A plan to improve the health and wellbeing
of people of the Waikato
mihi

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

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

"Mehemea ka moemoeā ahau
Ko au anake
Mehemea ka moemoeā e tātou, Ka taea e tātou"

“If I am to dream
I dream alone
If we all dream together
Then we will achieve”

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Appendix 1: Locations of the wānanga and supporting provider
This is a plan to improve our Waikato health system and futureproof it for the challenges we will face in the coming years. The Health System Plan will put our strategy of Healthy people. Excellent care and our Iwi Māori Health Strategy, Ki te Taumata o Pae Ora, that is being developed, into action.

The Health System Plan describes a future health system that will improve health outcomes particularly for Māori and enable the people of the Waikato the opportunity to achieve their full health potential. Health is broad and can be influenced by many factors including the environment and the community itself.

This plan outlines actions the system can take to partner with and support our communities to build on the expertise they have.

Our current health system is organised to treat people who are ill. This plan is about change. It shifts the focus to achieve a different balance of services for illness and wellbeing, shift services from hospitals to community settings, and working with consumers and whānau to provide services that meet their needs. This plan identifies actions the Waikato health system can take to work as one cohesive, integrated and coordinated health sector, and involve the community and whānau in its planning and delivery.
Improvement in health outcomes and equity in health and wellbeing are the focus

Some groups in the Waikato don’t enjoy the same good health as others. We know that different health outcomes for different groups are caused by a number of issues, past and present. Avoidable differences in outcomes are known as inequity. This difference is unfair and avoidable. For example, kidney failure is one of the complications of diabetes. Māori with diabetes are 2.8 times more likely to have kidney failure compared to non-Māori with diabetes.

With this plan, our objectives are to:

- improve health outcomes for our population particularly for Māori and other priority groups, and
- achieve health equity with a priority for Māori.

The concepts of equality and equity are easily confused.

Health equity is the opportunity for everyone to attain his or her full health potential. It requires removing obstacles to health such as poverty, racism and other forms of discrimination, and addressing the resulting consequences, including lack of access to good jobs with fair pay, quality education and housing, safe environments and healthcare (Boston Public Health Commission, 2019).

Health equality arises when everyone gets the same treatment but the obstacles are not considered.

Figure 1 illustrates the concept where equality means everyone gets the same bicycle irrespective of their physical needs. With equity, the differences between people are recognised, obstacles are addressed and people get a bicycle fit for their needs (Ministry of Health, 2018).

The focus of the plan is to give people the opportunity to achieve their full health potential.

Population groups with more diverse needs or different abilities (e.g. intellectual, physical or sensory) need to be supported to take those opportunities.

Discrimination is one of the key drivers of social exclusion and is correlated with negative physical and mental health effects (United Nations, 2016). Discrimination affects people’s opportunities, their wellbeing and their feeling of control over actions and their consequences.

Across society, distinctions of people are made based on ethnicity, race, sex or gender and other characteristics that should have no bearing on people’s achievements or on their wellbeing.

Prejudice and discrimination are often deeply entrenched and can limit the impact of laws, services and income for those groups that experience discrimination. The health system plays a significant role in determining and changing attitudes towards specific groups and on overall levels of tolerance (United Nations, 2016).

Māori and other ethnic minority groups (such as those from the Pacific) have differences in health outcomes that cannot be explained by socioeconomic reasons alone.

Institutional racism is a form of discrimination within organisations and structures based on ethnicity or race that forms a barrier to Māori and other ethnic minorities achieving equity (Canne et al, 2016; Canne and Griffith, 2018).

It exists in organisations when the standard model for the dominant culture ignores the needs of other cultures.

The fact that all structures in the health system are set up around the implicit norms of the dominant culture perpetuates institutional racism (Poynter et al, 2017). These norms decide who gets treatment, and which organisations get to deliver health services (Harris et al, 2006). This suggests that successful strategies to combat institutional racism require fundamental changes to the structures of health systems and services (Poynter et al, 2017).

Strategies used by organisations include the diversity of membership on decision making groups, incorporating diversity into organisational policies and procedures, workforce diversity, improving the cultural awareness and behaviour of the health workforce to respond to the needs of different cultures.

Health organisations have a responsibility to address all forms of discrimination. Discrimination can affect the health workforce as well as the people who use the services. Waikato DHB will lead by example to address prejudice and discrimination, and particularly focus on eliminating institutional racism. For those groups who have a need for services to be more responsive, the Waikato DHB will work across the health system to ensure more responsive services are provided to treat people earlier, support people to live well and prevent people acquiring avoidable conditions.

Health equity is an aim and principle that weaves through the Health System Plan. The commissioning approach will drive Māori health improvement and ensure-equity is a key performance requirement across all providers of health services including those services provided by Waikato DHB itself (see Gifford et al, 2018).

The mindset of the health sector also needs to be aligned to achieve equity in health and wellbeing. It should include:

- a widening of the scope of health to include wellbeing so providers consider the social and clinical needs of people and whānau
- collaboration with other stakeholders to partner with and support communities to address the factors that influence their health and wellbeing – the determinants of health.

1 Diagram adapted from original concept developed by ‘Robert Wood Johnson Foundation 2017’.
The determinants of health – factors that influence health and wellbeing

Within the Waikato Health System Plan, health is treated as a broad concept and considered as a state of physical, mental and social wellbeing where people are able to live well with or without health conditions. It includes the prevention of avoidable health conditions. Wellbeing is subjective. It is a positive rather than neutral state and therefore health and wellbeing is a positive aspiration – of ‘feeling good and everything is going well in life’.

Many factors influence the health of individuals and communities. They include:

- social and economic environment,
- physical environment,
- person’s individual characteristics and behaviours.

These factors have considerable impacts on health whereas the more commonly considered factors such as access and use of health services often have less of an impact.

The Waikato Health System Plan takes a long term view and sets out the direction of travel across six goals over a ten year horizon. For each goal, a range of actions are outlined that are applicable across all health services in the Waikato. More specific activities are outlined where greater focus is required.

There is broad recognition that the health system needs to be innovative and brave if it is to achieve equity and have a sustainable and well performing health system. The Health System Plan provides clear areas of focus and invites people to think outside the box and do things differently to help reach its goals.

In the words of one of the remarkable Waikato-Tainui leaders, Te Puea Herangi:

“Mehemea ka moemoemoe ahau, ko au anake. Mehemea ka moemoe e tātou, ka taea e tātou”

“If I am to dream, I dream alone. If we all dream together, then we will achieve”

Diagram adapted from original concept developed by Dahlgren and Whitehead, 1991.
The health system needs to change and work as one

In July 2016 the Waikato DHB published its strategy Healthy people. Excellent care. The strategy identifies a vision for the Waikato DHB as an organisation and describes the organisation as part of a wider health and social system.

Healthy people. Excellent care outlines six key focus areas or strategic imperatives. The vision is contained in the title; for people to be healthy and to live healthy lives (Healthy people), care to be easy to get to and use, be consistently good and to give users a good experience (Excellent care). The focus areas are broad and described in figure 4.

Healthy people. Excellent care identifies the need for transformative innovation causing significant change. The strategy moves away from thinking about hospitals as the most important part of the health system to thinking about care that meets the needs of people provided closer to where people live. The focus is on the community.

Waikato DHB’s Iwi Māori Health Strategy, K te Taumata o Pae Ora is in development where a key focus will be the Whānau Ora approach to improving the wellbeing of whānau as a group and addressing individual needs within the context of whānau and iwi.

In order for the system to operate effectively for our population, it needs to move away from the current paradigm where different parts of the system operate in silos, and there is little joined-up thinking and planning across the system participants.

To achieve Waikato DHB’s vision, health and social care must be well connected, coordinated and cohesive. Only then will the Waikato benefit from a system of integrated health and social services that align with the values contained in Healthy people. Excellent care.
### Risk factors in Waikato

#### Smoking

- **Māori**
  - 20% Waikato all
  - 17% NZ
- **Non-Māori**
  - 18% Waikato all
  - 15% NZ

Mothers smoking 2 weeks after birth

- 33% Māori
- 6% Non-Māori
- 16% Waikato all
- 12% NZ

By 2028, it is projected that Waikato will drop down to 13%.

#### Smoking now

- **Māori**
  - 12% Waikato all
  - 9% NZ
- **Non-Māori**
  - 9% Waikato all
  - 7% NZ

#### Smoking in 2028

- **Māori**
  - 8% Waikato all
  - 6% NZ
- **Non-Māori**
  - 6% Waikato all
  - 5% NZ

Fewer people smoke and we expect this will continue to drop but we can do better for Māori (especially mothers) to help them quit.

By 2028, 71% of our Māori adults and 46% of our non-Māori adults are projected to be obese. This is concerning because it is a risk factor for a range of diseases in later life.

### Protective factors in Waikato

#### Fully immunised 8 month olds

- 88% Waikato all
- 91% NZ

Most of our 8 month olds are fully immunised but we could do much better to immunise the 18% of our Māori babies that are not protected from vaccine preventable illnesses.

#### Our adults are getting more physically active

- 55% Māori
- 48% Non-Māori
- 49% Waikato all
- 50% NZ

Waikato up from 48% in prior period.

### Increase in avoidable disease

#### Diabetes in adults

- **Māori**
  - 1 in 11 Waikato all
  - 1 in 25 NZ
- **Non-Māori**
  - 1 in 20 Waikato all
  - 1 in 22 NZ

#### Asthma in children

- **Māori**
  - 21% Waikato all
  - 14% NZ
- **Non-Māori**
  - 17% Waikato all
  - 15% NZ

Successful diabetes management is poorer for Māori and we are not responding adequately to Māori needs.

#### High cholesterol

- **Māori**
  - 8% Waikato all
  - 9% NZ
- **Non-Māori**
  - 9% Waikato all
  - 8% NZ

#### High blood pressure

- **Māori**
  - 12% Waikato all
  - 13% NZ
- **Non-Māori**
  - 8% Waikato all
  - 12% NZ

### Access to health services

#### ASH* Admissions

For every 100 people in the population, the following hospital admissions could have been avoided if seen early enough:

- 0-4 year olds
  - 11% Māori
  - 8% Non-Māori
  - 9% Waikato all
  - 8% NZ

- 45-64 year olds
  - 7% Māori
  - 8% Non-Māori
  - 7% Waikato all
  - 9% NZ

* ASH (Ambulatory Sensitive Hospital Admissions) are mostly acute admissions that are considered potentially reducible through interventions delivered in primary care. E.g. COPD, respiratory infections, dental conditions.

#### People not accessing primary care

- Unfilled prescription due to cost
- 15% Māori
- 6% Non-Māori
- 7% Waikato all
- 7% NZ

- Unmet need for GP due to cost
- 21% Māori
- 14% Non-Māori
- 15% Waikato all
- 15% NZ

- Unmet need for GP due to lack of transport
- 7% Māori
- 3% Non-Māori
- 3% Waikato all
- 2% NZ

### Registration with an LMC in the first trimester of pregnancy

- 59% Māori
- 84% Non-Māori
- 72% Waikato all
- 75% NZ

#### Risk factors in Waikato

- 48% of our children currently meet recommended fruit and vegetable intake guidelines but this is decreasing and projected to decrease to 32% by 2028.

#### Protective factors in Waikato

- 48% of our children are watching television for 2 or more hours a day

#### More of our 5 year olds are free of tooth cavities

- 6% Māori
- 5% Non-Māori
- 7% Waikato all
- 8% NZ

87% of Māori children eat home cooked food but the remainder that are regularly eating take-away is 5 times higher than that of their non-Māori peers.

#### Access to health services

- Successful diabetes management is poorer for Māori and we are not responding adequately to Māori needs.

#### Access to health services

- Fewer people smoke and we expect this will continue to drop but we can do better for Māori (especially mothers) to help them quit.

#### Access to health services

- By 2028, 71% of our Māori adults and 46% of our non-Māori adults are projected to be obese. This is concerning because it is a risk factor for a range of diseases in later life.
3.2. National and regional context

The Health System Plan sits within a wider national and regional context.

**New Zealand Health Strategy**

- People-powered
  - Milieutel hana kowhai
- Closer to home
  - Kia ana mai ki te kāinga
- Value and high performance
  - Te whānau hua ki te tika o ngā mara

**He Korowai Oranga**

- Overall aim
  - Pae Ora
    - Healthy futures for Māori
  - Whānau Ora
    - Healthy families
  - Mauri Ora
    - Healthy individuals

**New Zealand Disability Strategy**

- Outcome areas:
  1. Education
  2. Employment and economic security
  3. Health and wellbeing
  4. Rights protection and justice
  5. Accessibility
  6. Attitudes
  7. Choice and control
  8. Leadership

**Midland Regional Services Plan**

- Improve Māori health outcomes
- Improve quality across continuums of care
- Improve quality across all regional services
- Build the workforce
- Improve clinical information systems
- Efficiently allocate public health resources

**Waikato Health System Plan**

The National and Regional context:

- The Waikato Health system currently spends more than it receives particularly in hospital services. The need to continue to resource hospitals puts pressure on the ability to invest in community based services.

- Waikato has a high attendance rate at emergency departments but a low proportion of those subsequently admitted to hospital. This generally indicates people using emergency departments as a first point of contact rather than a general practice.

If current admission rates and length of stay continue along with expected population changes, we would need another 440 hospital beds by 2030.

- Waikato DHB’s financial performance rate has been progressively declining. The Waikato health system currently spends more than it receives particularly in hospital services. The need to continue to resource hospitals puts pressure on the ability to invest in community based services.

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How this plan has been developed

The Health System Plan has been informed by current services and strategies, literature, data analysis, understanding current and future challenges, and engagement with communities and providers.

The process began by engaging with the community (including wider health sector participants) about how care could be better provided in community settings.

As part of the engagement process wānanga were held in seven Māori communities to ensure significant insight into Māori perspectives were incorporated. Rangatahi were engaged through seven separate hui. The Waikato DHB acknowledges and thanks the providers who supported both the wānanga and rangatahi forums (see appendix 1).

Our communities view health services as one system of delivery rather than as separate entities. Organisational and professional distinctions made by health workers can create barriers to a high quality and seamless health experience.

It is important to consider the impact that changes in one part of the system can have to another. The provision of more care in the community means we must also consider what this means for hospital and other related services.

The Health System Plan is a plan for the whole system and has been informed by the work of the Care in the Community planning project. The plan brings together a range of different plans to provide a holistic and clear understanding of what features to strengthen and promote.

How this plan has been developed

4.1. What our communities want to change

During the engagement process our communities shared many experiences from their interactions with health services, issues they encountered and provided valuable perspectives on how the system could be improved.

This feedback was organised into themes for analysis. Ideas for improvement were tested against trends and directions in the local and international literature and thinking. The various members of our communities, such as iwi, consumers and health workers were consistent in their messaging.

What communities and the health sector expect to see addressed can be summarised by six themes:

- **Improve responsiveness to Māori** – Most health services are not designed to meet the needs of Māori. They do not respect tikanga Māori, are not focused on whānau wellbeing, and are not delivered in accessible settings.

- **Empower communities** – Resource allocation and service design are controlled by health care organisations. Health system planning and decision-making is not responsive to local needs.

- **Enable healthy living** – People and whānau don’t have access to the support they need for wellness. This includes access to, and control over their personal health records.

- **Enhance primary and community health care** – The majority of interactions people have with health are with primary and community health care providers. There are funding, professional and organisational boundaries across the services that create barriers to positive consumer experiences and improved outcomes.

- **Develop our workforce** – Increasing population demand and constrained workforce availability will threaten service access for consumers and intensify pressure on the staff of already vulnerable community services.

- **Improve access** – The current configuration of service delivery creates access barriers for people – geographic, cultural, financial, different sectors of society are not coordinated well, and services are not available in time or when people are able to attend.

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**Community and provider engagement**

- **43** engagement sessions
- **7 wānanga** Taumarunui, Thames, Te Kuiti, Waharoa, Hamilton, Huntly, Tokoroa
- **213** participants
- **70%** pakeke
- **28%** kāumatua
- **2%** rangatahi
- **102** participants in health sector engagement
- **6** goal definition workshops
- **60** participants in strategic options workshop
- **207** participants
- **23** online surveys
- **57** consumers
- **6** focus groups
- **9** in-depth interviews
- **13** health workers in workforce focus group

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**What our communities told us – Wānanga**

- **Provide local services so whānau health is more accessible**
- **Cost is an issue and time is an issue**
- **Good health is inaccessible because it is expensive (money and time): health services should be more affordable so whānau can prioritise their health**
- **Mobile services**
- **Build local capacity**
- **Lack of support information and guidance for whānau carers**
- **Employ more staff with knowledge of tikanga and te reo Māori**
- **The health system needs to be reconfigured to support and empower Māori to achieve and maintain good health**
- **Our end users are feeling disconnected from the services. We should be bringing services together – we should be working together as one**
The process of engaging communities and the health sector on improving health and wellbeing has brought together a collective vision for the Waikato health system for the next 10 years.

The vision for the Waikato health system will:

- Shift from an illness to a **wellness approach**
- Become **whānau-focussed** rather than provider focussed
- Actively involve communities in the process of planning and decision making
- Actively develop services in community settings as an **alternative to hospital** provided care
- Evolve a broad **team based approach** to providing health and social services
- **Build strong leadership** with a mindset change at all levels (e.g. community, providers, DHB)
- Continually **challenge the status quo** to enable **transformative change**
- **Build effective inter-sectoral partnerships** between sector leaders, stakeholders and whānau
  - Build relationships that are **purpose driven** and **deliberate**
- **Leverage** evidence-based planning tools to guide the development and implementation of interventions
- Become a **learning system**
  - Think outside of the square
  - Improve the process of implementing and evaluating initiatives
  - Improve approaches that enable rapid turn-around of development and improvement (‘fail fast, succeed faster’)
  - Encourage spread of successful innovation
- **Improve the visibility of the good work** that is already occurring in the Waikato
  - **Back the successes**
  - **Build relationships** with the community, providers and the DHB

The vision for good health and wellbeing in the Waikato is illustrated on the following pages.

**Within ten years:**

- our people will enjoy good health and wellbeing supported by the communities they live in
- communities will be supported to address the things they need for good health and wellbeing. Health and social services are part of the community
- people will have easy access to information and services that are supported by technology and provided by health workers in a way that focuses on the needs of whānau
- where possible, services will be provided in the communities people live
- providers will be well connected, communicate well and coordinate between themselves
- all paths/services in the health system are connected therefore people with multiple needs can access services through any part of their journey – ‘any door is the right door’
- irrespective of the type of care people need, all paths will lead them back to the support of their whānau, families and communities.
Vision of good health and wellbeing in the Waikato

Enhance wellbeing and prevention

Improve access and choice close to where people live

Whānau centred – listen to the voice and experience of whānau

Support whānau as active participants in their health

Address determinants of health

Te Iwi Ngakau

Community Health Services

Health Services

Social Services

People at Heart

Libraries

Schoools

Community Services

Waikato District Health Board

Health System Plan

DRAFT APRIL 2019
6.1. Enhance wellbeing and prevention. Address the determinants of health

The health system is currently focussed on, and resourced, to provide services to people who are ill. These services will continue to be improved so that people have services available to them, particularly when they need them urgently.

That said, we know that an increasing number of people are developing conditions that are preventable, for example diabetes in adults. Some of those people go on to use hospital services when that could also have been avoided.

As the demand for hospital services goes up, so too does the need to resource that demand.

Our projections tell us we will need another 440 hospital beds by the year 2030—this is not sustainable or desirable. This scale of hospital growth would crowd out investment in services that make a difference to overall population health outcomes and the ability to address health inequities experienced by Māori.

The evidence supports the community view that our health system needs to urgently achieve more balance in our approach and to focus on wellbeing and prevention as a long-term investment strategy. In order to enhance wellbeing and ensure a greater focus on prevention, we must address the determinants of health. The health sector invests almost exclusively in one of the determinants; health services themselves.

Addressing the wider determinants of health will mean utilising different ways of working with other government, non-government and local government agencies. More importantly, it will mean the health providers will need a much closer relationship with communities to understand their priorities, and to work with and support communities to address them.

Empowering people to manage their own health means the health sector needs to reorient itself to enable it. This may require a change in mindset and changes to the traditional roles of providers and funders.

This is not a one-size-fits-all approach as different communities will require different approaches.

6.2. Be whānau centred – listen to the voice and experience of whānau

Being whānau centred requires the health sector to consider the needs of whānau and families, and the needs of individuals in the context of their whānau or family.

The system itself needs to change in order to be responsive to the needs of whānau and address inequity.

Organisations will need to overcome their own internal barriers and address the structures and policies that lead to inequity.

Significant commitment and leadership are required if cultural competence and cultural safety are to improve and lead to better experiences for whānau and health workers.

6.3. Improve access and choice where people live

Access is critical to improving Māori health outcomes and achieving equity. There are many barriers to access such as cost, distance, the time of day a service is scheduled, confusing locations such as hospitals, the lack of local services and a lack of choice.

In an age of enhancing consumer responsiveness and experiences, there is a desire to provide services tailored to the needs of individuals, whānau and communities.

Health must not just be more responsive but should anticipate challenges and issues—a closer relationship with communities is needed for this.

Currently, communities are not supported or enabled to participate in planning and service design. Furthermore, family and whānau are often the carers and the health system must acknowledge their roles and support them.

Health and social services hold information that is neither shared nor easily accessible. Easier consumer access to information on services is an enabler of access, choice and improved outcomes. Access to system level information will also support community participation in the planning and improvement of services.

Organise the health system around localities to improve access.

The topography of the Waikato DHB district naturally identifies distinct localities. The Health System Plan will use the locality concept as a way to support communities and to plan, deliver and coordinate services locally.

Localities are not the same as communities (Jones and Moon, 1993). The term locality is used in health to describe space or geographic locations, features and boundaries. It is commonly used to describe a geographic area or neighbourhood. Waikato DHB proposes using a locality framework of seven localities using similar boundaries as the Territorial Local Authorities. The names of the localities used in this plan are temporary placeholders. A separate process with communities and stakeholders will be used to identify appropriate names for each locality.

A locality approach will enable the health sector to:

- partner with local communities and stakeholders to address local priorities
- support the development of local networks
- support the development of community leadership and expertise
- configure services aligned to the needs of localities
6.4. Support whānau and families as active participants in their health

Whānau Ora describes a Māori approach that incorporates the knowledge, skills, attitudes and values of Māori society. Whānau – the principle of extended family structure, sits at the core of Kaupapa Māori principles. It acknowledges the relationships Māori have to one another and to the world around them.

Whānau Ora is a Kaupapa Māori approach using whānau focussed models of service integration to improve outcomes, not just health. It differs from traditional health and social approaches that focus on the needs of individuals. Whānau Ora is about increasing the wellbeing of individuals and whānau to lead full lives and uses the power of whānau to improve the wellbeing of individuals and whānau. It provides whānau with appropriate services and support so they can become more self-managing and achieve their aspirations.

Whānau Ora puts whānau and families in control of decision making, build on their strengths and abilities, supports and develops opportunities that enable whānau to achieve their aspirations. Whānau Ora approaches take a long term view to help whānau achieve their potential. Instead of many government agencies providing services to whānau, whānau Ora provides the infrastructure for agencies to work alongside whānau to achieve the goals and aspirations that whānau themselves have identified.

To become more self-managing and achieve their aspirations, whānau Ora approaches take a long term view to help whānau achieve their potential. Instead of many government agencies providing services to whānau, whānau Ora provides the infrastructure for agencies to work alongside whānau to achieve the goals and aspirations that whānau themselves have identified. Depending on the whānau need, time is spent addressing immediate health and social concerns, helping whānau to move beyond crisis to a space where they can think and plan for the future and develop steps to reach that future state. It aims to build on the skills and interests and strengths of the whānau and build their capability to become self-determining and live full and happy lives.

What is community development and why is it important?

It is a process where community members are supported by agencies to identify, take collective action and generate solutions to common problems that are important to them. It empowers community members and creates stronger and more connected communities. It is a grass roots process by which communities become more responsible, organise and plan together, develop healthy lifestyle options and achieve social, economic, cultural and environmental goals. It ranges from small initiatives within a small group to large initiatives that involve the broader community.
a vision for the future
– a whānau focussed approach to health and wellbeing

The challenge
How do health services support whānau with complex health and social needs when the issues can be seen as too difficult, time consuming and expensive to resolve?

The outcome
Whānau focussed services support the whānau to deal with their immediate health and social issues and they develop a long term plan that they want to achieve and have support where they need it

The impact
Whānau are able to manage their health conditions, live well in a healthy home, and enjoy life.

Current state
John is 47, married with a teenage son and lives in suburban Hamilton. Things are tough. Because of a downturn in his industry, John has not been getting the hours at work like he used to and his income fluctuates.

John has high blood pressure, not the best diet and recently he has felt some tingling in his fingers and toes that is not going away. His wife Beverley is in poor physical health and has periodic bouts of depression which means she cannot work. John knows that he should probably visit a doctor but he has not been for years.

He simply cannot afford it – he cannot find the time during the day and it is money he cannot really afford. He also knows that it will take longer than 15 minutes to sort out.

The last time he went, John felt stupid when he could not provide some seemingly simple information to the receptionist, the appointment was rushed and he felt uncomfortable talking to the young female doctor. It is just another hassle he could do without.

Unfortunately, his son Sam has been really unhappy lately. Sam is struggling to fit in at school and John and Beverley suspect he is self-harming.

John knows that they cannot manage this challenge on their own. He does not know who to call, but sees a number in the local paper and calls it.

Future state
John’s call is answered by the mental health crisis services. After they work out that there is no immediate crisis, the service finds out a bit more about the situation and with John’s permission, make contact with the general practice his whānau is enrolled with. Within six hours of his first call a friendly person from the practice calls and invites John and his whānau in for a health and wellness check. Initially, John feels sceptical but the appointment is at a time the whole family can attend and the person says it will be free and will take one hour to start with. The whānau are asked to go to the local laboratory to have some blood tests done two days before their appointment as they haven’t had any done for a while. No form is needed as the practice can request it electronically.

The appointment is not at all what John had expected. First of all, they meet Jimmy who is from the local Whānau Ora service and says he is going to talk to them about their wellbeing and any social matters. Jimmy sees people wherever they wish to meet but also in different practices around Hamilton. The practice staff sees people wherever they wish to meet but also in different practices around Hamilton. The practice staff will also see the whānau about their health issues.

Jimmy spends time talking with them, getting to know the family, their circumstances and the urgent issues they see. Information is recorded electronically on a tablet. Jimmy identifies that the health issues are more urgent than social issues.

Once Jimmy has finished, the whānau are offered the choice of seeing the nurse and doctor together or individually – they choose to do everything as a whānau. They see the practice nurse who asks other questions about their health and does a number of checks including of John’s feet.

They then see the doctor. After a full physical examination, the doctor tells John that his blood pressure is too high, has Type 2 diabetes and some loss of kidney function. He discusses treatment, what the whānau needs to do to manage it themselves such as a better diet and prescribes medicines. The medicines are prescribed electronically.

Beverley needs support to help with anxiety and to support John with his diabetes. The whānau see a dietician who meets with them by video, they have a plan to eat well and be regularly active.

The whānau are then given a video call with all the arrangements to be made. They write down the questions to ask and feel confident to do so.

At the next meeting, after the urgent health issues have been addressed, John, Beverley, Sam and Jimmy talk about their long term plans – what the whānau would like to achieve in the future and how they can meet their goals. The whānau is linked to a local Kaupapa Māori kai and activity group and with advice and support from the dietician who meets with them by video, they have a plan to eat well and be regularly active.

There are ups and down, GP visits, medications, hospital specialist appointments, relapses – but the family aren’t alone. Jimmy helps them to line up appointments and get through the systems. They write down the questions to ask and feel confident to do so.

Thanks to Jimmy’s support the whānau are in a better space to know where to go and what to do if there is something they cannot manage alone. Within 18 months Sam is doing better, Beverley’s depression is manageable and her physical health improves. She has been able to volunteer and is looking to get a job. John is finishing off a qualification so that he can apply for a better job with more certainty of income. Everyone has lost a few kilos and John’s heart issues and diabetes are now well managed.

Things are on the up.

Income so Jimmy sets up a meeting and says he will come along.

After the podiatrist, John is asked to see the doctor again who has since spoken to a kidney specialist and explains a change to his medicines. John doesn’t have to do anything other than go to the pharmacy to collect the medicines (or they can deliver). At the pharmacy, the pharmacist talks to them about their prescribed medicines including others they take – what they are for, any side effects they might experience and what to do if they do. While at the pharmacy, the dietician calls on his mobile and they agree to meet one evening as a whānau by a video call with all the arrangements to be emailed to him with links.

Sam is referred to specialist mental health services and will be seen within the week. They talk through how they could work together as a family to support him. Jimmy will also be in touch with Sam’s school, to make sure everything is in place there.

It becomes clear that John and Beverley may be eligible for some income supplements from Work and Income so Jimmy sets up a meeting and says he will come along.

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Things are on the up.
To achieve good health and wellbeing over the next ten years, the following goals have been identified:

• Partner with Māori in the planning and delivery of health services
• Empower whānau to achieve wellbeing
• Support community aspirations and address determinants of health
• Improve access to services
• Enhance the capacity and capability of primary and community health care
• Strengthen intermediate care

There are also five supporting areas that need to be addressed if the sector is to be successful in achieving the goals:

• Commissioning
• Leadership and partnerships
• Technology and information
• Workforce
• Quality improvement

A number of actions and underlying activities to achieve the goals have been identified. The phasing is an indication of the order activities should be undertaken to guide detailed implementation planning. The actual timing of initiatives will be identified in detailed plans for them.

The whole sector is responsible for these actions. Individual organisations have responsibilities for actions within their own services and workforce. We must work collectively, lead and own them. As the actions and activities will be phased over a 10 year period, they will be reviewed on a regular basis to ensure ongoing relevance.
goal 1

Partner with Māori in the planning and delivery of health services

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

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

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

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

Activities

<table>
<thead>
<tr>
<th>Phasing</th>
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<tbody>
<tr>
<td>Waikato DHB works with Māori to develop an ongoing programme for the whole DHB that progressively:</td>
</tr>
<tr>
<td>• addresses structural, policy and procedural barriers to achieving Māori equity</td>
</tr>
<tr>
<td>• builds knowledge and awareness, shapes beliefs, and debunks myths and stereotypes</td>
</tr>
<tr>
<td>• supports staff with the right behaviour</td>
</tr>
<tr>
<td>Waikato DHB develops policies and processes that enable Māori to participate in the planning, development, delivery, quality and performance of health services it provides and commissions</td>
</tr>
<tr>
<td>Examples of this include:</td>
</tr>
<tr>
<td>• Evidence of Māori involvement in governance processes such as clinical governance, project steering groups, system leadership groups</td>
</tr>
<tr>
<td>• Evidence of the involvement of Māori whānau in the design of services</td>
</tr>
<tr>
<td>• Practice oriented around Māori models of health</td>
</tr>
</tbody>
</table>

Action 1.2 Reorient commissioning to achieve equity

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

Activities

<table>
<thead>
<tr>
<th>Phasing</th>
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<tbody>
<tr>
<td>Develop an outcomes performance framework for the Waikato health system that identifies inequity and unmet need, and make performance information publicly accessible. The framework includes an intervention logic that enables different parts of the sector to understand their contribution to achieving equity</td>
</tr>
<tr>
<td>The Waikato DHB commissioning approach involves a progressive shift from focusing on throughput to outcomes, and requires extensive engagement and co-design with providers and Māori consumers. Māori participate in the monitoring and evaluation of the outcomes</td>
</tr>
<tr>
<td>Equity of outcome indicators are built into service agreements, with Waikato DHB and providers sharing responsibility for improving these outcomes and freely sharing data to support this</td>
</tr>
<tr>
<td>Service agreement duration is extended for providers meeting defined capability and performance standards</td>
</tr>
<tr>
<td>Waikato DHB supports providers to understand inequities in their patient populations and lends expertise to help with strategies to address them</td>
</tr>
</tbody>
</table>
Action 1.3 Build requirements for partnership with Māori into provider service agreements

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

<table>
<thead>
<tr>
<th>Activities</th>
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<tbody>
<tr>
<td>Waikato DHB progressively includes requirements for partnership-based ways of working in service agreements with providers.</td>
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<tr>
<td>Examples of this include:</td>
<td></td>
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<tr>
<td>• Evidence of Māori involvement in governance</td>
<td>2</td>
</tr>
<tr>
<td>• Māori workforce participation to reflect population proportion</td>
<td></td>
</tr>
<tr>
<td>• Practice oriented around Māori models of health</td>
<td></td>
</tr>
<tr>
<td>• Evidence of contribution towards achieving equity</td>
<td></td>
</tr>
<tr>
<td>• Evidence of the involvement of Māori whānau in the design of services</td>
<td></td>
</tr>
<tr>
<td>• Ensuring services do not worsen inequities (e.g. through application of the Health Equity Assessment Tool)</td>
<td></td>
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<tr>
<td>• Publication of performance information including movements to achieving equity</td>
<td></td>
</tr>
<tr>
<td>Waikato DHB supports the sector to develop partnership based ways of working through sharing its own experiences, resources, networks and relationships</td>
<td>1</td>
</tr>
<tr>
<td>Provider service agreements include a requirement to enable Māori consumers to provide feedback and to demonstrate how improvements for priority areas have been made through process change and performance information</td>
<td>2</td>
</tr>
</tbody>
</table>
**Action 2.2 Advance initiatives to better support whānau as carers**

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

**Activities**

<table>
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<tr>
<th>Activities</th>
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<tbody>
<tr>
<td>Develop pathways that inform whānau at a locality level of where to go for advice and services</td>
<td>1</td>
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<tr>
<td>Support the development of peer support networks in communities of need</td>
<td>2</td>
</tr>
<tr>
<td>Develop protocols for individualised care planning that consider the need to support both carers and whānau</td>
<td>1</td>
</tr>
</tbody>
</table>

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

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

**Activities**

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<tbody>
<tr>
<td>Waikato DHB partners with Māori to identify specific community health literacy issues to prioritise (e.g. discharge communication, medication information)</td>
<td>1</td>
</tr>
<tr>
<td>Workforce is upskilled in health literacy to better support whānau and communities</td>
<td>1</td>
</tr>
<tr>
<td>Whānau and consumers can access bilingual, culturally appropriate information to support health literacy and self-management</td>
<td>2</td>
</tr>
<tr>
<td>An interagency approach is taken to coordinate health information and ensure consistency and accessibility of health messaging</td>
<td>2</td>
</tr>
</tbody>
</table>
The Waikato health system is reoriented to ensure equitable and enhanced access to the resources and environments that keep people well.

This will mean:

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

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

Rationale:

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

Activities Phasing

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<tr>
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<tbody>
<tr>
<td>Waikato DHB and other partners work with Māori to understand locality priorities, the resources they have, and agree on a plan to support the localities</td>
<td>1</td>
</tr>
<tr>
<td>Waikato DHB resources and supports communities to facilitate community development and leadership</td>
<td>1 2</td>
</tr>
<tr>
<td>Waikato DHB provides additional resources for health promotion</td>
<td>2 3</td>
</tr>
<tr>
<td>Where there is evidence of health benefits, Waikato DHB directly invests in population health interventions</td>
<td>2 3</td>
</tr>
<tr>
<td>Waikato DHB actively looks for co-investors for intersectoral solutions</td>
<td>2 3</td>
</tr>
</tbody>
</table>
Action 3.2 Expand the inter-sectorial approach to address determinants of health

Rationale:
- Factors outside the health system such as income, housing, social support, employment, and education have large effects on the health of populations.
- Evidence shows that population health interventions are highly cost-effective and can be equity positive. They also address acute demand by reducing the prevalence, severity and incidence of disease.
- Responsibility for addressing the determinants of health is scattered across multiple government agencies, but the health system often bears the burden of unhealthy impacts. As health affects the determinants, a collective approach is required to redress this imbalance.
- A health event provides an opportunity to improve health by actively engaging whānau with housing, educational, financial, community and other health and social services in a mana enhancing and culturally safe way.

Activities Phasing

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<tr>
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<tbody>
<tr>
<td>Waikato DHB works in collaboration with other health and social agencies (e.g. education, local government, transport, housing, police, employment and social development) to form coalitions aimed at addressing determinants of health in the Waikato, and supporting the effective delivery of Whānau Ora</td>
<td>1</td>
</tr>
<tr>
<td>Iwi and Māori are involved as partners in both governance and operations, and Māori-based analyses and frameworks for action are employed</td>
<td>2</td>
</tr>
<tr>
<td>Support communities in their priorities to spread information and encourage change, with health education and promotion supported by health professionals</td>
<td>1</td>
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</table>

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

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

Activities Phasing

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<tbody>
<tr>
<td>Waikato DHB works in collaboration with other health and social agencies (e.g. education, local government, transport, housing, police, employment and social development) to implement the Health in All Policies framework during local public policy development. This is informed by priorities identified by the local communities and builds on the coalitions formed in each locality and the district</td>
<td>1</td>
</tr>
</tbody>
</table>
goal 4  Improve access to services

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

This will mean:
- cultural competence and safety underpin the way services are planned and provided particularly for Māori
- equity in access to services is achieved for Māori
- a model of virtual primary health care, co-designed with consumers, communities and caregivers, operates to bridge geographic barriers
- innovative community care approaches to improving access for priority populations are supported and evaluated
- care is delivered in a range of settings that are accessible for consumers and their whānau (e.g. marae, homes, workplaces, schools, digital spaces)
- support is provided to improve access to organised screening programmes as well as opportunistic screening
- where feasible, services for people with long term conditions are decentralised
- health and social service providers are inter-connected, ensuring ‘every door is the right door’ for consumers and whānau to simplify and enhance access to multiple health and social services
- urgent care and after-hours services are affordable and accessible, particularly for rural whānau
- consumers and whānau have an online portal to access their health records and shared care plans, and other reliable health-related information as part of a digital strategy
- consumers and whānau are able to control who has access to their personal health records.

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

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

Activities Phasing

| Develop a coordinated strategic district wide approach to improve cultural competency and safety at an organisational level | 1 |
| Waikato DHB strengthens its approach to tikanga and cultural competency through changes to its own practices and services, and assists commissioned providers with this too | 1 |
| Waikato DHB takes a planned approach to improving cultural safety including initiatives that address structural and policy matters that lead to prejudice and discrimination and shares its learning with other providers | 1 |
| Waikato DHB leads sector Māori workforce development by enhancing its own workforce plans to increase the proportion that are Māori across clinical and non-clinical areas in proportion to the population | 1 |
Action 4.2 Collaborate in the development of district-wide service delivery models that enhance access for Māori and other priority populations

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

<table>
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<tr>
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<tbody>
<tr>
<td>Develop system wide service delivery models for priority areas aligned with locality priorities to achieve health equity</td>
<td>1</td>
</tr>
<tr>
<td>Develop a district-wide coordination framework to guide the practical coordination initiatives that care providers at a locality level put into place</td>
<td>1</td>
</tr>
<tr>
<td>Develop alternative approaches to face-to-face services, as settings where services can be provided</td>
<td>1</td>
</tr>
<tr>
<td>Explore co-location and collaborative service delivery with health and intersectoral partners</td>
<td>1</td>
</tr>
<tr>
<td>Provide greater access to specialist care and/or expertise through use of mobile teams and technology delivered in different settings e.g. schools, marae, general practice led clinics, pop-up clinics</td>
<td>2</td>
</tr>
<tr>
<td>Develop initiatives that address cost barriers for people with high and complex needs particularly general practice services and access to subsidised medicines</td>
<td>1</td>
</tr>
<tr>
<td>Improve transport options for areas and people of highest need to facilitate access to specialist services including those provided outside of the district</td>
<td>2</td>
</tr>
</tbody>
</table>

Action 4.3 Access barriers for people with disabilities are eliminated

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

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<tr>
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<tbody>
<tr>
<td>Improve access to health services for people with disability/impairment, and progressively integrate health and disability services</td>
<td>1</td>
</tr>
<tr>
<td>Develop appropriate systems and policies to identify people with disability/impairment</td>
<td>2</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Activities</th>
<th>Phasing</th>
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<tbody>
<tr>
<td>Develop workforce plans that enable the service delivery models to be delivered in a sustainable way and build a local workforce</td>
<td>1</td>
</tr>
<tr>
<td>Following the development of service delivery models, establish programmes that give the workforce the appropriate skills, knowledge and competencies needed to meet quality standards or expectations</td>
<td>2</td>
</tr>
<tr>
<td>Establish mobile specialist teams and locally-based clinical staff to support the service delivery approaches in community settings where feasible</td>
<td>2</td>
</tr>
</tbody>
</table>
**Action 4.5 Support district-wide service delivery models with technology and information**

**Rationale:**
- Experience to date shows an appetite for using technology in the Waikato amongst consumers and providers that is broader than video interaction.
- The development and integration of technology across the system is difficult for a number of reasons therefore providers including Waikato DHB have followed their own strategies. In a constantly evolving industry, there are significant risks with over-planning. The strategic principle is inter-operability.
- The commissioning approach needs to be informed by information that provides a population perspective of quality and performance, and the outcomes being achieved.

**Activities Phasing**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Phasing</th>
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<tbody>
<tr>
<td>Waikato DHB and its partners agree a strategy for health technology in the Waikato, which has alignment across the health sector to ensure a consistent approach to consumer access, content and support for agreed initiatives</td>
<td>1</td>
</tr>
<tr>
<td>The technology component of services will be expanded through trialling, evaluating and scaling up well-designed pilots with defined use cases</td>
<td>2</td>
</tr>
<tr>
<td>Collaborate across the sector to share consistent and reliable information and to develop a district wide dataset with analytical tools that can be progressively used for needs analyses and the measurement of outcomes achieved</td>
<td>3</td>
</tr>
</tbody>
</table>

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

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

**Activities Phasing**

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<th>Activities</th>
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<tbody>
<tr>
<td>The Waikato health system agrees an action plan that improves the shared health record and care plans, collaborating with stakeholders within the district (and Midland Region where appropriate). This record is consumer-centred and gives consumers access to their information through patient portals</td>
<td>1</td>
</tr>
<tr>
<td>All providers involved with a consumer’s care have access to appropriate information to inform their service provision</td>
<td>1</td>
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</table>

**Action 4.7 Trial personalised care using whānau care budgets**

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

**Activities Phasing**

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<th>Activities</th>
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<tbody>
<tr>
<td>Enhance awareness of what services are available and how they can be accessed</td>
<td>1</td>
</tr>
<tr>
<td>The concept of personalised care is advanced in the Waikato, with exploration of how people living with mental health or other long-term conditions can be empowered to determine their own care using whānau care budgets</td>
<td>3</td>
</tr>
<tr>
<td>Establish a whānau care support team that assists people with planning and advice on where to allocate their budget, to approve personal care and support plans and monitor outcomes</td>
<td>3</td>
</tr>
<tr>
<td>Establish an evaluation and research initiative to investigate short and long term outcomes, and benefits of whānau care budgets</td>
<td>3</td>
</tr>
</tbody>
</table>
Action 4.8 Improve access to services after-hours

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

Activities Phasing

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<tbody>
<tr>
<td>Establish an urgent and emergency care network that shares information, provides oversight on service quality, workforce support and development, and coordination between services</td>
<td>1</td>
</tr>
<tr>
<td>Develop a district wide service delivery model for the provision of urgent and emergency care services to meet future demand and reduce demand where feasible</td>
<td>1</td>
</tr>
<tr>
<td>Develop enhanced after-hours coverage and access through locality delivery models</td>
<td>1</td>
</tr>
<tr>
<td>Link the urgent and emergency care service delivery approaches to the development and use of intermediate care options</td>
<td>1</td>
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</table>

Action 4.9 Develop strategic approaches to sustainable hospital services

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

Activities Phasing

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<th>Activities</th>
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<tbody>
<tr>
<td>Address the capacity constraints for elective surgery and procedures</td>
<td>1</td>
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<tr>
<td>Develop strategic service delivery models for priority hospital services. Identify potential investment needs (high level) and align with system service delivery models</td>
<td>1</td>
</tr>
<tr>
<td>Instigate work to address efficiency and effectiveness to enable appropriate treatment and care delivery</td>
<td>1</td>
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</table>
Primary and community health care teams are a way of working rather than a specific group of health workers. The concept of team based approaches includes any health workers needed to support an individual and whānau. By focussing on how to work effectively together, primary and community health care service providers are able to focus on health and wellbeing in a seamless way.

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

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

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

<table>
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<tr>
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<tbody>
<tr>
<td>Waikato DHB establishes a locality framework and appoints locality leadership roles to lead local planning and improvement of health services</td>
<td>1</td>
</tr>
<tr>
<td>Establish locality networks with Māori, local providers and stakeholders to coordinate and improve health services and care. Locality networks are also established to address the determinants of health</td>
<td>1</td>
</tr>
<tr>
<td>Establish local priorities, stocktake of services and resources, and agree plans to address priorities</td>
<td>1</td>
</tr>
<tr>
<td>Align DHB, primary health organisation and non-government organisation configuration to support effective locality planning and delivery of services</td>
<td>2</td>
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</table>
Action 5.2 Develop expanded primary and community health care approaches with a focus on quality, equity and teamwork

Rationale:

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

Activities Phasing

- Realign service delivery models taking into account the desire to have care provided closer to home and work with locality networks on how those approaches can be coordinated, resourced and delivered in their settings. In developing the service delivery models, identify where and how DHB-based specialist services provide timely general practice access to advice and diagnostics
- Minimum standards for primary care are built into service agreements, incorporating key elements of expanded primary health care models, responsibility and accountability for access and health equity for Māori
- Develop expanded roles for community pharmacists as part of expanded service delivery approaches and identify opportunities where co-location may be beneficial particularly for pharmaceutical advice on the treatment of health conditions, self-management and early intervention
- Enhance community health pathways to incorporate wellbeing, link to Whānau Ora and other whānau focussed approaches and encourage their use through promotion, improving systems to make them easy to use and upskilling clinicians

Action 5.3 Develop, strengthen and embed whānau-centred approaches

Rationale:

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

Activities Phasing

- Develop more whānau focussed programmes with Māori, consumers and stakeholders to address health and social issues that are aligned with district and locality priorities
- Collaborate with stakeholders on developing a workforce to enable ongoing delivery of the programmes
- Expand the primary and community health care team with a workforce who can assess and support whānau in addressing their immediate social needs
- Develop community and hospital health pathways and optimise their use across the district
- Collaborate with stakeholders on a district wide approach to improving the knowledge and awareness service providers have of the determinants of health and how whānau can be linked into programmes and services
Often people do not need to be in hospital for the level of care they are getting or they need a higher level of care than is available to them when at home but do not necessarily need to be in hospital. The gap between care provided to people when at home and hospital care is bridged through accelerated development of alternative community care services and settings that avoid unnecessary travel and unplanned hospital use. Intermediate care is an alternative option and not a step in care that all people have to go through.

This will mean:

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

goal 6 Strengthen intermediate care
Action 6.1 Develop specialist services closer to home

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

**Activities Phasing**

| The Waikato health system, in conjunction with providers and regional DHB partners, determines which specialist services could be appropriately delivered in the community, with explicit aims of addressing geographic and ethnic inequities in access to care | 1 |
| Using the service delivery models development process, determine which additional specialist services linked to the service delivery models can be decentralised, where the demand for these services is distributed throughout the region, how they could be provided and how specialist support for primary care can be improved | 2 |
| In the interests of accessibility and patient experience, some services may be better delivered to patients near Waikato DHB borders by other DHBs | 2 |

Action 6.2 Reorient services to reduce hospital admissions

**Rationale:**
- There are programmes that enable people to be discharged from hospital early and to be supported by specialist services in their homes or in appropriate facilities close to home. These may be able to be configured to be used for people with deteriorating conditions as an alternative to being admitted to hospital.
- General practice has access to programmes to provide services in community settings as an alternative to hospital. The suite of activities should fit with clinical care models and evidence-based best practice, community-based services in different localities and evolving service delivery models and be directed to those who would most benefit.

**Activities Phasing**

| Reconfigure the programmatic approaches to focus on people (particularly Māori) with acute conditions to enable access to a broad suite of services that avoid hospital admission | 1 |
| Waikato DHB in collaboration with stakeholders look at whether step down services could also be used for step up services to avoid hospital use, identify changes needed and a plan for how this can be implemented and maintained | 2 |

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

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

**Activities**

| Support early discharge/hospital flow by providing services locally to patients in appropriate settings | 1 |
| Build stronger links with primary and community care that allows collaborative discharge planning, including a system for early notification of discharge and so that local providers can prepare. Integrate early discharge services provided by specialist services with primary and community care, whānau ora and whānau focussed approaches | 1 |
| Build local expertise so that Waikato DHB can work towards commissioning from community based providers | 3 |
Supporting activities needed to achieve the goals

There are a number of key areas where activity is needed to support and enable the goals and actions to be achieved. Some of the goals and actions could be viewed as enablers. These have been explicitly identified as goals and actions due to their fundamental importance and the need to prioritise them.

8.1. Leadership and partnerships

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

Activities

Establish a district wide leadership structure (involving Māori, clinical and consumer expertise) with responsibility to monitor and lead change for quality and performance improvement

8.2. Commissioning

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

Activities

Integrate the role of the district leadership into the commissioning process and cycle

Clarify planning and decision-making processes within Waikato DHB and the district, identifying where authority, accountability and responsibility lie

Develop and promote a service planning framework that includes the development of long term system views for:
- maternity, children (tamariki) and youth (rangatahi)
- older people
- cancer
- mental health and addictions
- people with multi-morbidity and long term conditions
- hospital based services

Ringfence a Health System Plan budget to resource a portfolio of prioritised initiatives that are developed for implementation

Take a portfolio approach to the planning and delivery of initiatives. Benefits are viewed across the portfolio rather than by individual project so initiatives can flex around risk profiles

8.3. Workforce development

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

Activities

Ensure training and education activities provided by organisations are underpinned by tikanga, sharing of ideas and content

Promote health as a career (particularly in schools) and support initiatives that enable Māori and Pasifika to attain academic achievements, succeed in roles where learning is through experience (e.g. placements, internships) and choose appropriate pathways to a health career

Establish programmes where medical, nursing and allied health workforce training can be achieved in a mix of settings e.g. hospital/primary health care, urban/rural
8.4. Technology and information

Technology is a critical enabler to a health system that is able to improve access, improve outcomes and be more efficient. As consumers and health professionals become more accustomed and dependent on information, it is important that the systems are inter-operable and integrated.

What this will mean:

- Information systems and tools will be configured around the needs of consumers and frontline staff.
- A shared electronic health record will be accessible by consumers and authorised providers.
- People with complex conditions will have shared care plans accessible to consumers and authorised members of the health care team.
- A shared strategic approach to technology is agreed between Māori, consumers and key stakeholders.
- Information is shared across the sector to enable better targeting of services, monitoring and measurement of performance and inform decisions on services.

Activities

Generally, technology and information is needed to support all the actions of this plan. Specific technology and information activities have been included as actions under the goal, Improve access to services.

8.5. Quality improvement

What this will mean:

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

Activities

Develop and integrate a whole system quality improvement framework with decision making processes, leadership and clinical governance structures, system data analytics functions and reporting.

Initially, focus will be on services that require whole system approaches, and that have opportunities for large scale impacts on inequities, such as cancer, diabetes, cardiovascular disease, maternity and mental health.

Develop an outcomes intervention logic (based on the equity framework) with networks, leadership and clinical governance groups that can be used to measure and improve system performance. Performance information will be shared with the public.

Prioritise the resourcing of the Waikato Research Innovation and Improvement Hub to provide district wide expertise on the planning and delivery of change, inform improvements, conduct research and advise on benefits and outcomes achieved. Resourcing allows for rapid turnaround and long term research.

how this plan will be put into place

All stakeholders including Māori and consumers will have a role to play in the delivery of the plan. Delivering on our strategic goals will require collective action, pooling resource and expertise. Coordination of key initiatives will be across the district.

The plan will be achieved through multiple projects and programmes over the next 10 years. It is intended that key projects and programmes are overseen as a single portfolio. A portfolio establishment group will be used to prioritise and set up initiatives. A portfolio steering group will provide the oversight after the establishment period.

A portfolio approach means the benefits of the projects and programmes are viewed in their entirety. A portfolio approach gives the flexibility to work within a single budget and allows funding, people and other resources to be shifted to areas of need. If a project is not performing, there is the potential to reinvest the resources elsewhere.

Portfolio initiatives are expected to be resourced by the sector where relevant and delivered through a collaborative project approach so that expertise can be shared.

Initiatives to be progressed each year will be outlined in the Annual Plan for Waikato DHB.

How will we know if we are successful?

A series of population indicators and project success measures will be developed and linked so that contributors at each level of an outcomes framework can be identified.

From a Health System Plan perspective, success can be described in terms of addressing the objectives of Healthy People Excellent Care. The objectives of radical health improvement for Māori leading to health equity for Māori underpin the Health System Plan.

Indicators of success will include short, medium and long term outcomes. There are existing frameworks such as Whānau Ora that include health outcome indicators for whānau leading healthy lifestyles. Many frameworks are well aligned with the Health System Plan therefore use of similar indicators will reduce the need for providers to collect different information and make sharing easier. These are expected to be clarified following engagement with Māori, consumers and other stakeholders during implementation.
**Aged residential care (ARC)**  
Aged residential care refers to care funded by the government through DHBs. It is for people who can no longer live without a significant level of practical support. It includes the following types of long-term care provided in a rest home or hospital; rest home care; continuing care (hospital); dementia care; specialised hospital care (psychogeriatric care).

**Care coordination**  
A proactive approach to bringing together care professionals and providers to meet the needs of service users, to ensure that they receive integrated, person-focused care across various settings.

**Care Plan**  
A personalised care plan empowers individuals, promotes independence and helps people to be more involved in decisions about their care. They identify an individual’s full range of needs taking into account not just medical needs but wider ones such as family, personal, ethnic, economic and circumstances. They are completed with individuals, can be modified regularly and often have many people involved, not always at the same time. With medical needs, many health professionals may be involved for their own specialty areas. The care plan can also include actions that an individual can take if their condition worsens.

**Cultural safety**  
An environment that is spiritually, socially and emotionally safe, as well as physically safe for society that has its own beliefs, ways of life, art, etc; a way of thinking, behaving, or working that exists in a place or organisation (such as a business).

**Cultural competence**  
Culture can relate to more than ethnicity alone e.g. socioeconomic status, religion, gender, age, sexuality or disability. Cultural competence is the ability to interact effectively with people of different cultures. It requires an awareness of cultural diversity and demonstration of the attitude and approach that allows people to work effectively cross culturally. It applies to people working with each other and with patients and whānau.

**Disability**  
Disability is not something that individuals have, individuals have impairments. These impairments might be long-term or short-term and can be sensory, physical, neurological, psychiatric/psychological, or intellectual. Disability is the process which happens when one group creates barriers by designing a world only for their way of living and not taking account of others abilities or impairments.

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**Engagement**  
A participatory process where stakeholders are involved in dialogue about their views on a topic.

**Equality**  
Everyone is treated the same based on the assumption that everyone has the same needs.

**Equity**  
Unequal treatment of unequal needs with the aim of achieving similar outcomes.

**Health care teams**  
The collective of health and social services professionals who are involved in the planning and provision of care to an individual or whānau. They may not all be located together in the same place and may operate virtually. Some may be indirectly involved such as health promoters providing information and education to a community.

**Healthcare record**  
A health care record is a collection of information from different sources (e.g. general practice, hospital, pharmacy, immunisation register, laboratory, screening database) about a patient’s health care status and history. It would include information about illness, medications and prescribed, hospital admissions and discharges, specialist reports, imaging and lab test reports and wellness plans.

**Health in All Policies (HiAP)**  
Health in All Policies (HiAP) is a way of working collaboratively across different sectors to achieve agreed common public policy goals. It is an approach to include health and wellbeing considerations in policy making across different sectors that influence health and wellbeing such as local Government, education, housing, transport.

**Intermediate care**  
Intermediate care is a level of health care for people who are not severely ill but need support to regain their ability to live independently.

**Model of care**  
A model of care defines the way health and social services are delivered. They can encompass the broader holistic needs of people, describe an end to end journey and could include self-management, prevention, early detection and intervention, treatment, rehabilitation as well as services provided by other social services. Models of care describe what services people should have access to, how they get into and move between them as well as describing enablers for the model of care e.g. how providers share information between themselves and with people.

**Outcome**  
A result or consequence. A health outcome is a change in health status as a result of one or several interventions.

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Portal
A portal is a website that is a single point of access for many different sources of electronic information. It allows the user access information from one place easily.

Primary care
Primary care is often considered the first point of contact in the community for health care. Primary care is often seen as general practice. The term primary health care also relates to first points of contact but is considered wider than general practice and includes any health services in community settings e.g. pharmacy.

Provider
A provider is an agency that the DHB funds to deliver services under a specific agreement.

Stakeholder
Person, group or organisation that has an interest or concern in something.

START
Supported Transfer and Accelerated Rehabilitation Team (START) is part of the Waikato DHB’s Older Persons, Rehabilitation and Allied Health service. START is the Waikato DHB service that supports patients to make a safe and quicker transition from hospital to home. It provides the intensive support and rehabilitation some patients need, but in their home rather than through a longer stay in hospital.

Strategy
A strategy is a plan of action designed to achieve a long term or overall aim.

Virtual care
Virtual care is the provision of health services and information using technology to connect consumers and providers when they are not in the same location.

References


Gifford, H, Batten, L, Boulton, A et al. Delivering on Outcomes: the experience of Maori health service providers Policy Quarterly – Volume 14, Issue 2 – May 2018


### appendix 1

Locations of the wānanga and supporting provider

<table>
<thead>
<tr>
<th>Wānanga location</th>
<th>Date</th>
<th>Participants</th>
<th>Supporting provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taumarunui</td>
<td>23 July 2018</td>
<td>48</td>
<td>Taumarunui Community Kokiri Trust</td>
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<tr>
<td>Thames</td>
<td>26 July 2018</td>
<td>11</td>
<td>Te Korowai Hauora O Hauraki</td>
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<tr>
<td>Te Kuiti</td>
<td>27 July 2018</td>
<td>36</td>
<td>Taumarunui Community Kokiri Trust</td>
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<td>Waharoa</td>
<td>31 July 2018</td>
<td>26</td>
<td>Te Hauora O Ngati Haua</td>
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<td>Hamilton</td>
<td>1 August 2018</td>
<td>39</td>
<td>Raukura Hauora o Tainui Te Kohao Health</td>
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<tr>
<td>Huntly</td>
<td>3 August 2018</td>
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<td>Raukura Hauora o Tainui Te Kohao Health Waahi Whanui</td>
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<tr>
<td>Tokoroa</td>
<td>7 August 2018</td>
<td>20</td>
<td>Raukawa Charitable Trust South Waikato Pacific Islands Community Services Trust</td>
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<td>Rangatahi forums</td>
<td>1 October 2018</td>
<td>119</td>
<td>Te Ahurei a Rangatahi</td>
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