening primary care – extending hours

The long term vision is to improve access to primary care. While this depends critically upon workforce development, and this is beginning to occur in our Health Care Homes, primary care services are still precarious in terms of workforce, and have limited capacity. While workforce development continues, we will continue to develop community consultation and engagement, so that the expectations of the community are clearly articulated and understood, and we will support the use of telemedicine to improve access to primary care services where this is appropriate and acceptable. We expect that these measures will continue to improve access to primary care in a continuous basis, while continuing the underlying workforce development that is fundamentally needed to improve access to primary care.

Providing sustainable hospital services

Our principles for the future of hospital services in the Wairarapa are:

- Clinical services coordination lies in the community. The core task of coordination of care lies with primary and community services, and the hospital is one of a number of services that provide support.
- Acute care and resuscitation, and obstetrics are core capabilities for a provincial population such as the Wairarapa.
- Those services that can be safely and sustainably provided outside a hospital setting should be delivered in the community.

Some hospital services currently have low rates of provision, and a number of services are on the margin of sustainability, both clinically and financially. We envisage a core provision of acute care that must be provided locally, and a range of services that will be provided with the support and collaboration of neighbouring hospital services. This is well aligned with the direction of the current health system reforms. Considering the possibilities around such collaboration now will mean that Wairarapa is well placed to ensure that system reforms are responsive to local needs when changes are made.

Enabling factors

Many factors will enable the success of the specific directions we have identified. Three particularly key enablers will be:

- Community engagement, to ensure that changes to our health system are responsive to community need;
- Effective clinical governance to ensure that changes to services are well supported and maintain high levels of quality and safety;
- Effective information technology, to empower patients with complete, safe information, and so that health information can be shared across teams of people providing care.

1. Where does this plan come from and what is its scope?

1.1 The strategic plan Hauora Ma Tatou is the starting point

Wairarapa DHB has released its strategic direction for the year 2030: *Hauora Ma Tatou*. This sets out a clear picture of the challenges of health and social inequity for the Wairarapa community, and aims to address those inequities, particularly in recognition of slow progress in the past.

Hauora Ma Tatou identifies eight areas for action, where Wairarapa DHB must work with its community to focus on activities that will make a difference to the health and wellbeing of whānau in the Wairarapa District. Those areas of action are:

- Action 1 – Integrating health and social services
- Action 2 – Strengthening primary care
- Action 3 – Excellence in older persons' services
- Action 4 – Improving access to health and disability services
- Action 5 – Close connections between primary and secondary care
- Action 6 – A fit for purpose hospital
- Action 7 – Building a sustainable workforce
- Action 8 – Tamariki-Mokopuna our children and young people are our future

Health system planning is a continuous process, and aspects of these action areas are being considered all the time. In some areas immediate actions have been identified and are underway, while in other areas further planning and direction is needed at the next level of specificity. And there are complex interactions between all of these areas – for example a sustainable workforce is key to success in each of the other areas of action.

Some of the specifics defined within the areas of action are relatively short term activities, while other are longer term aspirations. The scope of this Health System Plan is to consider the direction over the next ten years for some of these action areas, recognising that other current and future planning processes will address other aspects.

The areas that this plan specifically addresses are:

- Strengthening Primary Care. This area also addresses some aspects of the Improving Access to Health and Disability Services stream from the strategy, since the strategy identifies issues of access to primary and community care as important for the Wairarapa. In particular, this plan considers issues around geographic access and extended hours access.
- A fit for purpose hospital. A number of immediate actions were identified within this stream, and considerable activity has been undertaken to review the immediate

effectiveness of hospital processes. This plan sets out the longer term direction for how hospital services can be delivered in the Wairarapa, considering the range of services and how they can be fitted within the wider context of hospital activity in neighbouring districts.

1.2 This is a time of change

Far-reaching changes to our health system have been announced, and it is clear that health services are entering a period of substantial change. In that context, this plan sets out preferred directions from a consideration of the current state of services and the needs of the Wairarapa population. While overall structures and directions have been announced at a national level, there is much work yet to do in order to develop the picture of health services at the level of localities across New Zealand. While the specifics of engaging with local communities, designing and commissioning services are yet to be developed, it is expected that this plan will be an input into the future direction of services into the Wairarapa, providing a contribution to the next stages of planning and development as new structures are set in place, and decisions are made.

It is clear that the future planning of services will occur in defined commissioning roles, that will be distinct from the operational management of services, This plan is principally developed from a commissioning perspective, considering the preferred areas in which to invest in the future, while recognising that partnership with service delivery stakeholders is crucial to effective implementation.

It is also clear that the direction indicated by the Health and Disability Review Transition Unit envisages a strong local presence and input into planning. Locality structures have yet to be designed, but there is an expectation that the Wairarapa community will have effective input into health system decisions, and that the needs of the community will be the starting point for locality planning. In this sense, while structures are changing markedly, the overall process of considering needs, equity and resources for the health care of a local population will remain at the heart of the commissioning process.

Finally, the events of 2020 have presented (and continue to present) a significant challenge to all parts of our health system, and have accelerated change on a number of fronts. Specifically relevant aspects are considered in later sections, but visions of the way that people expect to receive care, and the means by which it is possible to provide effective, integrated services, have been challenged by the covid-19 pandemic. This further orients the environment to one of change, in which new and different ways of doing things can be embraced.

2. Strengthening primary care – services across the District

2.1 The Wairarapa is a dispersed District

With a population of 49,000, which is rapidly growing through domestic immigration, the Wairarapa District is relatively dispersed. While some population is concentrated in the towns of Masterton, Carterton, Greytown, Featherston and Martinborough, a total population of approximately 14,000 lives outside those towns.

Travel times can be significant, with a duration of nearly 45 minutes from the town of Martinborough to Wairarapa Hospital. People living South of Martinborough or Featherston have longer travel times, and may face substantial difficulty in accessing services. The populations in the Northern part of Masterton District, and in the more remote areas near the East Coast are also small, but geographically remote. Public transport is limited even between the main towns, and is non existent beyond those.

There are a number of services (including a St John shuttle) that are able to support access to Wairarapa Hospital for people who do not have alternative means of transport, but these services have limitations, and patients are not always well informed about them. Ensuring that these services have capacity to respond to demand will be one component of improving access across the District.

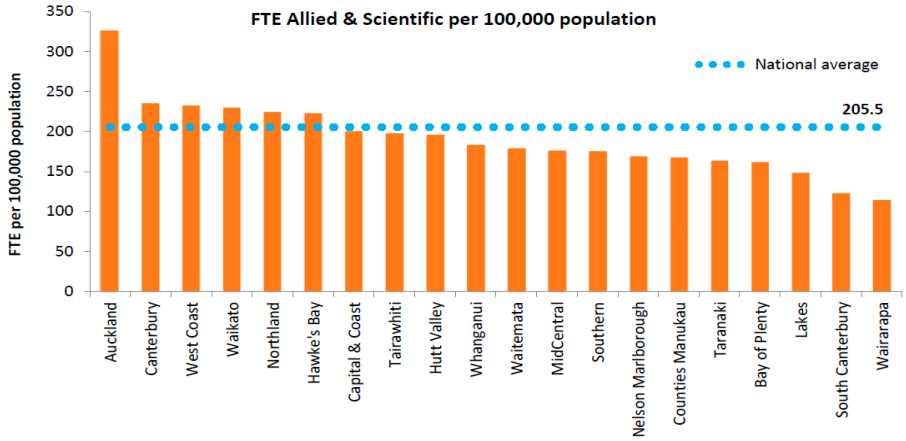
District	Urban Population	Rural Population	Total
Masterton	21,400	6,100	27,500
Carterton	5,800	4,160	9,960
South Wairarapa	7,300	4,100	11,400
Total	**34,500**	**14,360**	**48,860**

2.2 DHB services have limited capacity

Wairarapa Hospital has limited capacity, and there is a need to find alternative ways to deliver services that could be provided safely and effectively outside a hospital environment. The opportunity to provide services in alternative settings includes a range of services including rehabilitation, and a number of outpatient services.

The DHB allied health workforce in the Wairarapa is at a very low level compared to other districts in New Zealand, at a little over half the national rate per capita. This workforce is key to being able to provide services in the community, supporting patients in their homes and providing integrated services that enable people to stay well with the support of primary health care services.

Figure 20: Population density of Allied & Scientific by DHB



2.3 Patterns of service use are variable

There are distinct geographic patterns of service use across the district, but these vary markedly for different services. The maps below show the absolute numbers of service contacts, and the population rate of contacts for key community and outpatient services. Other services will be considered in the future, while these are considered to be the immediate focus:

Figure 1: District nursing - number of contacts

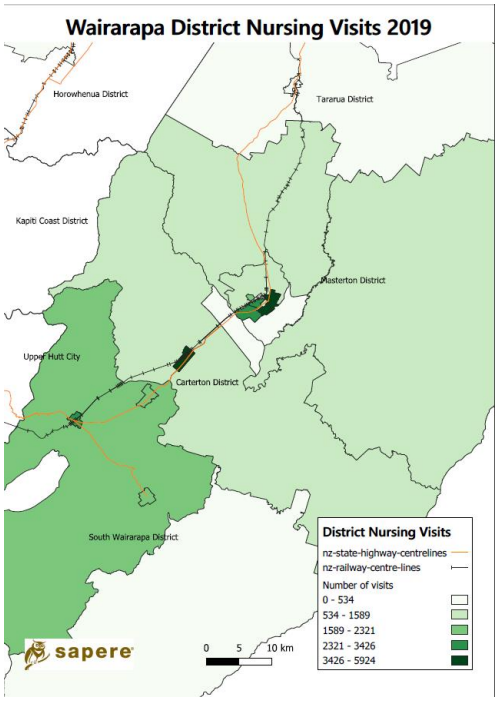


Figure 2: District Nursing - population rate of contact

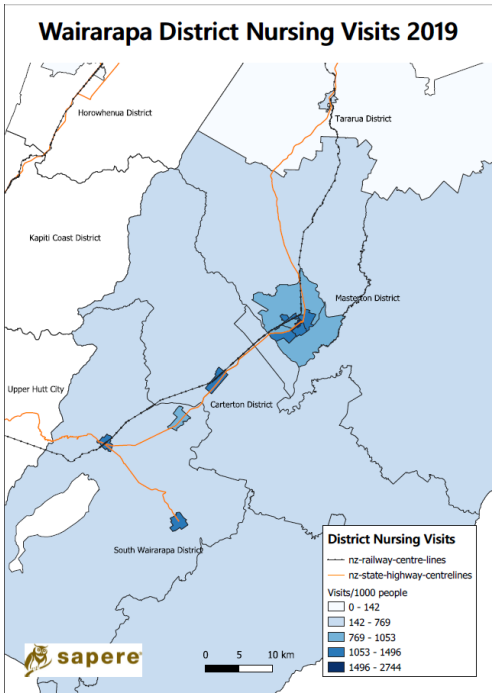


Figure 3: OT and physio – number of contacts

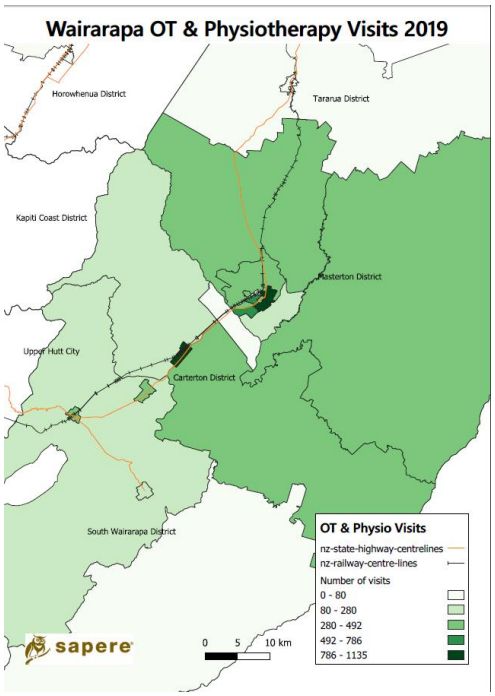


Figure 4: OT and physio - population rate of contact

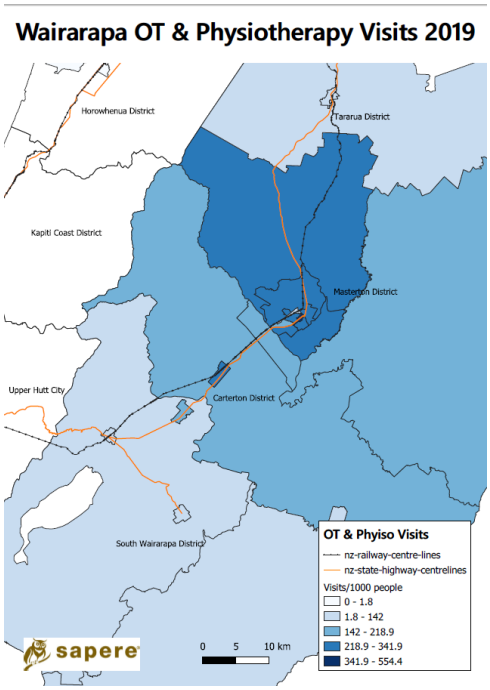


Figure 5: Paed outpatients - number of contacts

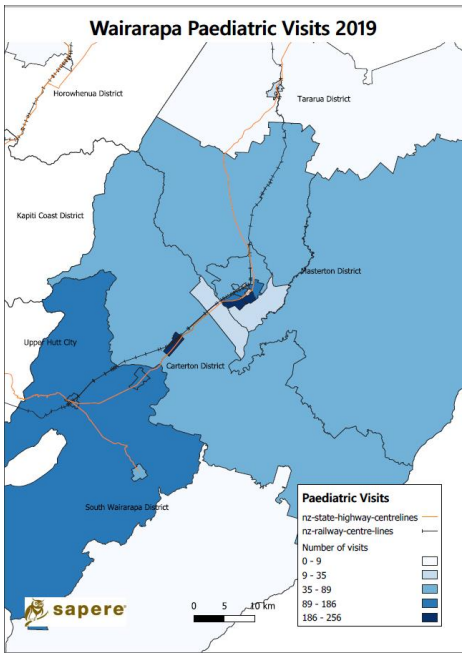


Figure 6: Paed outpatients - population rate of contacts

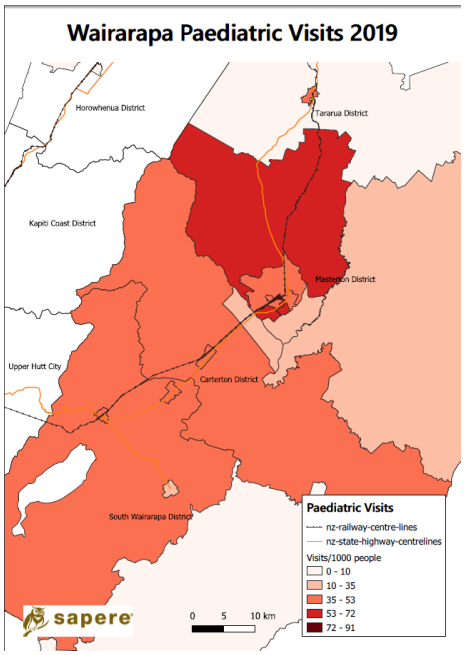


Figure 7: Gen med outpatients - number of contacts

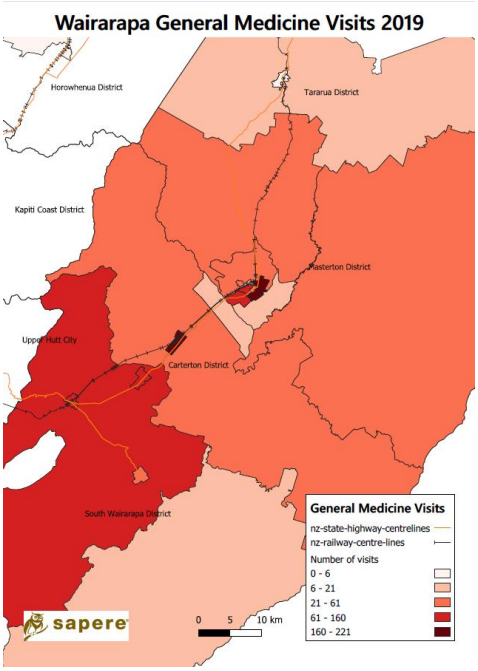
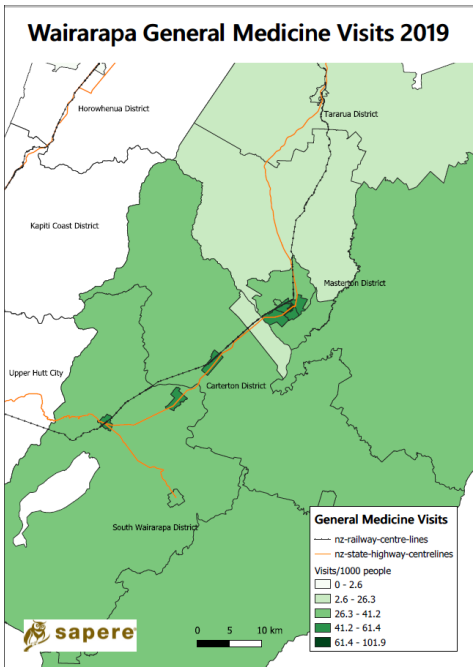


Figure 8: Gen med outpatients - population rate of contact



There are a number of distinct patterns in these maps. District Nursing shows concentration around the towns, but a higher level of absolute delivery in rural South Wairarapa than in other rural areas, potentially reflecting higher need and remoteness for those communities. Occupational Therapy and Physiotherapy services appear to be quite concentrated in Masterton and Carterton, with lower rates and smaller number of delivery in the South.

People visiting paediatric outpatients come from across the district, and in absolute numbers come from the rural South more than from other rural areas, although population rates are fairly consistent across the whole District.

General medicine outpatient visits have a slightly higher rate in the urban areas, which possibly reflects more concentration of older populations in the towns. Population rates are moderately consistent across the District.

Overall, and particularly in the context of low allied health staffing, these results suggest that there is scope for increasing a number of services in the community. The challenge is that absolute numbers of people accessing any one services can sometimes be small, meaning that delivering a service in a local setting can be highly resource intensive. However there are models that can support the effective and efficient delivery of services in local settings, when local community services are integrated and can work together.

2.4 There are existing models

A number of models exist that demonstrate the delivery of services in a community setting that might otherwise be provided in hospital.

Clinics and procedures

Counties Manukau DHB has supported shifting a range of services to a community setting, including:

- Patient education and self-management
- Long-term conditions follow up appointments, education and management
- Skin lesions
- IV Chemotherapy
- Carpal tunnel and other minor surgery
- Renal dialysis chairs and self-management

These are all examples of services that can be provided in the community, with a mix of DHB workforce working in different settings, and funding community services providers to undertake services. There are already some examples of this in the Wairarapa (for example, some minor surgery is already done in general practice), but there is scope to invest in expanding the range of services and systematically organising delivery in community settings. This has the potential to reduce pressure on hospital space and activity, and to provide care closer to home for some patients.

Integrated nursing services

The Bay of Plenty DHB operates an integrated home based nursing service, with nurses from several different organisations (DHB, PHO and NGO) working in a consistent manner to provide a common set of services focussed on the holistic health needs of patients. In this case funding is organised around distinct packages of care, which can be provided by nursing workforce from any of the different provider organisations, with a central coordination function that connects patients to services and monitors delivery. The packages are:

- Initial or first contact care, when a community nurse has the first interaction with a patient following a referral for any reason or when a community nurse sees the patient when a patient's needs have significantly changed. The aim is to identify the patients' health and social needs and deliver whatever care required to commence a positive engagement with the community nursing services.
- Short term care, provided to patients who require care for a short time frame or following a hospital admission e.g. 4 visits or fewer. The aim is to enable the patients to get to their normal living environment as soon as possible and regain independence.
- Short term continuing care, recognising that a number of patients will require moerate levels of care, but for a longer time period as they return to full function.
- Complex continuing care, with a focus on disease management plans, health literacy, and integrated case management with an identified key worker.

The key supports for this service lie in effective service coordination, and linkages back to primary care services as the overall coordinator of care for a given person and their whānau.

Specialist support

There are a number of existing models in which specialists either provide services directly in the community, or provide additional support for primary care services to provide care to more complex patients. These approaches have the potential to avoid some of the need for hospital based outpatient services, reduce the need for patient travel, and support primary care services to work at the top of their scope.

There are a number of examples across New Zealand. Two brief examples are: Canterbury DHB has a service in which a respiratory physician visits general practices and meets with general practice teams. The respiratory physician does not see patients, but will review cases and be a resource for primary care teams to draw upon when managing their patients. There is some evidence that this reduce outpatient appointments, and contributes to better long term conditions management for complex patients.

3 DHB mental health services have recently established a service that provides phone access to a psychiatrist for general practice. This has been strongly welcomed, and there is high use of the service. It is early to measure direct impacts, but anecdotally the specialist support is highly welcome.

Community paediatric services

Paediatrics is a service that has a particularly strong history of defining specific community roles, and community paediatric services exist in a number of parts of New Zealand, including Nelson-Marlborough, Counties-Manukau, Auckland, Hawkes Bay and MidCentral. Hawkes Bay have a service in which a 0.5 FTE paediatrician (of which 0.2 is direct clinical work, and 0.3 project work) is supported by a number of other professionals in the community paediatric team, including:

- 0.5 FTE Family Violence Intervention Programme Coordinator
- 0.6FTE Child Protection Programme Coordinator
- Developmental Assessment Programme (multidisciplinary assessment service for children suspected of ADHD or Autistic Disorders)
- Analyst support as required.

There is also strong liaison with the local public health team.

Hawkes Bay has identified a number of outcomes arising from their community paediatric service, including:

- Reduction of admissions to the Children's Ward of 20%
- Over 900 staff trained in dual assessment of child abuse and domestic violence
- Increased referrals to Child, Youth and Family of seven times and identification of domestic violence increased by three times
- Reduced mean age at diagnosis for children with autistic disorders
- Workforce development programme for Resource Teachers Behaviour and Learning, with improved referrals and Individual Education Plans
- Closer working relationships with CYFS, Special Education, Police and NGO sector
- Reduced child injury admissions.

2.5 Opportunities

There are a number of areas where there are opportunities to enhance services provided across the district. Three key areas for development are:

1. **Telemedicine specialist support**. The opportunity to support primary care services to manage patients without need for referral to secondary services has the potential to improve the efficiency and effectiveness of care. This approach has already been begun in 3DHB mental health services, and a high priority would be to extend this to general medicine, enabling general practice to access support for complex patients and manage them in a more timely and effective manner. Effective support could often be provided by phone or videoconference, avoiding the need for travel overhead for busy clinicians. This will require working closely with primary and secondary care clinicians to establish the specifics of how the service will work, including:

   - The preferred means for communication, whether the phone model currently being developed in mental health services, or videoconference approaches that allow face to face discussion and sharing of information;
   - Amount of time and funding required for effective support, and the frequency with which support sessions will be offered;
   - Developing the clinical governance needed to underpin the programme, managing risks and ensuring that both primary and secondary clinicians are providing safe care, and are not placed in uncertain or professionally unsustainable positions.

2. **Investment in multidisciplinary community health teams**, providing packages of care in the community that are centred around the person. The coordinated package approach has potential, so long as it is well supported by a) connection and information back to primary care as the overall coordinator of health care, and b) effective IT systems that mean that information is shared in a timely manner. Multidisciplinary teams of nurses and therapists will have the capability to better support people in the community. There is the potential to build upon the existing Focus coordination service to develop aspects of this approach, which could also support more community based rehabilitation.

   Wairarapa currently has some multidisciplinary team meeting activity in primary care, aimed at supporting elderly patients, but there is potential to make MDTs more systematic and focussed, and to use them effectively for a wider group of patients. Multidisciplinary teams could have a role in driving these approach.

   The workplan to develop this approach will require:

   - Defining the population that the service will work with. This will have the greatest equity impact if focussed upon populations with high deprivation and frequent use of services, and it will be key to ensure that the service is culturally and physically accessible for Māori in the Wairarapa;

- Modelling the volume of service that will need to be delivered (and identifying the minimum scale at which a service can be effective); and
- Identifying specific resource for the service that can be invested in over and above existing community services.
- Designing the clinical teams, and the communication and accountabilities that ensure they integrate into existing services across the health system.

It will be important, if this service is going to be successfully developed, to ensure that it is established with a viable level of commitment, avoiding the trap of establishing a small scale pilot that is starved of resources. This will require investment in allied health staff, as well as specifically ringfenced time from other clinicians.

3. **Working alongside schools**. Wairarapa has a good history of developing school connections with some of its health services, and there is an opportunity to build upon this. There is an infrastructure of school facilities across the district, which are supplied with high speed internet connectivity. Building relationships with schools has the potential both to enhance community engagement, and to provide services in facilities that are more accessible to some of our more remote communities.
   Schools are hubs within local communities, and provide an opportunity for health services to connect better with those communities. Some of these approaches are already under active consideration by general practices, but require a specific service development process in order to ensure that they are effective and efficient and meeting community needs.

   While the immediate opportunity is to work with schools for the delivery of a number of existing health services, the wider opportunity is to develop services in communities with broader intersectoral input. This will involve working with other agencies at a local level within the Wairarapa to establish a range of other services that could potentially work as hubs. That range of services could include housing, Ministry of Social Development, Oranga Tamariki and other social agencies.

As well as these future directions, there is currently moves to develop a community paediatric service for the Wairarapa, with collaboration from MidCentral DHB. It will be important to learn from existing models elsewhere in New Zealand in order to ensure that the model is stable and successful. In particular, it will be important to ensure that the model includes roles beyond the community paediatrician, and that it is well supported by the Regional Public Health Service.

More generally, there is a longer term vision of a shift of emphasis in services to a more community focussed orientation overall. Services should be provided more flexibly to communities, with better connection between community health services and other social services, including education and social development. A significant barrier to this vision arises from information systems, which are currently fragmented and present challenges both to service collaboration and to the information available to patients. But while IT limitations provide a challenge to better coordinated community delivered services, it will still be possible to make progress with the specific service developments identified here.

3. Strengthening primary care – extending hours

3.1 There are two distinct issues

Extending the time at which primary care services can be accessed was an issue that arose from stakeholders in the development of Hauora Ma Tatou. Discussion about extending hours for access to primary care can take place in several different contexts. One is the issue of access after hours for urgent care. This is a complex problem, faced by communities across New Zealand, and is in part dependent upon the interface between primary care, paramedic services, and the hospital Emergency Department. There is currently an extensive work programme being applied to improving the process efficiency and flow of the ED, which lies out of the scope of this plan.

The other context in which extending hours for access to primary care is an issue is as part of the wider consideration about access to primary care services for routine or non-acute care, but at times that are not constrained by the traditional 8am-5pm weekday schedule, a timetable that is enshrined in the national Primary Care Services Agreement. This issue is more aligned with the views that arose from the Hauora Mo Tatou material, and is the principal focus of this part of the plan.

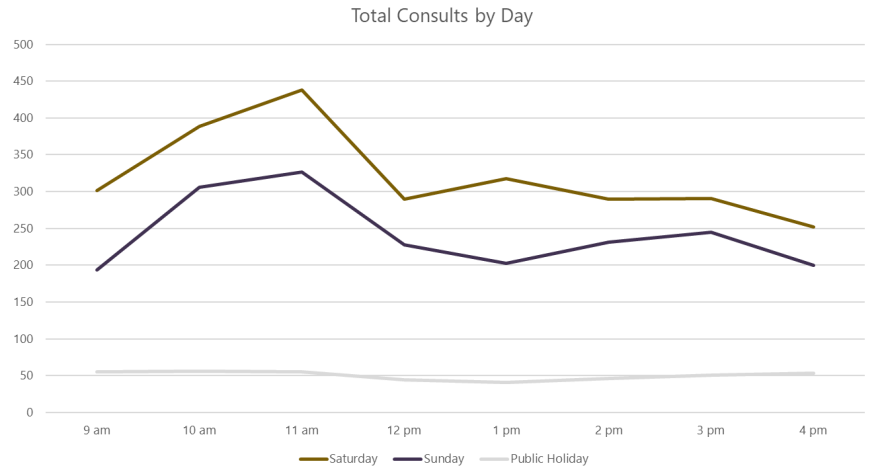
3.2 Current state

Most Wairarapa general practices open to 7pm on one night a week, providing a degree of extended hours access to care for those who find it difficult to access care during the day. As well as this service, the Wairarapa After Hours Health Services is provided in Masterton at Masterton Medical Limited. The roster covers GPs across the whole district, and services are charged at a higher cost ($67, or $36 with CSC for adults) than is typically the case for daytime and weekday consultations in the Wairarapa.

This after hours service is fairly busy, exhibiting a peak on Saturday mornings, and delivering just under 5000 consultations annually. There is limited anecdotal evidence to suggest that a proportion of the weekend demand consists of less acute need, with more routine long term conditions and other primary care demand. This raises a question about whether the community seeks improved access to primary care services outside the usual weekday time, particularly when individuals and whānau may have difficulty leaving work or other commitments for a consultation. Equity issues can arise from employment circumstances if the people with the most need for care have to use sick leave or take leave without pay in order to have their needs met.

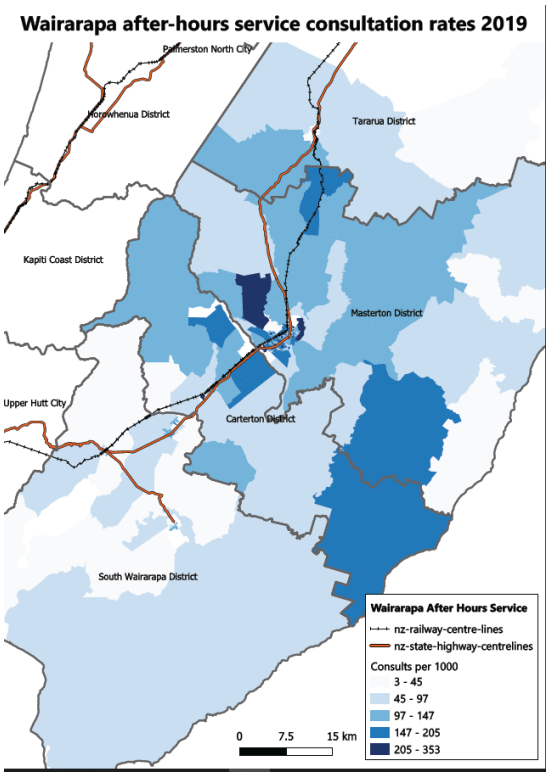
Some of these issues are canvassed in the responses to the Wairarapa DHB Māori Health Survey. Respondents expressed a range of views, but there was a strong articulation of a need for more convenient access to care. High need rural populations may have occupations that are a barrier to accessing primary care during routine weekday times.

Figure 9: Wairarapa After Hours weekend utilisation



As might be expected, distance appears to be a factor in the current utilisation of the After Hours Service, with higher rates of use from communities around Masterton, and low rates in more distant areas. IT should be noted that small numbers make for volatility in rates in some of the more remote areas – the map below shows high rates at Castlepoint that are likely to be artefactual rather than real.

Figure 10: After hours consultation rates per 1000 population



3.3 Emerging models

The challenge of providing extended hours primary health care is a significant issue for much of New Zealand, whether in urban or rural settings. Public expectations of access to care are changing, and new modes for accessing care are emerging. To some extent this has been accelerated by the experience of providing care in a state of lockdown during 2020, in which telemedicine rapidly became an important part of the means for delivering primary care services.

A number of models are emerging across New Zealand:

A focus upon earlier opening hours

Current work on options for extended hours access to care in the Counties Manukau District is considering the need for earlier morning services. There is some suggestion from communities in that case that this is the time when access to care may be more convenient than during the day, if the workforce can be found to deliver such a service.

Specific extended hours centres

A number of urban areas across New Zealand have specific centres that are for extended hours access for a given population. These are considered complementary to the wider offering of general practice in those districts, and will also have a particular emphasis upon accident treatment, requiring to be accredited with ACC and to have a number of diagnostic and other facilities available. While this is an option in a number of cities, an operation on a larger scale than the current Wairarapa After Hours is unlikely to be effective in a rural setting, and would not improve care for populations further from Masterton.

Local telemedicine services

All general practices in the Wairarapa offered telephone consultations during lockdown. A number of practitioners have continued to offer this service to people enrolled with them, and every practice continues to have some degree of telephone offering. There is scope to support this approach further. Supports could include:

1. Joint community/clinician consultation, in order to clarify community needs and expectations, as well as fully understanding the limitations that exist in delivering services in this way;
2. Peer support for clinicians delivering care in this manner, in order to provide assurance and a degree of clinical governance for those less experienced in providing care by telephone.
3. A consistent funding and co-payment charging policy for phone consultations.

Wider telemedicine services

A number of telemedicine services have emerged in New Zealand, taking direct enrolments from larger populations, with a relatively small backup offering of face to face care in support. These services are being actively promoted in urban Auckland, and may have some interest in supporting rural areas where workforce is the greatest challenge for primary care. Whether such services choose to set up in the Wairarapa is largely not a question of planning, but one of the market and the opportunity. But it can be noted that when practices are, even if intermittently, not taking enrolments for new patients such telemedicine services may see that as an opportunity. Compass Health, which support Wairarapa practices as their PHO, is currently exploring options for developing a telemedicine service that could build from existing primary care, without competing with and fragmenting a service and workforce that is already under pressure.

Telemedicine is not a silver bullet for resolving problems of accessing primary health care. Some consultation has physical elements, the rapport with the clinician may not work in the same way, and not all patients prefer to receive care in this manner. In remote areas phone and internet connectivity may not be technically adequate, although this is fast changing. But forms of telemedicine are likely to be one part of the overall response to changing expectations of how primary care is delivered.

3.4 Workforce is the big constraint

Even when preferred directions are clear, the big challenge for developing extended hours lies in the workforce. Primary care workforces are generally under pressure across New Zealand, and this applies especially to rural and provincial areas, where recruitment and retention can be difficult. Even in very large scale urban areas such as Auckland, recruiting clinicians who are willing to work extended hours is highly challenging, and can take a considerable resource, both in time and money. From this perspective, the current after hours arrangement has some benefits, as a service that is sustainable with the current workforce, and that doesn't place excessive demands upon a limited number of clinicians.

There is no single clear answer to the challenge of workforce for extended hours services, although broadening the workforce may be part of the answer. Much depends upon the nature of the care that is needed by the community. If the need is for acute care, then a workforce that draws upon paramedics may be able to assist with alleviating the workforce challenge. If the need is more for core primary care management, then a broadened workforce with nurse practitioners and pharmacists may be part of the answer. The specifics for any one district will also depend to some degree upon the contingencies of who is available, and what attractive roles can be developed. Addressing these issues will have to be done in a manner coordinated with Health Care home development, as that programme supports primary care to develop the workforce, and to establish new roles with more flexibility to deliver care in different ways.

3.5 Preferred direction

There is no clear short term answer to the challenge of extending hours of primary care access. But in the medium and longer term there are several key steps that will help to develop services in the direction that is needed. These are:

4. **Continued and enhanced community consultation** in order to explore further the needs and expectations of the community. The Māori Health Survey is a good recent example, and the re-establishment of the DHB Consumer Council will also serve to support this. But without further qualitative understanding of community expectations of access to primary care in a rural district in the 2020s, it will be challenging to justify the specific investments that are likely to be needed. Community discussion should include the clinicians who deliver primary care services. This will help to ensure that the community is informed about the very real challenges of providing extended primary care, and will help clinicians to hear about needs directly from the community.

5. **Support for telemedicine across the District.** Working locally with primary care to support the use of telemedicine where appropriate and acceptable. There are roles for both DHB and PHO to consider supports for primary care clinicians, including peer support, training and potentially funding, under some circumstances, in order to offset co-payment loss where that is an issue.

Extending access to primary care services is a complex and rapidly changing area. The expectation is that deepening consultation and encouraging the local use of telemedicine will develop understanding and experience in both the community and in primary care, so that as wider developments in workforce and in telemedicine services occur the Wairarapa will be best placed to take advantage of them, and to ensure that they are well tailored to the local community.

4. Hospital services

4.1 Background

Services at Wairarapa Hospital face significant challenges. The volume of services is approaching or exceeding the capacity of the building. The ability to maintain a sustainable clinical workforce is always a challenge in rural and provincial areas, and this is the case with Wairarapa, with use of locum staff at a high level in some specialties, and challenges for recruitment and retention. Over and above this the service faces the challenges usually associated with smaller scale, making it difficult to provide a wide range of services in a clinically sustainable manner. As broader changes play out in the wider New Zealand health system, the challenge is for Wairarapa to express a strategic approach that will address these issues, which is also consistent with the signalled direction of change.

4.2 Principles

We have identified a number of principles that will underpin our approach to the future direction of hospital services. These are:

- Clinical services coordination lies in the community. The core task of coordination of care lies in the community, with primary and community services the continuous health presence for a person over their life course. From this perspective, the hospital is one of a number of services that provide support to community health providers to work with individuals and whānau for the whole of their care.
- Acute care and resuscitation, and obstetrics are core capabilities for a provincial population such as the Wairarapa. Maintaining these capabilities in communities of similar size is the current state across much of New Zealand in districts with similar populations and geography such as Marlborough or Tairawhiti.
- Those services that can be safely and sustainably provided outside a hospital setting should be delivered in the community.

4.3 Provision across different health boards

As with much of New Zealand, it is expected that the population will age over the next decade, placing pressure upon a number of core hospital services, particularly general medicine, general surgery and orthopaedics. Demand for obstetric and paediatric services is likely to remain at current levels, although the younger age structure of the Māori population means that these services will serving a proportionately higher number of Māori than today.

The Wairarapa Hospital meets only a proportion of the demand for hospital services for the population. As with many provincial services, a significant part of the total hospital care is delivered by neighbouring DHBs. The table below summarise the volumes and types of care provided in the Wairarapa and from other areas.

The table below shows the expected number of discharges for people resident in the Wairarapa District to 2038, if driven by demographic change:

Table 1: Forecast inpatient discharges for Wairarapa residents

	2018	2023	2028	2033	2038
Wairarapa DHB	9810	10776	11741	12649	13441
Capital and Coast DHB	1437	1575	1675	1749	1803
Hutt Valley DHB	840	904	957	1012	1040
Mid Central DHB	142	152	164	179	186
Other	313	339	356	381	412
Total	**12542**	**13746**	**14892**	**15970**	**16881**

The table below shows the volume of casemix funded inpatient discharges for Wairarapa residents, indicating the kinds of inpatient care that are provided in different proportions across facilities.

Table 2: Casemix provision for Wairarapa residents 2018/9

PUC	Description	Wairarapa	Capital & Coast	Hutt Valley	MidCentral	Other DHBs	Total
W10001	Maternity inpatient	758	24	29	5	4	820
M00001	General Internal Medical Services	502	1	16	1		520
S45001	Orthopaedics	473	41	9	1	4	528
S00001	General Surgery	351	85	45	6	7	494
S30001	Gynaecology	208	30	13			251
S40001	Ophthalmology	194	69	9		1	273
W06003	Specialist neonates	91	22	5			118
M55001	Paediatric Medical Service	71	5	6			82
S70001	Urology	65	16		41		122
S60001	Plastic & Burns	56		159			215
M05001	Emergency Medical Services	8					8
M25001	Gastroenterology	2	6	7		4	19
D01001	Inpatient Dental treatment			20	2		22
M10001	Cardiology		132	2	1	4	139
M10005	Specialist Paediatric Cardiac					4	4
M20001	Endocrinology & Diabetic		2				2
M30001	Haematology		23			2	25
M45001	Neurology		6			1	7
M49001	Specialist Paediatric Neurology					4	4
M50001	Oncology		27		5		32
M54001	Specialist Paediatric Oncology		1				1
M60001	Renal Medicine		4				4
M65001	Respiratory		65				65
M70001	Rheumatology (incl Immunology)		12	8			20
S05001	Anaesthesia Services		4				4
S15001	Cardiothoracic		30				30
S25001	Ear, Nose and Throat		26	113	2	2	143
S35001	Neurosurgery		28			1	29
S55001	Paediatric Surgical Services		54				54
S75001	Vascular Surgery		68				68
TOTAL INPATIENT DISCHARGES		**2,779**	**781**	**441**	**64**	**18**	**4,103**
		68%	**19%**	**11%**	**2%**	**0%**	**100%**

It is clear that some services appear to have extremely low levels of provision in total, including gastroenterology and inpatient dental services. Unsurprisingly subspecialist services such as respiratory medicine or vascular surgery are provided predominantly from Wellington, although some, such as ENT, are provided more by Hutt Valley DHB. MidCentral currently provides a relatively small proportion of this inpatient mix, other than in urology.

4.4 What is needed in the Wairarapa

The table below sets out a proposed provision of DHB services that will be needed in the Wairarapa for the future. The challenge is to make the core local provision sustainable, and to work with collaboratively with neighbouring services to provide access to more specialised care that cannot be provided sustainably or safely on a small scale at a local level.

Table 3: Proposed Wairarapa hospital service provision

Area	Service	Provision
Surgery	Gen surg	Acute local. Elective in collaboration with other DHBs
	Ortho	Acute local. Elective in collaboration with other DHBs
	Urology	In collaboration with other DHB
	Ophth	In collaboration with other DHB
	ENT	In collaboration with other DHB
	O&G	Obstetrics local, Gynae acute local, Gynae elective in collaboration
Integrated services, principally supporting a primary care and community delivery	Diabetes Respiratory Cardiac Long Term Conditions Cancer	These services lend themselves to specialist provision in a closely integrated manner with primary care, supporting enhanced primary care services to manage most patients directly,
Medical	Gen med	Local provision of both acute and elective care.
	Gastro	In collaboration with other DHB
	Rehabilitation	Yes, but not necessarily within the hospital
	Paediatrics	Local provision, but with support from neighbouring DHB
	MHAIDS	Locally provided, in collaboration with neighbouring DHBs
	Elderly	Locally provided, but principally focussed on supporting care in community settings where feasible.
Maternity	Primary maternity	Antenatal across the district, delivery provided in Masterton
Support across both Hospital and community settings. These services will be provided locally by Health New Zealand, but will typically support both primary community services as well as hospital services, in an integrated manner.	Anaesthetics	
	ED	
	Radiology	
	Community nursing, NASC	Working in integrated multidisciplinary teams
	Oral health	Working in integrated multidisciplinary teams
	Disability and support services	Working in integrated multidisciplinary teams
	Testing	
	Pharmacy	Working in integrated multidisciplinary teams
	Specialist services eg cleft palate	Locally provided in collaboration with other DHBs
	Psychology	Working in integrated multidisciplinary teams

This list of services presents a vision of the core provision that will be available locally for the people of the Wairarapa. Some of these services can be provided on a standalone basis, while others will need to be provided in collaboration with neighbouring DHBs in order to achieve sustainability. A

number of areas, such as diabetes and respiratory services, should be oriented towards integration with primary and community care in multidisciplinary teams, as described in section 2.5 above.

4.5 Models for more collaboration

Implementation of this picture will require detailed and specific service and workforce modelling for each service described above. At a broad level, where services are not likely to be sustainable or safe when provided locally, they will need to be provided in collaboration with other hospital services. This happens now, as different DHBs provide services that are charged back through Inter District Flow (IDF) charges.

But IDFs are not the only model for collaboration. Canterbury and the West Coast DHB have developed a highly collaborative model of hospital based services that sees clinicians working together across the two institutions to provide care to the combined population. This can have the advantage of being less transactional and having less volatility in costs for services, while clinicians work as part of a larger team and can have wider experience across both rural and urban services.

Further, as hospitals will become part of a single organisation as an arm of Health New Zealand from 1 July 2022, it is likely that the opportunities to look at cooperation between services will increase. This direction is likely to be one that will be of interest to services across New Zealand.

There three broad approaches to working with neighbouring services to provide care. These are:

The traditional tertiary model, in which only a small number of services nationally have the capability to provide a given kind of care. This is unlikely to change markedly, and tertiary care for people in the Wairarapa will continue to be provided in other districts, principally by Wellington, Auckland and Starship.

Visiting clinicians from a larger service is the second broad approach to local provision. Where there is another, larger service, which has enough critical mass to maintain skills and to have a flexible workforce roster, then visiting clinicians can be an effective means to provide service locally. This happens now in a number of places, however, if the neighbouring service is itself under pressure, then the sustainability of providing the visiting workforce can be problematic.

Combining services and populations is the third general approach. In this case the approach is to step back and look at the need from a whole population across a larger area, and consider how to use the clinical team to provide care across multiple sites. Where there are two small provincial services this may, in some cases, have the potential to make a new service that is more sustainable than either was individually. In the case of the Wairarapa there is potential to explore this approach, particularly with Palmerston North Hospital which has its own challenges of sustainability.

As an example of a more population based approach, we set out data for Ear Nose and Throat services for the Wairarapa and MidCentral populations. Wairarapa currently sends ENT patients to a highly pressured service at Hutt Valley DHB. There may be scope to work with MidCentral to provide ENT services across the two populations, with Wairarapa contributing about 20% of inpatient demand.

The majority of ENT services are planned, and could be provided at either site, depending upon how best to deploy staff, and how to make the best use of available theatre facilities.

Table 4: ENT volumes for Wairarapa and MidCentral 2018/19

	Combined			Wairarapa			MidCentral		
Provider DHB	**Acute**	**Planned**	**Total**	**Acute**	**Planned**	**Total**	**Acute**	**Planned**	**Total**
MidCentral	219	788	1007		3	3	219	785	1004
Hutt Valley	1	133	134	1	128	129		5	5
Capital & Coast	27	47	74	19	31	50	8	16	24
Other DHBs	4	14	18		1	1	4	13	17
Total	251	982	1233	20	163	183	231	819	1050

While there is considerable uncertainty in the environment for provision of hospital services, the direction set here of focussing on a core locally managed provision while working more closely with other services across the region to ensure that Wairarapa people have equitable access to a wider range of services is consistent with the strategic direction set out by government. Implementing this approach will require:

- Informed consultation with communities about the range of services they will have access to, and how this compares across New Zealand;
- Effective clinical governance that can ensure the quality of collaborative services;
- Engagement with clinical workforces to understand the feasibility of different roster configurations and use of facilities.
- Joined up funding across services.

5. Enablers

The broad directions set out in this plan are critically dependent upon other factors, including workforce development and continued investment in community services. But there are three particularly important factors that will underpin the successful implementation of the directions outline here – effective community engagement, good clinical governance, and capable information technology.

5.1 Community engagement

Wairarapa DHB has made some steps forward in community engagement, but there is a considerable distance to go. Holding a conversation with the community will be key both for understanding community needs and priorities, and for ensuring that the community is well informed about the strengths and weaknesses of different options and choices.

Community engagement should also involve clinicians and particularly clinical leaders from across the health system. This is key both so that clinicians can hear from the community, including from voices that they may not otherwise hear from, but also so that the community can understand that there is clinical logic behind decisions – considerations of service quality are often not transparent to non clinical audiences, even when these are an important part of decisions about service sustainability.

Developing the local programme of community engagement is therefore fundamental to developing an effective health service that responds to needs, and has buy in from the communities that it serves. This is a key workstream that underlies development across the health system.

5.2 Clinical governance

Clinical governance, in the sense of an organisation-wide approach to the continuous quality improvement of clinical services, is a fundamental underpinning for service development. As services change and clinical roles evolve, it is important both for patients and for clinicians themselves that there is adequate support for professional development, quality improvement, and monitoring the safety and effectiveness of services. In the case of the services considered here, clinical governance will be particularly important for hospital specialists to provide support to primary care teams, as well as for the development of integrated multidisciplinary teams in the community. Governance processes will have to consider how new clinical roles and accountabilities work, and how information on service quality is most effectively used across a wider team of people.

Clinical governance will also be crucial in any close clinical collaboration with neighbouring hospital services. A unified approach to deciding upon processes of care, and how they will be monitored and improved will be needed for teams of clinicians who have been used to working for different institutions. Effective clinical governance will give both clinicians and the community confidence that the best possible services are being developed and provided for the population as a whole.

5.3 Information technology

The lack of effective information technology is a major barrier to service integration in New Zealand health care. The practical trajectory of New Zealand's health IT development is unclear, in light of the proposed unification of DHBs in 2022, but it is likely that there will be moves to consolidation and sharing of systems. The risk will be that decisions in the meantime will be delayed. Wairarapa DHB is a part of the 3DHB digital plan, with Capital and Coast and Hutt Valley DHBs, and will have to ensure that its preferred service development direction remains part of the agenda in this forum , and in other national settings.

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Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**CPHAC DISCUSSION PAPER** **Date: June 2021**
Author	Peter Gush, General Manager, Regional Public Health
Subject	**Regional Public Health activity throughout the Wairarapa Health District**
RECOMMENDATION That the Community & Public Health Advisory Committee • **RECEIVES** the report • **NOTES** the ongoing work required as part of the covid-19 response	

1 SUMMARY

This paper provides an update of the services Regional Public Health (RPH) provides in the Wairarapa DHB district. Where possible we have sought to align our activity with the actions in Strategic Direction 2020-2030 Hauora Mō Tatou.

2 CONTINUED COVID-19 RESPONSE

The response to the COVID-19 pandemic remains an ongoing work pressure for Public Health Units around the country. RPH has been responding to COVID-19 since January 2020. The ongoing response to COVID-19 has meant a shift to a new normal for RPH.

RPH is intrinsic to the public health response in the greater Wellington region, coordinating and leading case and contact management, contributing to programmes at the border, and providing a conduit between national policy and local practice. In addition, we are part of the national network of Public Health Units that collectively respond, in the current distributed model, to community resurgence occurring anywhere in the country. As one of the larger public health units we carry a proportionately large share of the workload.

During the latest February cluster in Auckland, RPH:

- Activated a seven day per week roster of dedicated COVID-19 staff.
- Took on responsibility for investigation and managing cases occurring in Auckland managed isolation facilities, to lift the burden on Auckland Regional Public Health Service (ARPHS).
- Provided data management services on Auckland close contacts, using the national case and contact management system (NCTS).
- Made daily symptom monitoring checks to over 12 Contacts over the duration of their 14-day self-isolation periods, including assessing and responding to changes in illness status; many of these contacts had pre-existing symptoms/conditions.

Seconded a staff member to Auckland to provide on-the-ground operational management support.

To ensure our ability to deliver a sustained approach to manage the response for the medium-to-long term we have worked with our staff to develop and implement a Coordinated Incident Management System (CIMS) operating model. This is an agile and scalable model that ensures we can rapidly transition between business-as-usual (BAU), COVID-19 response and back to BAU to accommodate increased COVID-19 response requirements within our community and to support a national response for outbreaks in other regions.

As a service, RPH has been in response mode for 14 months, varying only in degree. RPH leadership is extremely conscious of the ongoing burden on our highly committed workforce and their whānau, and are taking all practical measures to protect our team and to guard against burnout.

3 PUBLIC HEALTH NURSES (ACTION 8 – TAMARIKI-MOKOPUNA OUR CHILDREN AND YOUNG PEOPLE ARE OUR FUTURE)

This quarter has seen the successful implementation and delivery of the School Based Immunisation Programme (Dose 1 HPV and Boostrix immunisations). Despite complexities of staff rostering due to public health nurses working in COVID teams, the implementation went smoothly and without incident.

4 ALCOHOL REGULATORY AND HEALTH PROMOTION (ACTION 1 – INTEGRATING HEALTH AND SOCIAL SERVICES)

4.1 Thirsty Liquor (Masterton)

There has been renewed interest in RPH's opposition to this licence following an article in the Wairarapa Times-Age in February. The focus of the article is on, our opposition, health harms in the premises locale and RPH wanting a reduction in hours on Friday and Saturday Nights. A hearing date for this application has been set for mid-June by the District Licensing Committee.

4.2 Alcohol Retailer Compliance Visits

A RPH Public Health Advisor and a Masterton District Council Licensing Inspector jointly completed compliance visits on 13 premises. A number of the premises needed to update their Duty Manager Register, otherwise the inspections were pleasing.

4.3 South Wairarapa District Council (SWDC) – Liquor Control Bylaw

RPH attended a meeting with SWDC to discuss liquor bylaws in the region. They are looking to combine existing individual district bylaws into a single regional bylaw. The timeframe they are working to has the amended bylaw completed and in place by November 2021. RPH is supportive of the move and we will be advised when the new draft bylaw is out for public consultation should we wish to comment further.

5 TUPEKA KORE (TOBACCO FREE) TE KOHANGA REO & KURA INITIATIVE

RPH are working towards a 'Smokefree Aotearoa New Zealand 2025 with Kapua O Te Rangi, Wāhi Reka and O Ngati Hamu Kohanga Reo, and Te Kura Kaupapa Māori O Wairarapa supporting changes in kohanga reo and kura environments, staff and whanau. Health promotion activities are being planned to coincide with the celebration of Matariki. Activities will also include a review of smokefree/vapefree policies and signage, and promotion of the Te Hiringa Hauora (HPA) 'Drive Smokefree for Tamariki campaign. The campaign prepares whanau for the 'Smokefree and Vapefree Motor Vehicles Carrying Children Under the Age of 18 Years Law' which will be enforced from 28 November 2021.

6 SMOKEFREE 2025

RPH has been working with the WrDHB Smokefree Coordinator supporting the introduction of the new Smokefree legislation. Schools and Early Childhood Centres need their Smokefree signs replaced to cover the new vaping requirements, with signs to read "Smoking & Vaping is prohibited". Our school based Public Health Nurses have been asked to check signage when visiting, and to ensure schools know about the changes.

7 HEALTH PROMOTION – PUBLIC HEALTH ADVISORS (ACTION 1 – INTEGRATING HEALTH AND SOCIAL SERVICES)

In collaboration with Tu Ora Compass Health we facilitated a whānau hui at Te Pa to share nutritional key messages and finalise the Healthy Pouaka kai recipes. These will be introduced over the next four week as a nutrition focus at Wahi Reka Kohanga Reo. This includes a session of practical hands on preparing a lunch box in accordance with the Ministry of Health choking guidelines.

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In addition to the above Wahi Reka kohanga Reo have been supplied with Pēpe ora bags for whānau to collect when they pick up their tamariki. Demonstration lunchboxes are on display to inspire whānau with healthy lunch box ideas. Whānau are sharing their creative lunchboxes through their Kohanga closed Facebook group.

8 PĒPE ORA

Evaluation of the Pēpe Ora Expo gave great data and concluded our plans for 2022;

Estimated between 250 and 300 attended the Expo

Registrations	Hapū Māmā
113 Registrations	**11** attended
55 NZ Euro – 49%	**4** smokers
37 Māori – 33%	**1** referral to Stop Smoking Services
16 Pacific – 14%	**9** referred to Pepe Ora Parenting Support
5 Other – 5%	

14 attendees smoked – 13%
6 referred to Stop Smoking Services

For World Smokefree Day on May 31st we hosted our second Wahakura Weaving Workshop delivering safe sleep key messages for professionals working within this space. Hosting the workshop was Hāpai Te Hauora, Māori Public Health Unit with Jenny Firman, supported by three of our local weavers who collected the harakeke to weave on the day. We completed seven wahakura that will be distributed to whānau in our community.

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Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**CPHAC DISCUSSION PAPER** **Date: June 2021**
Author	Fiona Chamberlain, Service Development Manager Planning & Performance
Endorsed By	Sandra Williams, Executive Leader, Planning & Performance
Subject	Immunisation report for June 2021

RECOMMENDATION

It is recommended that the Committee:

1. **Note** the content of this paper

1 PURPOSE

This paper provides an update to the Committee on immunisation services.

2 IMMUNISATION

2.1 Childhood Immunisations

The target for Childhood Immunisations at 8 months of age is 95% fully vaccinated. The latest report from Tū Ora Compass Health shows that primary care have achieved 83.6% of target, with only 18 children in this cohort left to fully vaccinate.

MMR is scheduled to be delivered to children at age 12 months and 15 months. This is the changed schedule for MMR as this vaccination was previously given at 15 months and 4 years. The latest data from primary care reflects children immunised at this later age. 95% of children at age 6 years have received both doses of MMR.

Tū Ora Compass Health, Whaiora Outreach Immunisation Service (OIS) and medical centres are actively managing recall and follow up of overdue childhood immunisations. Additionally, the following processes in place – standard pre-call, re-call and referral processes. Lists are generated from the medical centres to identify and make contact with families two weeks prior to when the immunisation event is due. Standardised steps for re-call and referral to ensure that children are referred to OIS in a timely managed to prevent delays in immunisation. This captures children who have fallen through the gaps of the above process. This process includes automatic referral from Tū Ora Compass Health to OIS for

- All children who have not started their immunisation by 10 weeks of age
- All children who have not completed their immunisations are 6 months of age
- All children who have not completed their immunisations at 20 months of age.

A report is generated and placed on the Tū Ora Compass Health report server for providers to access which identifies children turning 8 months of age in the current month.

Overdue reports are generated fortnightly and sent directly to providers, as well as placed on the report server. This identifies all children up to the age of 6 years who are overdue for any immunisation event. This identifies those whom have been immunised, but have not messaged through to NIR; those who have left the region; and those who require referral to OIS for follow-up.

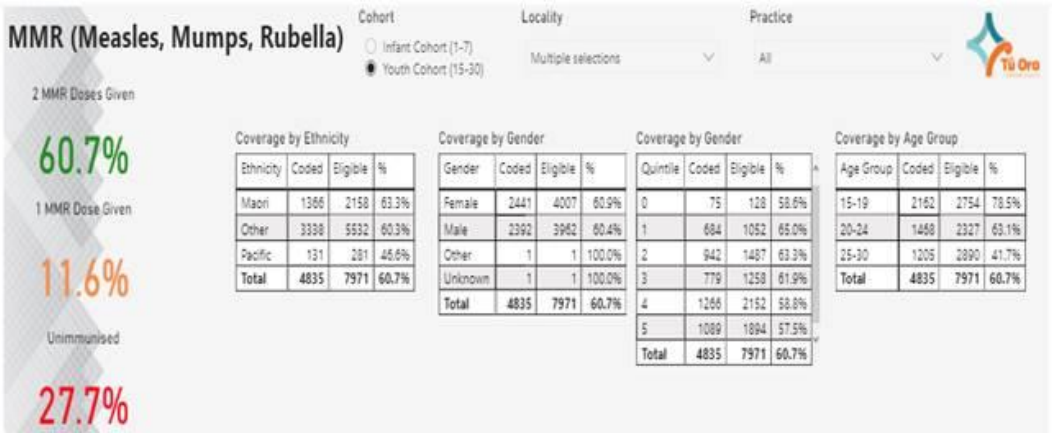
Tū Ora Compass Health also generate a DHB population report for milestone ages 8 months, 24 months and 5 years. This report identifies all children reaching the milestone age in the quarter selected.

They then check each child on this report on NIR to determine their current immunisation status, and refer those that require referring. This is a manual process and is very time consuming, so can only be done when workloads allow. However, the aim is to do them at least monthly, but preferably fortnightly.

2.2 Measles, Mumps and Rubella

On 1 April 2021, DHBs were advised by the Ministry that it was expected we would reduce our focus on MMR catch up vaccinations for those aged 15 to 30 years until October 2021 as our first priority was to be the COVID 19 vaccination roll out. There is still opportunity for practices to continue to offer opportunistic MMR vaccinations, but the national communications campaign and other promotional activities have been placed on hold. The total immunised for MMR 15-30 years is 60.7%

Māori continue to have the highest uptake of MMR to date, with 63.3% aged 15 to 30 being vaccinated.



2.3 Influenza

The Influenza vaccination programme commenced on April 14 2021, for those aged 65 and over. As of June 4 the total of over 65 years olds vaccinated for influenza was 66.8%.

The vaccine for those aged under 65, which is not the same vaccine, is now available and medical centres are busy vaccinating those eligible. Medical Centres and pharmacies are actively promoting this vaccination.

The DHB's staff influenza vaccination programme has commenced.

Covid-19 and Influenza vaccinations are available to a wider group of people at the same time. For those 65 years and over who do not have a Covid-19 vaccination booked, the Ministry recommends they receive their Influenza vaccination first, followed by Dose 1 Covid-19 14 days later, with Dose 2 Covid-19 a further 21 days after that.

2.4 COVID-19

Clinics for Covid-19 continue to run well with the fixed clinic on the hospital site and mobile clinics visiting Aged Residential Care facilities throughout the Wairarapa. To 6 June, the cumulative number of vaccinations given to the Wairarapa resident population was 4667 dose one vaccinations and 2829 dose two vaccinations.

The first community based clinic opens on Level 2 of the the Departmental Building in Masterton on 14 June. The Masterton Council has reallocated car parks at the site for the clinic. The Featherston Community Centre Clinic is due to open on 15 June. The Wairarapa Hospital training Centre site will close on Friday 11th June. There may be times in the future we use this site for temporary clinics to accommodate specific population groups.

Vaccination of Group 3 – those aged over 65 years, disabled people, and people with underlying medical conditions – is well underway. The planning includes close collaboration with the PHO and the medical centres as we roll out in a managed way with invitations to book going out to individuals from medical centres.

We are now using the National Booking Centre for our bookings and will be moving to the National Call Centre in June.

Tū Ora have employed a registered nurse vaccinator 0.4 FTE. This nurse is currently working within the Covid-19 vaccination team. Once Covid-19 programme scales down the nurse will be focussing on the 15-30 year old MMR campaign.

The Vaccinate Greater Wellington Website is the go-to place for all local updates

www.rph.org.nz/public-health-topics/vaccinate-greater-wellington