



WAIKATO
Health System Plan
Te Korowai Waiora

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



Te Korowai Waiora

**“Kotahi ano te kōhao o te ngira. E kuhuna ai te miro ma, te miro pango, te miro whero.
I muri i ahau, kia mau ki te aroha, ki te ture me te whakapono.”**

There is but one eye of the needle through which the white, black and red threads must pass. After I am gone, hold fast to the love, to the law, and to the faith.

Te Korowai – finely woven cloak covered with muka tassels (hukahuka). Hukahuka are made by the miro (twist thread) process of dying the muka (flax fibre) and rolling two bundles into a single cord which is then woven into the body of the cloak.

Waiora – The name “Waiora Waikato” was sanctioned by Te Arikinui Dame Te Atairangikaahu as a taonga (treasure) to the then Waikato Area Health Board in 1989. The translation of “Waiora Waikato” can be given as “Healthy flowing water”.

We extend our gratitude to Kaunihera Kaumātua for gifting the title Te Korowai Waiora.

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 te 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 Tūheitia
And the household of the Kāhui 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”

Te Puea Herangi (1883-1952)

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Foreword



KAREN POUTASI

Tēnā koutou katoa

We need to make big changes to meet the challenges of the future and to have a Waikato health system that works for our communities. This Waikato Health System Plan, Te Korowai Waiora, is a pathway to help us do this.

It will focus our work on what is needed to support the people of the Waikato to improve their health, make services easier to use and improve the way services are provided over the next 10 years.

It is a plan for everyone who uses or provides health services in the Waikato. The title, Te Korowai Waiora, reflects this. In some areas it builds on the good things that are already happening. In other areas it will mean doing things in a different way so that services will look different in the future.

The Waikato health system plan puts people at its heart. It describes a vision where every person and whānau in the Waikato has the opportunity to reach their full health potential. Some groups of people have more diverse needs or have differing access requirements. We must do more to help and support these groups so we can better meet their needs.

We need to radically improve Māori health and this requires us to work differently, and to work in partnership. There is a lot we can do that will result in better services and better health. Services must be planned and provided with strong input from whānau and Iwi.

Communities need to be more involved in the planning and improvement of services. This means health services are provided in a way that meet the needs of people, is culturally appropriate and enables people to make informed choices. We expect services to be provided closer to where people live and that we may all benefit from technology advances.

Our communities want us to help them to stay healthy as well as to treat them when needed. Good health is just part of wellbeing. We want health workers to recognise this by also identifying any broader needs people, whānau and families have and to provide guidance as to where help and support are available.

We also need to work within the resources available. Resources are constrained and we should see constraints as an opportunity to look at how we can enhance the way we deliver services and do things differently.

These are major changes. However, the challenge is to embrace new possibilities, be thoughtful and create a future where we deliver on our vision of *Healthy people. Excellent care.*

Nāku noa

Dr Karen Poutasi
Commissioner
Waikato District Health Board

Acknowledgements

Thank you to the people of the Waikato who generously contributed their personal stories and experience about health and wellbeing. Your wisdom has helped shape this plan.

Thank you also to the clinicians, providers, organisations and other contributors who, in the form of ideas, facilitation, writing, feedback, resources, research and thematic analysis brought this plan to fruition.



Introduction

1

This is a plan to improve our Waikato health system and futureproof it for the challenges we will face in the coming years. The Waikato Health System Plan, Te Korowai Waiora, will put our strategy of *Healthy people. Excellent care* and our *Iwi Māori Health Strategy, Ki te Taumata o Pae Ora*, into action.

The Waikato Health System Plan, Te Korowai Waiora, describes a future health system that will improve health outcomes, particularly for Māori, and enable the people of the Waikato to achieve their full health potential. Health is influenced by many factors including the environment and the community itself. This plan outlines actions the Waikato health system can take to partner with and support our communities to build on the expertise they have to improve health and wellbeing.

Our current health system is organised to treat people who are ill.

This plan shifts the focus to achieving a different balance of services to treat illness and those that will improve wellbeing, moving services from hospitals to community settings, and working with consumers and whānau/families to provide services that meet their needs. Unless we do something different, the demand for specialist services in community and hospital settings will continue to grow; further work is required to clarify how the growing demand for specialist services can be reduced by new and sustainable models of care.

This plan identifies actions the Waikato health system can take to work as one cohesive, integrated and coordinated health sector that involves the community and whānau/families in planning and delivery. Realising the goals identified in Te Korowai Waiora will be challenging and will require collaboration and commitment from everyone across the system.

2 Improving health outcomes and equity

Some groups in the Waikato don't enjoy the same good health as others. We know 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 everyone, and particularly for Māori and other priority groups
- 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 their 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).

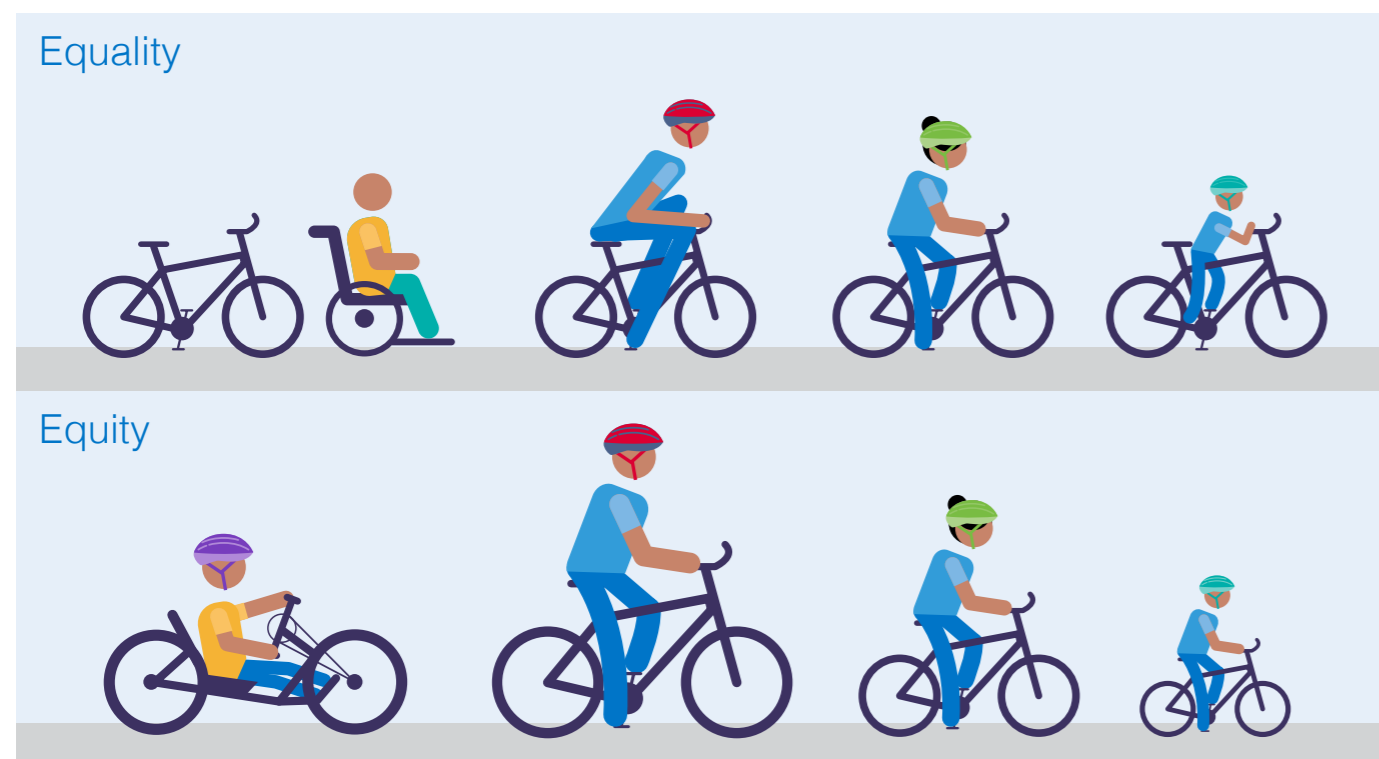
Health equality arises when everyone gets the same treatment but the obstacles are not considered.

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 this plan is to give people the opportunity to achieve their full health potential.

Population groups with more diverse needs or different abilities, such as intellectual, physical or sensory, need to be supported to participate in opportunities to help achieve their health potential.

Figure 1: **Equality vs equity**¹



¹ Diagram adapted from original concept developed by Robert Wood Johnson Foundation 2017.

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 people 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 Pasifika peoples) 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 (Came et al., 2016; Came & 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 increasing the diversity of membership on decision making groups, incorporating diversity into organisational policies and procedures, ensuring workforce diversity, and improving the cultural competency 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, 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 Waikato Health System Plan, Te Korowai Waiora. 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 realigned 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/families
- collaboration with other stakeholders to partner with and support communities to address the factors that influence their health and wellbeing – the determinants of health.

What is commissioning?

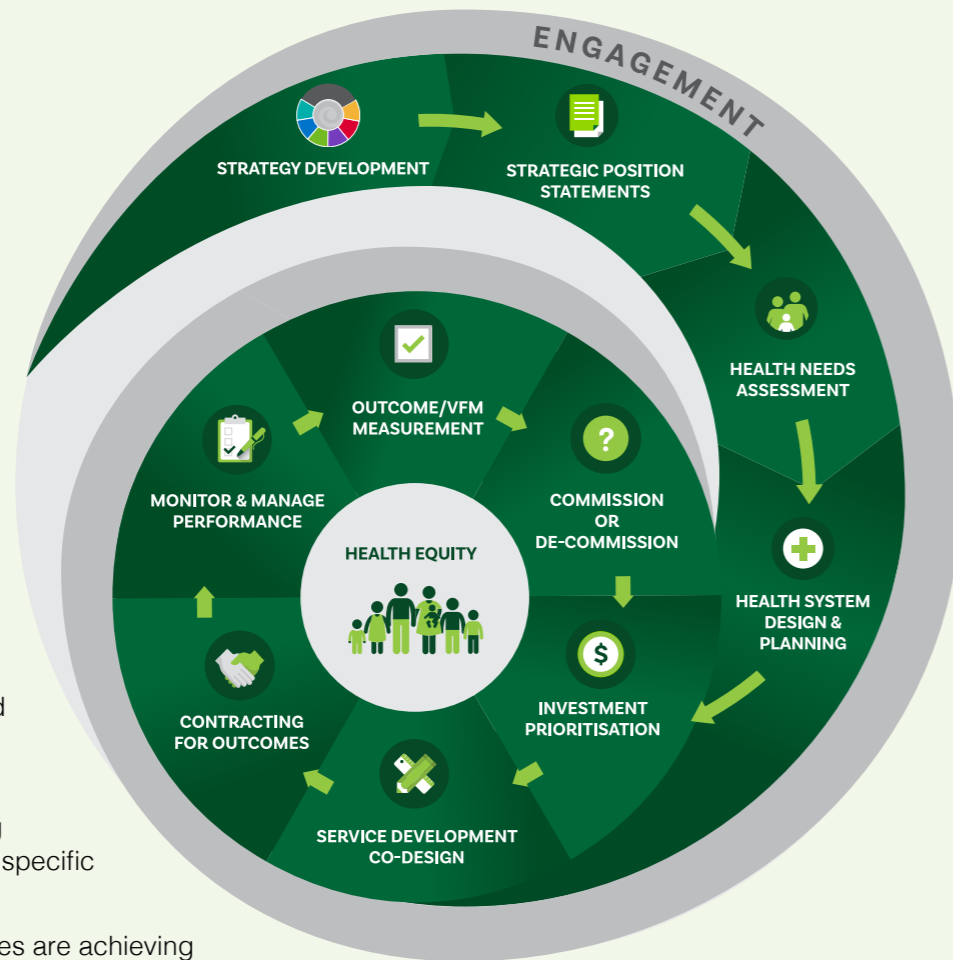
Commissioning decides what kind of services should be provided to people, who should provide the services, how they should be funded and what they should achieve (Ministry of Health, 2016). In the Waikato, Waikato DHB commissions most health services that are publicly funded. The Waikato DHB commissioning approach is depicted as a koru (see figure 2) where the core activities are represented in a continuous cycle of investment, review and reinvestment.

The Waikato DHB commissioning approach includes the following key activities:

- Developing Waikato DHB's strategic direction and aligning strategic imperatives across different service areas.
- Understanding the health and social needs of specific populations and communities.
- Developing services that respond to the needs. This involves engagement with the community, service users and the wider health sector to agree the desired outcomes and define how services will be delivered.
- Identifying and contracting providers for services and specific outcomes.
- Monitoring how well services are achieving the desired outcomes, managing provider performance and engaging with communities and the sector on improvements.
- Directing resources to services where communities will benefit and value is optimised.

The Waikato DHB approach is based on a partnership model with shared leadership and accountability to improve the health of the population, particularly Māori, and achieve health equity.

Figure 2: Waikato DHB commissioning approach



The determinants of health – factors that influence health and wellbeing

Within the Waikato Health System Plan, Te Korowai Waiora, 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, including their:

- social and economic environment
- physical environment
- individual characteristics and behaviours.

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

Figure 3: The determinants of health and wellbeing in our neighbourhoods²



The Waikato Health System Plan, Te Korowai Waiora, takes a long-term view and sets out the actions required to achieve seven goals over 10 years. For each goal, a range of actions and activities are outlined that are applicable across all health services in the Waikato.

There is broad recognition that the health system needs to be innovative and brave if it is to achieve equity, be sustainable and perform well. The Waikato Health System Plan, Te Korowai Waiora, provides clear areas of focus and invites people to think outside the box and do things differently to help reach its goal.

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

"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"

²Diagram adapted from original concept developed by 'Dahlgren and Whitehead, 1991'.

3 The health system needs to work as one

In July 2016 Waikato DHB published its strategy **Healthy people. Excellent care.** The strategy identifies a vision for Waikato DHB 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 and is provided closer to where people live. The focus is on the community.

Waikato DHB's Iwi Māori Health Strategy, *Ki te Taumata o Pae Ora*, is in development. It will focus on the Whānau Ora approach to improving the wellbeing of whānau as a group and addressing individual needs within the context of whānau and iwi.

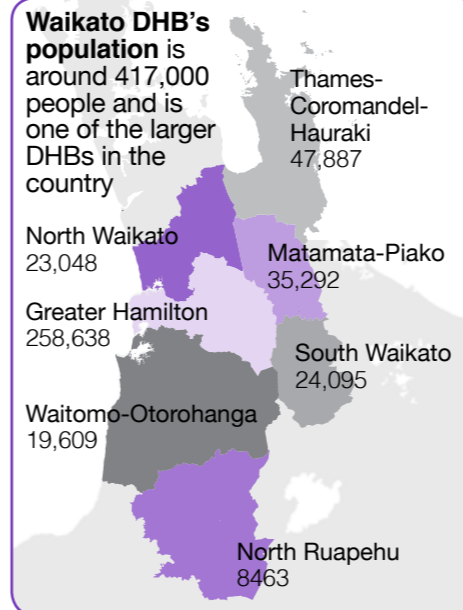
The health system needs to change to operate more effectively. Currently different parts of the system operate in silos and there is little joined-up thinking and planning. To achieve Waikato DHB's vision, health and social care must be well connected, coordinated and cohesive. Only then will the Waikato benefit from a system of integrated health and social services that align with the values contained in *Healthy people. Excellent care*.

Figure 4: **Waikato DHB Strategy summary**

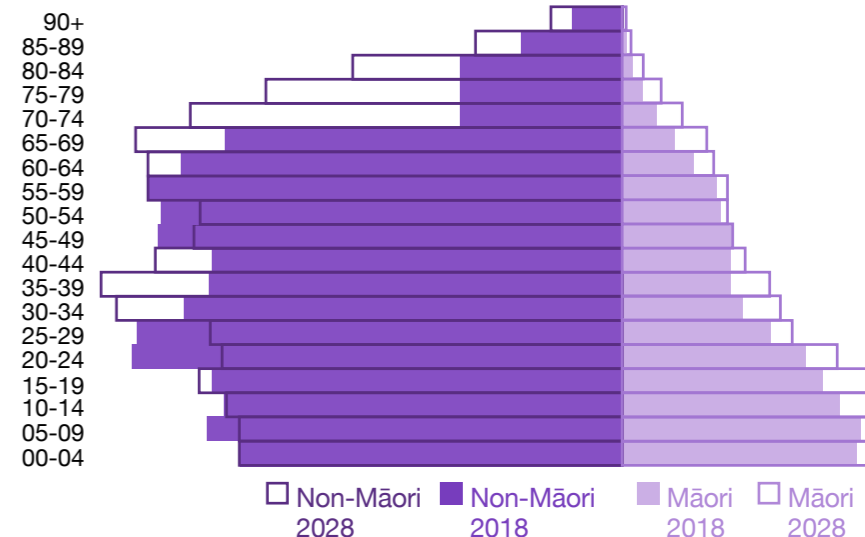


3.1. Challenges we face

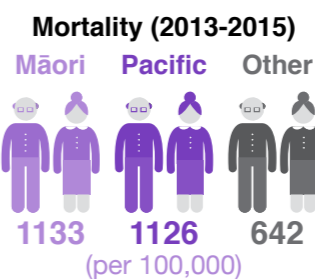
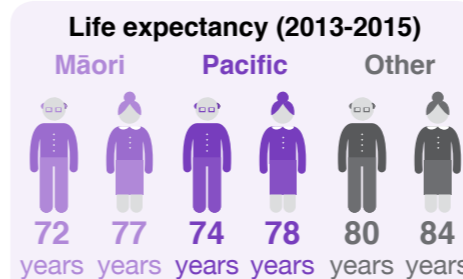
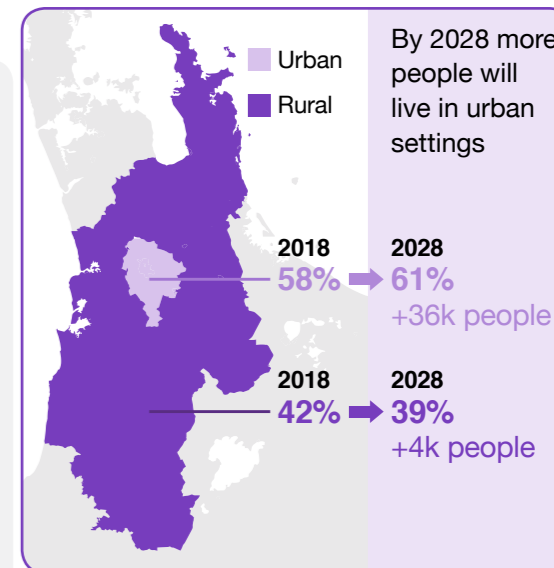
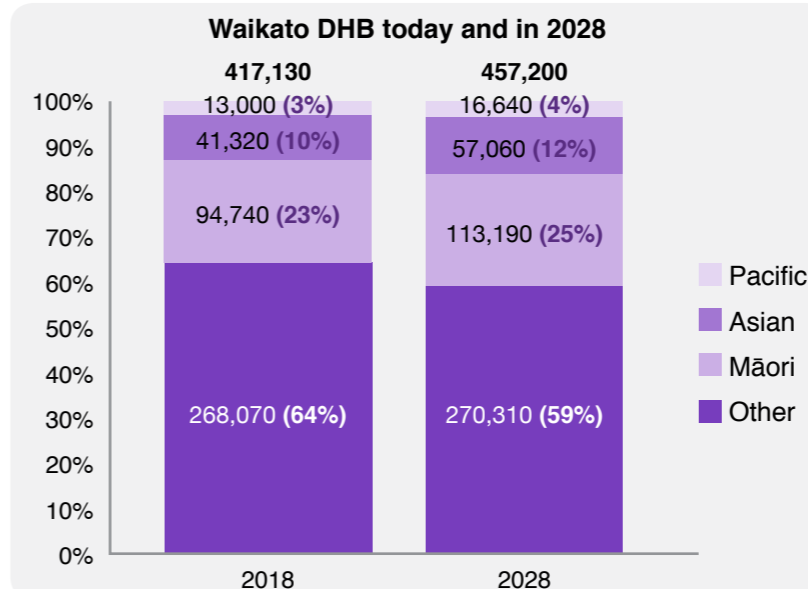
Our people



Waikato DHB population 2018 and projected to 2028



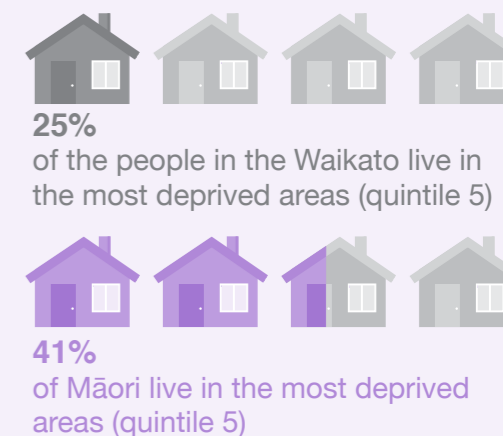
Our population is growing and getting more diverse



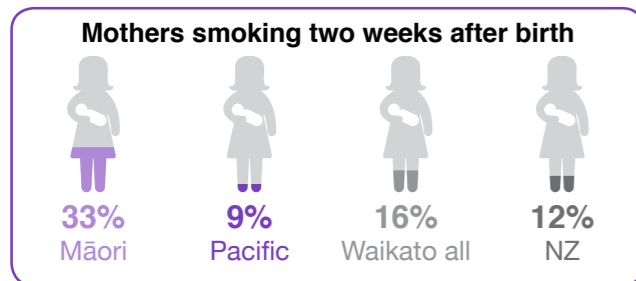
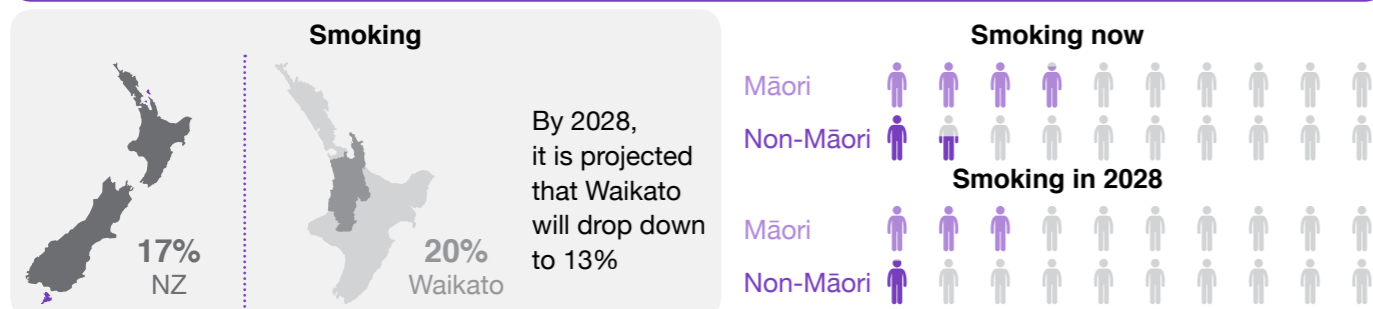
South Waikato and North Ruapehu have significantly lower life expectancy than the rest of Waikato

Māori mortality rates are nearly double non-Māori rates

Deprivation



Risk factors in Waikato

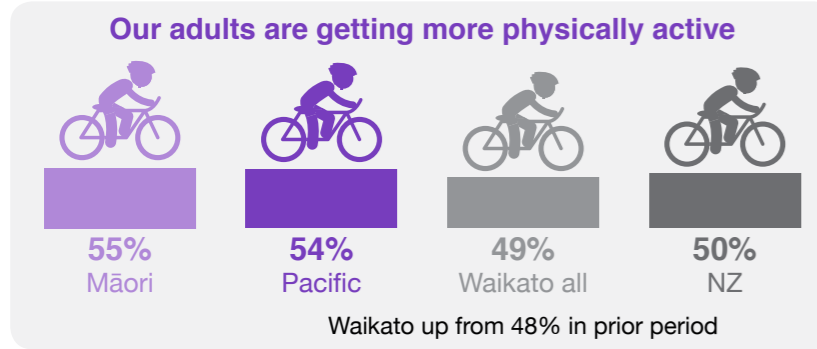
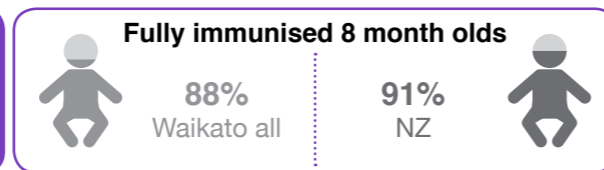


Fewer people smoke and we expect this will continue to drop but we can do better for Māori (especially mothers) to help them quit

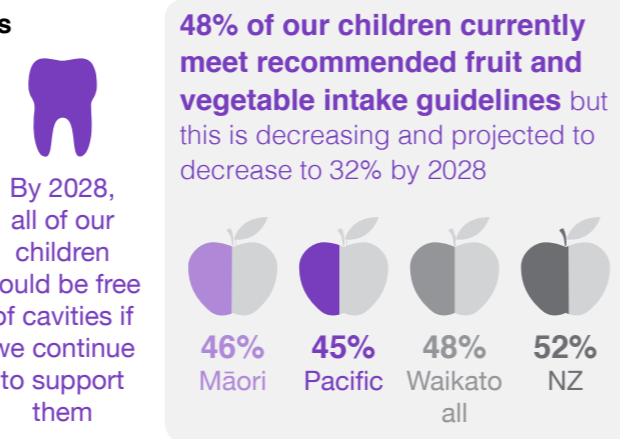
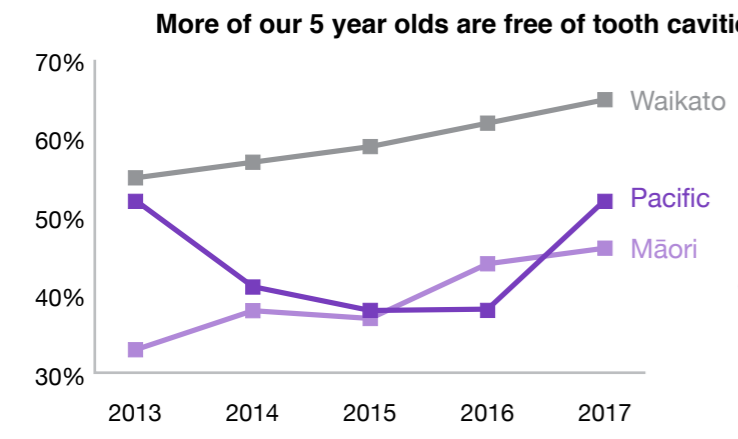
By 2028, **52%** of our **adults** are projected to be **obese**

Protective factors in Waikato

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

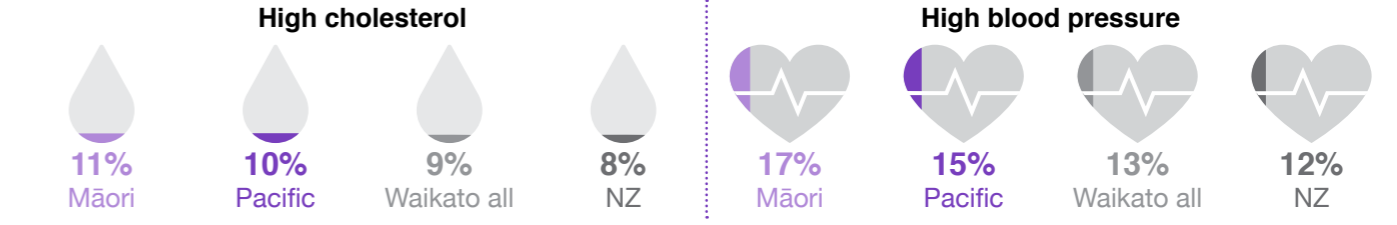
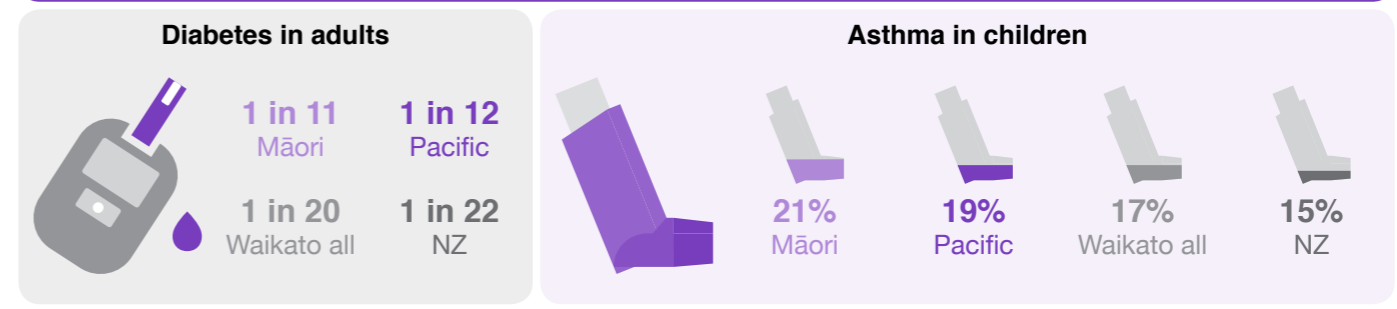


1 in 2 of our **children** are **watching television** for **2 or more hours a day**

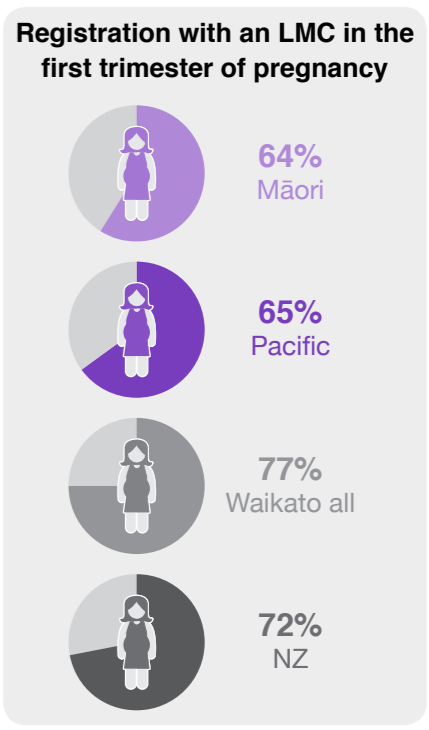
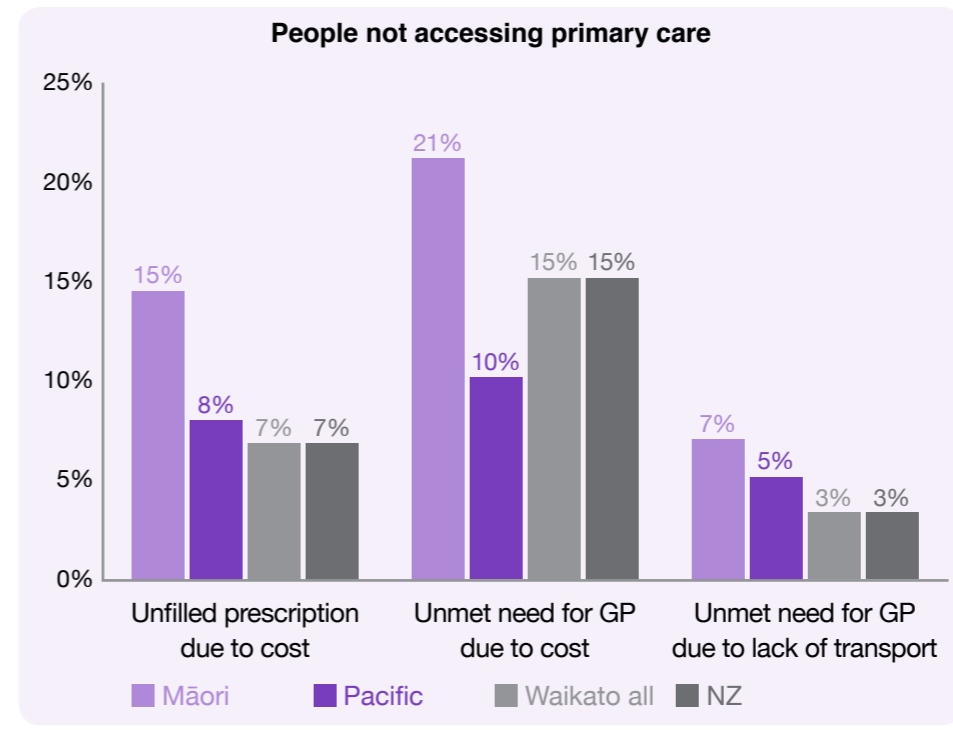
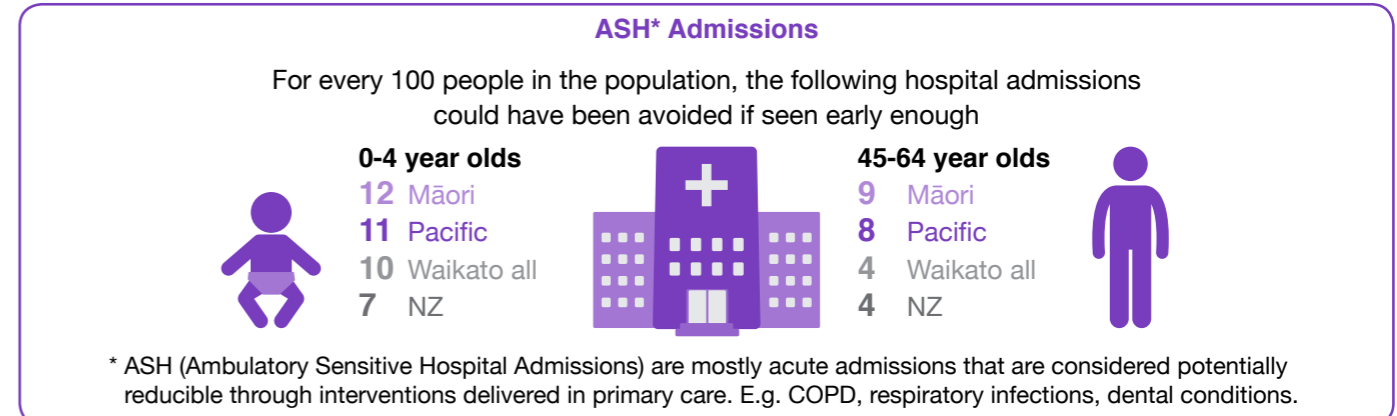


87% of **Māori children** eat **home cooked food** but the remainder that are regularly eating take-away is **5 times higher** than that of their **non-Māori peers**

Increase in avoidable disease

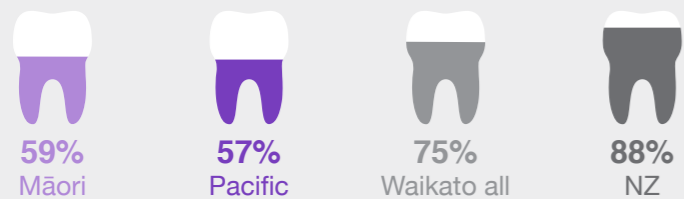


Access to health services

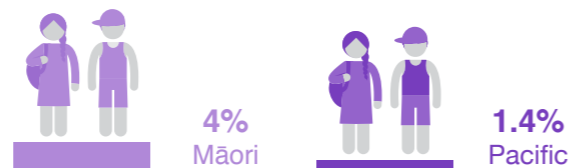


Access to health services

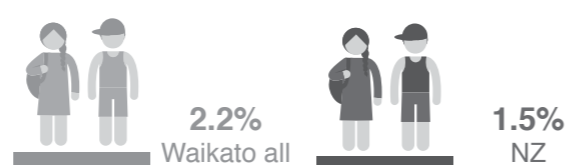
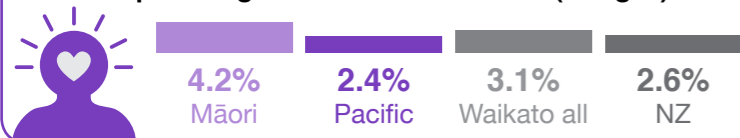
Children aged 0-4 enrolled with Community Oral Health



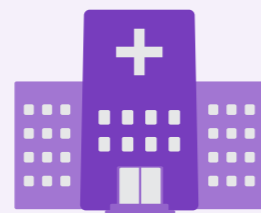
Rangatahi accessing alcohol and other drug services



People using mental health services (all ages)



Waikato DHB's financial performance 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



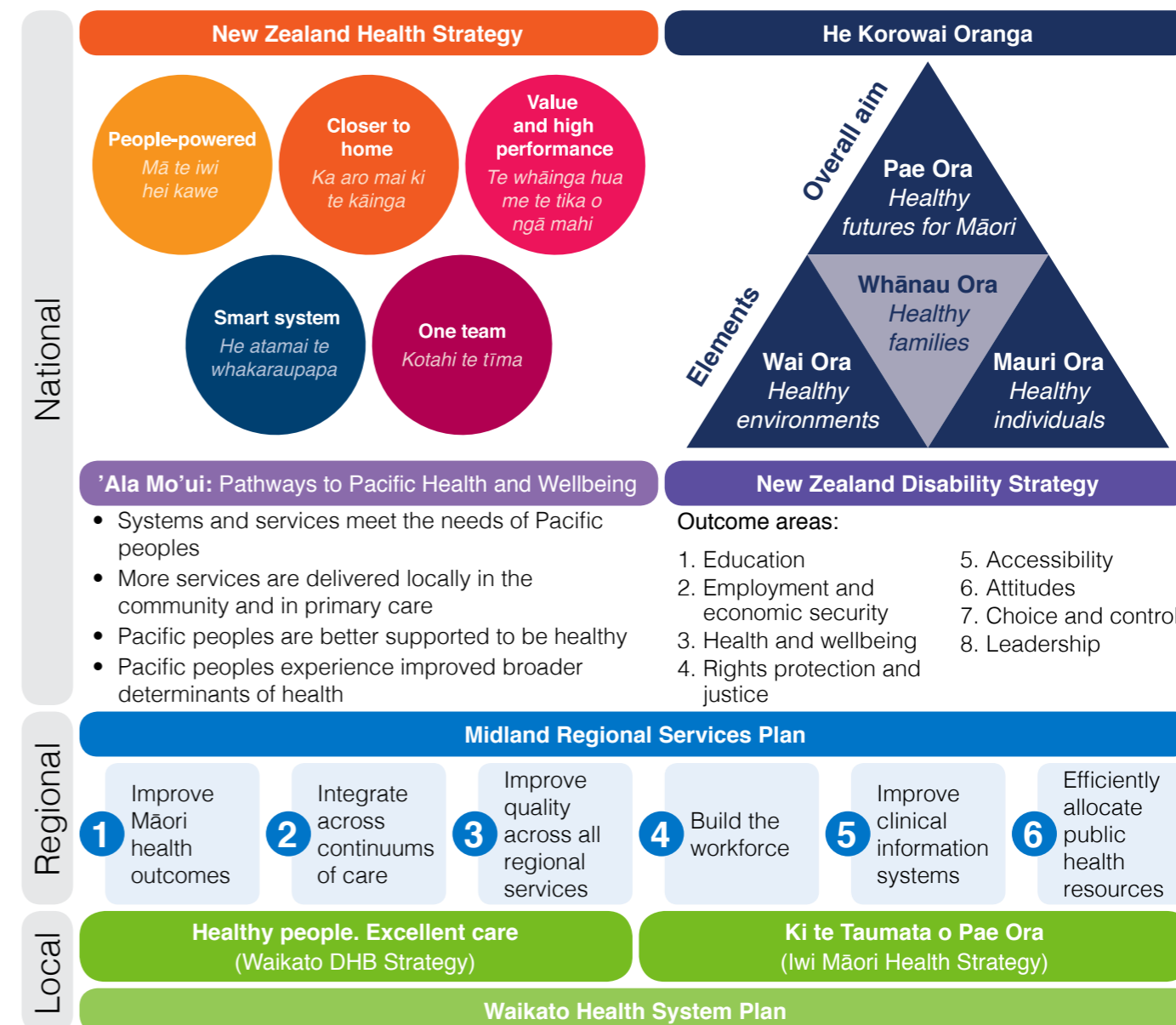
Waikato has a high attendance rate at emergency departments but a low proportion of those subsequently admitted to hospital. This generally indicates people using emergency departments as a first point of contact rather than a general practice

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



3.2. National and regional context

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



The New Zealand Health Strategy and He Korowai Oranga (New Zealand's Māori Health Strategy) provide guidance to all DHBs on what we want to achieve as a country. Alongside these overarching strategies are national strategies for specific areas such as:

- 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing
- Healthy Ageing Strategy
- New Zealand Disability Strategy
- New Zealand Digital Health Strategy.

Waikato DHB is one of five DHBs in the Midland region. The Midland region includes Waikato, Taranaki, Lakes, Bay of Plenty and Tairāwhiti DHBs, and provides

services for around 760,000 people. The DHBs in the Midland region work collaboratively on areas of common interest to make the best use of their collective resources. Waikato DHB provides a range of services to people in the other Midland region DHB areas if those services are not provided locally. Similarly, Waikato residents go to other DHBs for services not provided by Waikato DHB.

Predicted population changes in the lower South Auckland and North Waikato areas are likely to lead to Waikato and Counties Manukau DHBs working more collaboratively to ensure the growing communities around the boundaries of the two DHB areas are well served.

5 Vision for good health and wellbeing in the Waikato

Through the engagement process, our communities and the health sector have developed a collective vision for what the Waikato health system will achieve over the next 10 years.

The Waikato health system will

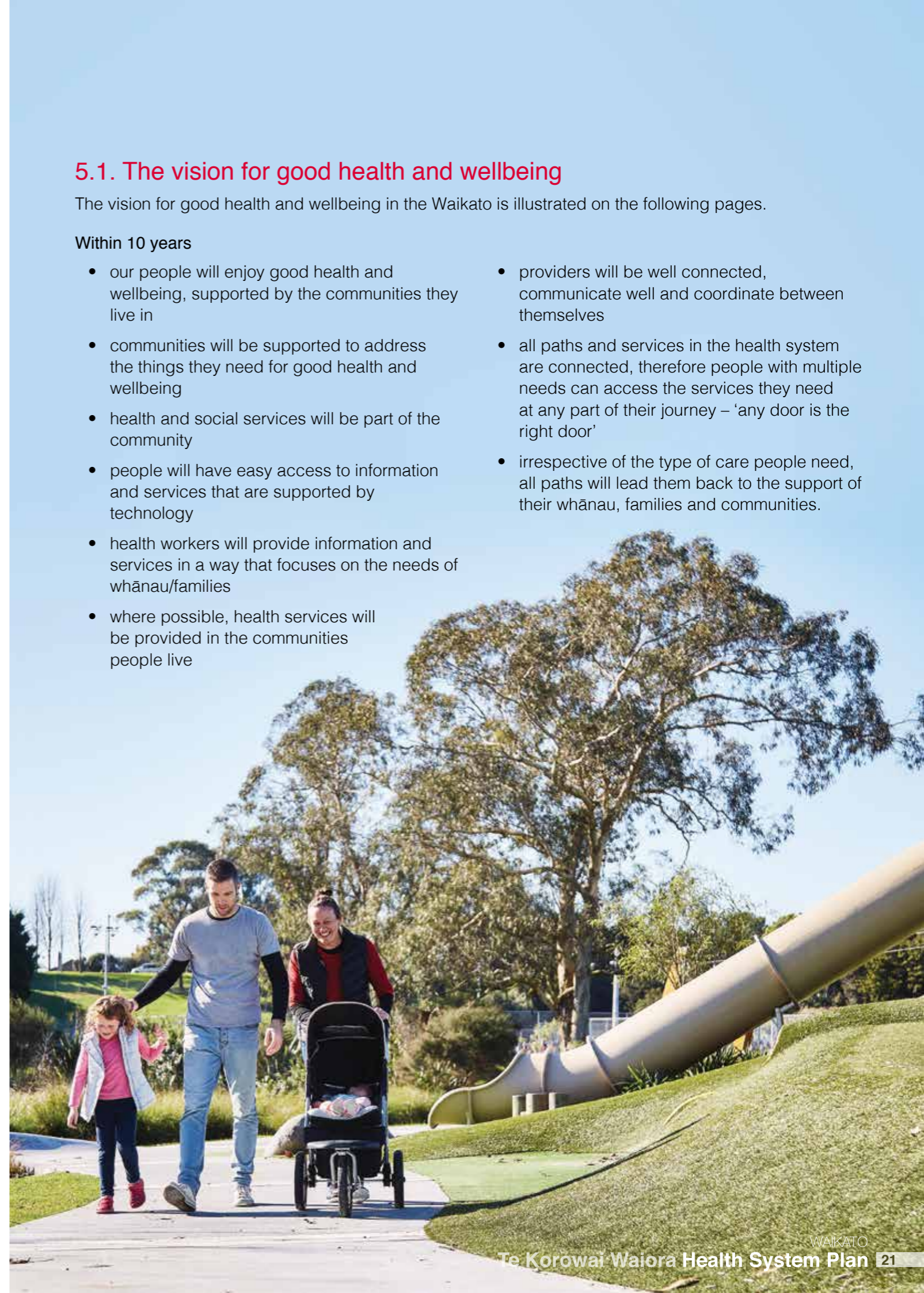
- shift from an illness to a **wellness approach**
- become **whānau-focussed** rather than **provider-focussed**
- actively **involve communities in the process of planning and decision making**
- actively develop services in community settings as an **alternative to hospital** provided care
- evolve 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/families
 - 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 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 the **spread of successful innovation**
- improve the visibility of the **good work** that is already occurring in the Waikato
 - **back the successes**
 - **build relationships** between the community, providers and Waikato DHB.

5.1. The vision for good health and wellbeing

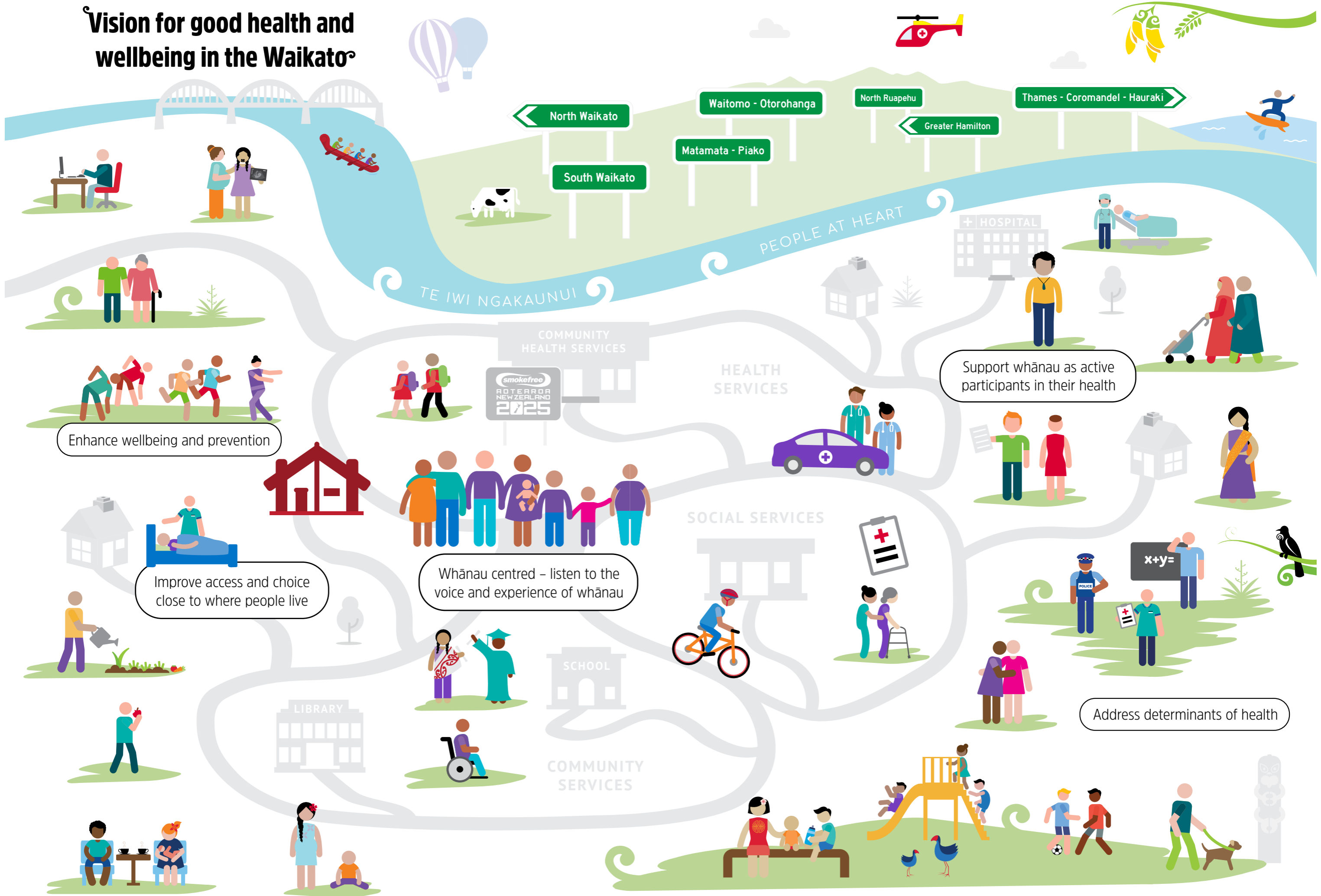
The vision for good health and wellbeing in the Waikato is illustrated on the following pages.

Within 10 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 will be part of the community
- people will have easy access to information and services that are supported by technology
- health workers will provide information and services in a way that focuses on the needs of whānau/families
- where possible, health services will be provided in the communities people live
- providers will be well connected, communicate well and coordinate between themselves
- all paths and services in the health system are connected, therefore people with multiple needs can access the services they need at 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 for good health and wellbeing in the Waikato



6 Changes enabling the vision

6.1. Enhance wellbeing and prevention – address the determinants of health

The health system is currently focussed on, and resourced for, providing 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.

We also know that an increasing number of people are developing preventable conditions, such as diabetes in adults. Some of these people go on to use hospital services, which could also be 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, which is neither 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 its 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 just one of the determinants; health services themselves.

Addressing the wider determinants of health will mean changing the way we work 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.

The health sector needs to reorient itself to empower people to manage their own health. 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/families

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 health system needs to change 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 to health services 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/families and communities.

Health must be more responsive but should also 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.

Easier consumer access to information about services is an enabler of access, choice and improved outcomes. Better 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 Waikato Health System Plan, Te Korowai Waiora 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 & Moon, 1993). The term locality is used in health to describe a geographical space, where stakeholders collaborate to address issues they are experiencing. Waikato DHB proposes using a locality approach for 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. Larger localities may have neighbourhoods as subsets.

A community is a group of people with a common interest. It includes people who live together in a particular area or place and can therefore overlap with a locality e.g. a rural community.

A community with a common interest could include ethnic groups, age, gender or people with specific health or disability needs. These communities are not necessarily organised and coordinated. A locality will be comprised of multiple communities.

People's health and wellbeing is linked with their everyday experience in their locality.

A better experience with health services provided closer to where people live will mean people are more likely to be engaged in managing their health.

If improvement in health outcomes and health equity can be addressed through the determinants of health and models that tackle multiple dimensions of wellbeing, then health services will need to work closely with communities and stakeholders in localities.

Close working relationships are fundamental for an integrated health and social system that provides the level of coordination needed to support people with complex needs.

A locality approach will provide us with a strong platform to work closely and collaboratively with communities to:

- partner with local communities and stakeholders identify and 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, this includes health connecting with social services
- monitor local health system performance and advise on improvements.

A number of existing community networks are already in place. Further development of a locality approach will recognise, respect and strengthen existing community networks.

6.4. Support whānau and families as active participants in their health

For the health system to be more responsive, consumers need to be more involved in their own healthcare and in planning for localities and the district.

Supporting consumers and whānau/families to address their own health and wellbeing means support for both short and long-term goals.

As the health sector has an illness orientation, it is able to address short-term health needs but is less able to support people over the long-term. There are opportunities for the health sector to take more long-term action, particularly to support people to live well with their health conditions, help people and whānau/families manage their health themselves and intervene earlier where possible.

There are many models of health and wellbeing, including Māori and Pacific models. The common aspect of all models is that health and wellbeing has many dimensions, such as physical, spiritual, emotional and social. The balance of these dimensions determines whether someone feels they have good health and wellbeing. To focus on the needs of an individual or whānau/family, health providers may need to work with a broad range of other providers to improve their health and wellbeing.

Whānau Ora is an existing approach used by Māori and Pacific providers in the Waikato. Whānau Ora is an inclusive, culturally anchored approach to providing services and opportunities to whānau to achieve their aspirations and goals.

The approach includes support to guide whānau through health and social systems.

In the Waikato, we wish to promote this approach as our model of health and wellbeing, and expand it so more whānau across the Waikato can have access to it. In addition, before whānau can focus their attention on long-term aspirations, we will support whānau to address their more urgent social needs.

The wider community can also be active participants in health through actions that are led by the community. Examples include peer support, sharing the expertise of networks and making that expertise available to other community members.

Support from different government and non-government agencies is needed to develop the cohesion, expertise and capacity to build on the strengths and resources of a community.

Waikato DHB would like to explore whether the less complex needs of whānau/families could be met through a social prescribing model, and how such a model would fit with Whānau Ora. Social prescribing allows health workers to refer people to a range of local, non-clinical services. It is consistent with community development and enables a structured approach to people being able to tap into local support networks, services and facilities.

What is community development and why is it important?

Community development 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.

Whānau Ora

Kaupapa Māori 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 only on the needs of individuals.

Whānau Ora uses the power of whānau to improve the wellbeing of individuals and whānau, and enable them to lead full lives. It provides whānau with appropriate services and support so they can become more self-managing and achieve their aspirations.

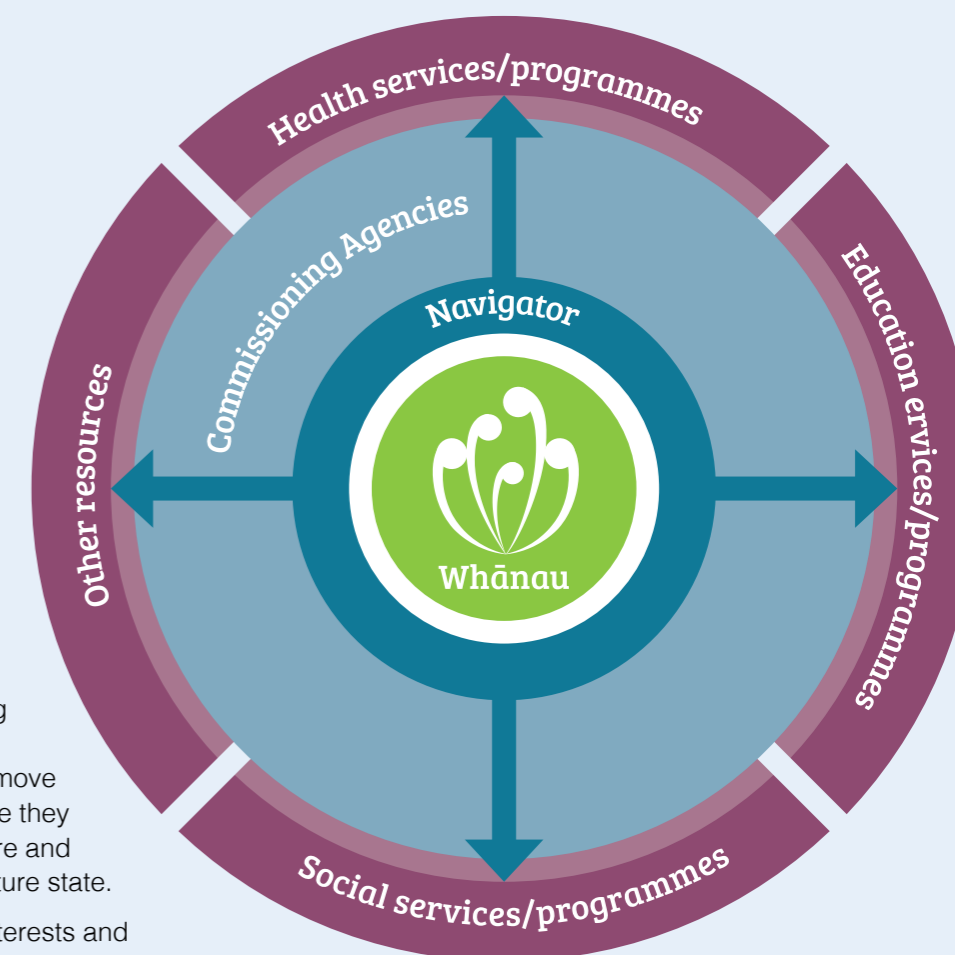
Whānau Ora puts whānau in control of decision making, builds on their strengths and abilities, and supports and develops opportunities that enable whānau to achieve their aspirations.

This means that Whānau Ora approaches take a long-term view to helping 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, interests and strengths of the whānau and build their capability to become self-determining and live full and happy lives.

Figure 5: Whānau Ora, Te Puni Kōkiri, Ministry of Māori Development



A vision for the future

– a whānau and family focussed approach to health and wellbeing

- The challenge** How do health services support whānau/families 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 whānau/families to deal with their immediate health and social issues. Whānau develop a long-term plan for what they want to achieve and have support available when 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 hasn't 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 isn't going away. His wife Beverley is in poor physical health and has periodic bouts of depression which mean she can't work. John knows that he should probably visit a doctor but he hasn't been for years.

He simply can't afford it – he can't find the time during the day and can't really afford the cost. He also knows that it will take longer than 15 minutes to sort out.

The last time he went, John felt stupid when he couldn't 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 they can't manage this challenge on their own. He doesn't 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 service. After they work out that there is no immediate crisis, the service finds out more about the situation and with John's permission, makes 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 family 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 expected. First of all, they meet Jimmy from the local Whānau Ora service. He 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 general practices around Hamilton. The practice staff will also see the family about their health issues. Jimmy spends time talking with John and his whānau, getting to know them, 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 the social issues.

Once Jimmy has finished, the family 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, he 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 better diet – and prescribes medicines. The medicines are prescribed electronically.

Beverley needs support to help with anxiety and to recognise when she may be getting depressed. A dietician will contact the family to talk to them and John has an appointment made on the spot to get his eyes checked. There is a podiatrist in the same building and John is able to see them in the next hour.

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 family by a video call. All the arrangements are 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. 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 family 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 downs, GP visits, medications, hospital specialist appointments, relapses – but the family aren't alone. Jimmy helps them line up appointments and get through the system. They write down the questions they want 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 can't 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

7 Goals for the next 10 years

The following 10 year goals have been identified to achieve good health and wellbeing for our communities. Within each goal, actions and activities to achieve the goal have been identified:

1. Partner with Māori in the planning and delivery of health services
2. Empower whānau to achieve wellbeing
3. Support community aspirations to address the determinants of health
4. Improve access to services
5. Enhance the capacity and capability of primary and community health care
6. Strengthen intermediate care
7. Enhance the connectedness and sustainability of specialist care.

Some of the goals and actions could be viewed as enablers, however they have been explicitly identified as goals and actions due to their fundamental importance and the need to prioritise them.

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

1. Leadership and partnerships
2. Commissioning
3. Workforce
4. Technology and information
5. Quality improvement.

Phasing of the activities

Within each goal and action, the order the activities should be undertaken is indicated with phasing, which will 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 and activities. Individual organisations have responsibilities for actions and activities within their own services and workforce. We must work collectively, lead and own them.

The actions and activities will be reviewed on a regular basis to ensure ongoing relevance over the 10 year period.



Goal 1 Partner with Māori in the planning and delivery of health services

Waikato DHB and health service providers will have collaborative partnership arrangements with Māori. This goal underpins all the actions of the Waikato Health System Plan, Te Korowai Waiora.

This will mean

- Māori will be 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 will operate at multiple levels of the health system as well as across organisations. Partnerships will enable Māori to participate at all 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, used as improvement indicators across multiple levels of the health system, and shared widely with the public, health providers and practitioners
- tikanga Māori will be normalised in the Waikato health system and underpins the way we work.

Action 1.1 Waikato DHB and Māori partner in a way that is an example to others

Rationale

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

Activities	Phasing
Work with Māori to develop an ongoing programme for the whole DHB that progressively: <ul style="list-style-type: none"> • addresses structural, policy and procedural barriers to achieving Māori equity • builds knowledge and awareness, shapes beliefs, and debunks myths and stereotypes • supports staff with the right behaviour 	1
Develop policies and processes that enable Māori to participate in the planning, development, delivery, quality and performance of health services. Examples of this include: <ul style="list-style-type: none"> • Māori involvement in governance processes such as clinical governance, project steering groups and health system leadership groups • the involvement of Māori whānau in the design of services • practice oriented around Māori models of health 	1



Activities	Phasing
Publish performance information including progress to achieving equity	1
Implement a strategy to increase the proportion of Māori in the Waikato DHB workforce	1
Enable a feedback process for Māori consumers to reflect on their experience, supported by a service improvement programme and information to address improvement priorities	2

Action 1.2 Reorient commissioning to achieve equity

Rationale

- Health service 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 inputs alone.
- Longer-term service agreements allow for trust-based relationships to develop between Waikato DHB and health providers, and for health providers to reorient their services to focus on outcomes and inequities.

Activities	Phasing
Develop an outcomes performance framework for the Waikato health system that identifies inequity and unmet needs, and make performance information publicly accessible	1
Shift the focus of Waikato DHB's commissioning approach from focussing on throughput to outcomes, which will require extensive engagement and co-design with health service providers and Māori consumers. Māori participate in the monitoring and evaluation of the outcomes	2
Build equity of outcome indicators into service agreements, with Waikato DHB and health service providers sharing responsibility for improving these outcomes and freely sharing data to support this	2
Extend service agreement duration for health service providers meeting defined capability and performance standards	3
Support health service providers to understand inequities in their patient populations and share expertise to help with strategies to address them	1

Action 1.3 Build requirements for partnership with Māori into provider service agreements

Rationale

- Consumers do not make distinctions between services provided or commissioned by Waikato DHB – 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, Waikato DHB can exert both soft (relationships, leadership and direction-setting) and hard (contracts and funding) influences to ensure services are fit for Māori consumers.

Activities	Phasing
<p>Progressively include requirements for partnership-based ways of working in service agreements with health service providers.</p> <p>Examples of this include:</p> <ul style="list-style-type: none"> • Māori involvement in governance • Māori workforce participation to reflect population proportion • practice oriented around Māori models of health • contribution towards achieving equity • involvement of Māori whānau in the design of services • ensuring services do not worsen inequities, e.g. through application of the Health Equity Assessment Tool • publication of performance information, including movements to achieving equity 	2
<p>Support the sector to develop partnership-based ways of working by sharing Waikato DHB experiences, resources, networks and relationships.</p>	1
<p>Ensure health service provider 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</p>	2



Goal 2 Empower whānau to achieve wellbeing

Whānau are supported to define and achieve their wellbeing goals and can shape the services they require.

Consumers, whānau and families will

- have access to assessment to identify whānau wellness priorities, plans to achieve those priorities, and services are resourced to support this
- be supported by health and social services to care for their own whānau
- have access to culturally-appropriate information and tools that support wellbeing.

Action 2.1 Expand resourcing for Whānau Ora in the Waikato

Rationale

- As it is currently structured, the health system is focussed on illness rather than prevention, is difficult for consumers to navigate and services are poorly coordinated.
- Whānau Ora is a successful model for addressing these issues as it involves holistic assessments, targets resources to whānau aspirations and wellbeing, and coordinates an intersectoral approach to keeping whānau well.
- Whānau Ora is inadequately resourced in the Waikato, with the opportunity available to expand the programme's reach to more whānau.
- Pacific models of Whānau Ora are provided by Pacific providers as part of a Midlands Collective and can also be expanded in the Waikato.

Activities	Phasing
Resource and embed the Whānau Ora approach as the wellness model of care for the Waikato district. Devise a workforce development strategy to support this expansion	1
Closely link Whānau Ora expansion with primary health care and other government agencies to ensure availability of the required services. This will ensure that needs assessments only occur once, that information is shared between relevant health service providers (controlled by whānau), and that whānau needs drive service capacity and development	2
Prioritise the development of Māori and Pacific Whānau Ora health service provider capability and capacity to enable access by the whole population	1
Monitor and review Whānau Ora approaches to inform improvements	2

Action 2.2 Advance initiatives to better support whānau/families as carers

Rationale

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

Activities	Phasing
Develop pathways that inform whānau/families about where to go for advice and services at a locality level	1
Support the development of peer support networks in communities of need	2
Develop protocols for individualised care planning that consider the need to support both carers and whānau/families	1

Action 2.3 Support whānau/families to make informed decisions regarding their health and wellbeing options

Rationale

- People want to be able to obtain, process and understand health information and services to make informed choices and self-manage their health and wellbeing.
- 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	Phasing
Partner with Māori to identify specific community health literacy issues to prioritise, such as discharge communication and medication information	1
Upskill workforce health literacy to better support whānau and communities	1
Provide whānau and consumers with access to bilingual, culturally appropriate information to support health literacy and self-management	2
Take an interagency approach to coordinate health information and ensure consistency and accessibility of health messaging	2



Goal 3

Support community aspirations to address the determinants of health

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 will form inter-sectoral collaborations to coordinate their efforts and provide local leadership
- these collaborations will support community development activities that enable local communities to identify and address social and environmental determinants of health that are important to them
- iwi and Pacific communities in particular will be supported to develop their own health environments, communities and institutions
- Māori and Pacific models of health will be used and further developed
- Waikato DHB will partner 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 influence 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. DHB and health service 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, families and communities.

Activities	Phasing
Together with other partners, work with Māori and Pacific communities to understand locality priorities, the resources they have, and agree on a plan to support the localities	1
Resource and support communities to facilitate community development and leadership	1 2
Provide additional resources for health promotion	2 3
Directly invest in population health interventions where there is evidence of health benefits.	2
Actively look for co-investors for inter-sectoral solutions	2 3

Action 3.2 Expand the inter-sectoral approach to influence determinants of health

Rationale

- Factors outside the health system such as income, housing, social support, employment and education have large effects on people's health.
- 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/families with housing, educational, financial, community and other health and social services in a mana enhancing and culturally safe way.

Activities	Phasing
Work 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	1
Involve iwi and Māori as partners in both governance and operations, and employ Māori-based analyses and frameworks for action	2
Support communities in their priorities to spread information and encourage change, with health education and promotion supported by health professionals	1

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
Work 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	2



Goal 4 Improve access to services

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

This will mean

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



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

Rationale

- Culture describes the way members of a group understand each other and communicate that understanding. Cultural safety in health is how a person experiences a health 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, such as youth.
- Māori consumers and whānau consistently reported that they want services (both Waikato DHB and contracted health service 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
Strengthen our approach to tikanga and cultural competency through changes to Waikato DHB practices and services, and assist commissioned health service providers with this too	1
Take a planned approach to improving cultural safety, including initiatives that address structural and policy matters that lead to prejudice and discrimination, and share learnings with other providers	1
Lead sector Māori workforce development by enhancing Waikato DHB workforce plans to increase the number of Māori in clinical and non-clinical roles, in proportion to the population	1



Action 4.2 Collaborate in the development of 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.
- Waikato DHB and a diverse range of health and social service providers deliver services in community settings. They may coordinate their services for an individual, but there is a lack of coordination, consistency and collaborative planning to improve access or use the diverse expertise found in community health service providers. Service delivery models need to include alternative settings and health service 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.
- Other health activities, such as health promotion, early intervention and self-management, could be suited to being delivered in community settings to improve engagement.
- 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 people who are most unwell use the most medicines.

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

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 or impairment
- 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.

Activities	Phasing
Improve access to health services for people with disability or impairment, and progressively integrate health and disability services	1
Develop appropriate systems and policies to identify people with disability or impairment	2

Action 4.4 Grow the capability and capacity of the workforce to enable the service delivery models

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 encourage people into health to grow a local workforce.

Activities	Phasing
Develop workforce plans that enable service delivery models to be delivered in a sustainable way and build a local workforce	1
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	2
Establish mobile specialist teams and locality based clinical staff to support the service delivery approaches in community settings where feasible	2



Action 4.5 Support service delivery models with technology and information

Rationale

- Consumers and health service providers in the Waikato have shown an appetite for using technology that is broader than video interaction.
- The development and integration of technology across the health system is difficult for a number of reasons, therefore health service providers, including Waikato DHB, have followed their own strategies. There are significant risks with over-planning in a constantly evolving industry, so the key strategic principle is interoperability.
- The commissioning approach needs to be informed by a population perspective on quality, performance and the outcomes being achieved.

Activities	Phasing
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	1
Expand the technology component of services through trial, evaluation and scaling of well-designed pilots with defined use cases	2
Collaborate across the sector to share consistent and reliable information, and develop a district wide dataset with analytical tools that can be progressively used for needs analyses and the measurement of outcomes achieved	3

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 health service providers.
- People 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/families. 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
The Waikato health system agree an action plan that improves the shared health record and care plans, in collaboration with stakeholders within the district (and Midland Region where appropriate). This record is consumer-centred and gives people access to their information through patient portals	1

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 are an effective means of empowering people with disabilities and their whānau/family to choose the services and support that are right for them.
- Personal health budgets in the Waikato would be supplementary to existing services and facilitate people accessing services they otherwise may not have had access to.

Activities	Phasing
Enhance awareness of what services are available and how they can be accessed	1
Advance the concept of personalised care in the Waikato and explore how people living with mental health or other long-term conditions can be empowered to determine their own care using whānau care budgets	3
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	3
Establish an evaluation and research initiative to investigate short and long-term outcomes, and benefits of whānau care budgets	3



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. People 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
Establish an urgent and emergency care network that shares information, provides oversight on service quality, workforce support and development, and coordination between services	1
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	1
Develop enhanced after-hours coverage and access through locality delivery models	1
Link the urgent and emergency care service delivery approaches to the development and use of intermediate care options	1



Goal 5

Enhance the capacity and capability of primary and community health care

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 their whānau/family. 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 will give priority to eliminating barriers and improving outcomes for Māori. Being responsive to Māori will be embedded in primary and community health care services
- an interdisciplinary team approach to community-based care will be co-designed and implemented utilising shared care plans
- patients and whānau/families will 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 will 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 will shape the improvement of primary health care through co-design of services, regular feedback mechanisms, and access to provider performance results
- primary health care providers will be able to access non-governmental organisations services directly rather than through referral to a specialist service
- primary care clinicians will have access to appropriate diagnostics, such as ultrasounds and cardiac investigations, through defined, resourced pathways
- community care professionals will have access to rapid specialist service advice through defined locality-to-specialist relationships, for example
- primary health care teams will have access to additional initiatives to assist in managing acute hospital demand.
- a Waikato community pharmacy model of care will be designed with communities, incorporating wellbeing, with a one team focus.



Action 5.1 Support 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.

Activities	Phasing
Establish a locality approach and appoint locality leadership roles to lead local planning and improvement of health services.	1
Complete a stocktake of services and resources in each locality, and combined with population health information, identify and agree on a plan to address priorities	1
Align Waikato DHB, Primary Health Organisation (PHO), and Non-governmental organisation (NGO) configuration to support effective locality planning and delivery of services	2



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/family 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 and efficiency, and facilitate a path to achieve equity for Māori and other priority populations in collaboration with other health and social services.
- There is the opportunity to bolster this innovation through effective use of care coordination functions, and an explicit commitment to achieving health equity for Māori.
- 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 to provide care closer to home and work, in partnership with locality networks to understand how service delivery models can be coordinated, resourced and delivered in their settings	1
Build minimum standards into primary health care service agreements, incorporating key elements of expanded primary health care models, responsibility and accountability for access and health equity for Māori	2
Evolve enhanced general practice models to focus on achieving equity	1
Formalise the concept of individualised care plans for people with complex clinical conditions. Develop individualised care plans together with people and whānau/families, as a central function of the primary and community health care team. Provide access to these plans via the patient portal	1
Develop expanded roles for the health workforce, including community pharmacists, as part of expanded service delivery approaches. Identify opportunities where co-location may be beneficial	1
Enhance community health pathways to incorporate wellbeing, link to Whānau Ora and other whānau-focussed approaches. Encourage their use through improving systems to make them easy to use, promotion and upskilling clinicians	1

Action 5.3 Develop, strengthen and embed whānau-centred approaches

Rationale

- Māori models of health are based on a wellness or holistic health model, such as Te Whare Tapa Whā, Te Wheke or 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, for example 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.
- Urgent social needs have the potential to overload Whānau Ora providers and limit the long-term support for whānau aspirations.
- In addressing immediate social needs, there is the real potential for unmet need to overwhelm services. Inter-sectoral collaboration is essential to facilitate strategic and operational planning and budgeting.
- Social prescribing is a means of enabling people to have access to a range of local, non-clinical services which are typically provided by local voluntary and community services that seek to address people's needs in a holistic way. There is the opportunity to develop a structured approach to social prescribing in the Waikato to support Whānau Ora and clinical care.

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	1
Collaborate with stakeholders on developing a workforce to enable ongoing delivery of the programmes	1
Develop a social prescribing framework that is suitable for the Waikato and aligned to Whānau Ora and clinical care	2
Develop community and hospital health pathways and optimise their use across the district	1
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 introduced to programmes and services	1



Goal 6 Strengthen intermediate care

The gap between primary and secondary care is bridged through the development of enhanced step up and step down services in the community.

This will mean

- there will be community options for care as an alternative to hospital for people who do not need to be in hospital (step up)
- the care of people in hospital can be transitioned in a timely way with care provided to them in their home or a community facility (step down), in a connected manner
- rural hospitals and other facilities will provide accessible local sites for bedded intermediate care
- people in local bed facilities will have wrap around services tailored to their needs provided by allied health, nursing and other appropriately skilled health care providers
- local community involvement with these facilities will be strengthened through co-design
- general practitioner and nurse practitioner admitting rights for short stays in intermediate care facilities will be expanded
- intermediate care services will be supported by specialist expertise, as identified through co-design processes.

Action 6.1 Improve transitions of care and extend step down care services

Rationale

- Transition of care from Waikato Hospital can be delayed if the services a patient requires 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, such as Supported Transfer Accelerated Rehabilitation Team (START), which could be scaled up and broadened.

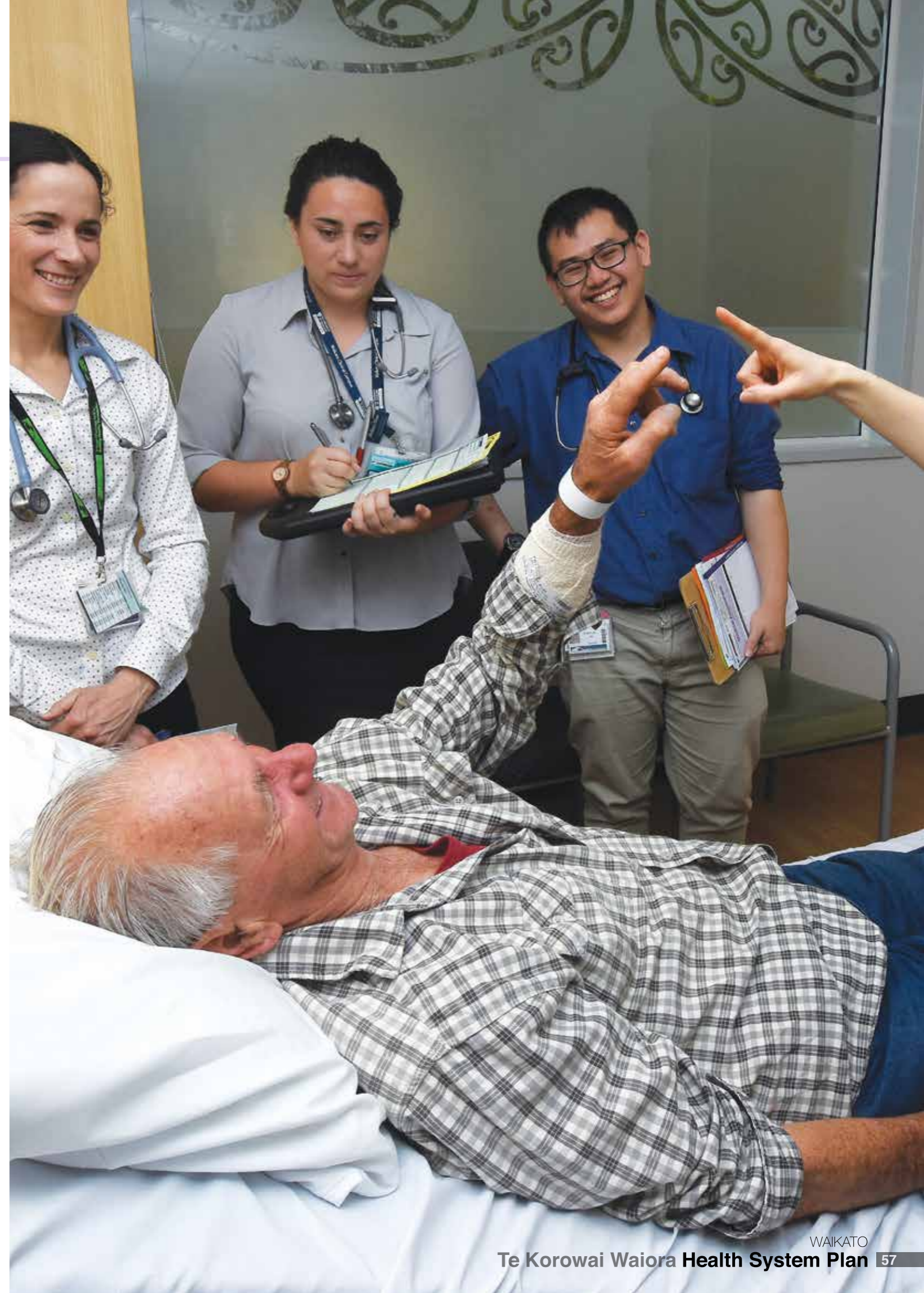
Activities	Phasing
Support timely transition and hospital flow by providing services locally to patients in appropriate settings	1
Build stronger links with primary and community care to allow collaborative transition of care planning. Integrate timely transition of specialist care services with primary and community care, Whānau Ora and whānau/family-focussed approaches	1
Build local expertise so that Waikato DHB can work towards commissioning from community-based providers	3

Action 6.2 Reorient services to reduce hospital admissions

Rationale

- There are programmes that enable people to be transitioned from hospital in a more timely manner and to be supported by specialist services in their homes or in appropriate facilities close to home (step down). These may be able to be configured to be used for people with deteriorating conditions as an alternative to being admitted to hospital (step up).
- 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
In collaboration with stakeholders, consider what step up services can be used by general practice to avoid hospital use	2
Reconfigure programmatic approaches, such as the primary options programme, to focus on funding people with acute conditions to access a broad suite of services that avoid hospital admission	1



Goal 7 Enhance the connectedness and sustainability of specialist care

Specialist services are a critical part of our care continuum. Further work is required to clarify how growing demand for specialist services can be met in the future.

This will mean

- services will be delivered in multiple settings
- the planning of clinical services will be guided by the Waikato Health System Plan
- cultural competence and safety will underpin the way services are planned and provided
- services will be reoriented to achieve equitable access to specialist care
- patients and whānau/families will experience their care as connected and coordinated across all parts of the system
- specialist services that can be decentralised will be delivered closer to where people live, either in person or through the use of technology
- the role of rural hospitals will be clarified as long-term service delivery models are developed and aligned
- we will work within, and make the best use of the available funding
- we will take a planned approach to long-term investment planning, defining future resource and facility requirements aligned with strategic service directions.

Action 7.1 Strengthen the integration between primary, secondary and tertiary services

Rationale

- There is an opportunity to improve the transition of care to home, a rural hospital or another facility if specialist services were available locally.
- Clarifying where primary and secondary care connect for specific specialist services will strengthen the integration.
- Care pathways for specific conditions require seamless connections, as the needs of patients change.

Activities	Phasing
Expand clinical service planning to incorporate new models of service delivery based on end-to-end care pathways	1
Build stronger links between primary and secondary care that allow seamless transition of care, including a system for early notification of care transition (discharge planning)	2
Clarify the role of rural hospitals	2

Action 7.2 Develop specialist services closer to home

Rationale

- Technology improvements are increasing the range of services that can be safely delivered outside of hospitals.
- Numerous existing community health facilities could be more efficiently used for specialist service delivery.
- With the support and advice of specialist expertise, primary and urgent healthcare centres can often manage presentations to emergency departments and referrals to specialist services.
- In the interests of accessibility and patient experience, some services may be better delivered to patients near Waikato DHB borders by other DHBs.

Activities	Phasing
Identify existing specialist services that can be provided in community settings	1
Provide greater access to specialist care and/or expertise through the use of mobile teams and technology	2
Develop approaches that allow general practice timely access to specialist advice and diagnostics	2

Action 7.3 Optimise system performance and ensure service sustainability

Rationale

- Effective clinical governance systems lead to an accountable health system which ensures continuous improvement of high quality clinical care.
- The Waikato population is aging and services are experiencing unprecedented growth. Demand will outstrip capacity under the current service delivery models. A long-term plan is needed to quantify the capacity required to meet growing demand and to optimise our investments to achieve equity and improve health outcomes.
- Waikato DHB plays a critical role in the regional delivery of secondary and tertiary services.
- Waikato DHB is a provider of last resort for acute and specialist services; this impacts the ability to optimise system performance.

Activities	Phasing
Strengthen clinical governance structures to facilitate whole of system performance improvement	1
Optimise use of hospital capacity for planned care and acute services	2
Develop service and capital investment options to meet forecast demand locally and regionally and to ensure long-term service sustainability	3



8

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.

8.1 Leadership and partnerships

Objectives

- Clinical governance will reflect the principles of
 - being consumer and whānau/family centred
 - an open and transparent culture
 - enabling all staff to actively participate and partner in clinical governance
 - a continuous quality improvement focus.
- A district-wide framework for planning, funding, service delivery and monitoring health system performance will support the delivery of the Waikato Health System Plan, Te Korowai Waiora.
- The district-wide framework will have clear roles and responsibilities for prioritising resources, service development, and a quality improvement approach. At the delivery level, relationships need to be fostered to translate district direction into local action.
- A system 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 Waikato DHB as commissioner of services, with shared responsibility for health system performance.
- Providers will have individual accountability to the commissioner and collective accountability to each other in the system leadership group.
- Partnerships will be developed with a broad range of stakeholders including NGOs not funded by health, volunteer groups and local government.
- The system 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 will 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

Empower Waikato DHB clinical teams to lead and improve quality by aligning clinical governance structures to facilitate whole of Waikato DHB performance and improvement. Processes should enable different perspectives, such as different professional groups, Māori and consumer, and structures should clarify roles and responsibilities

8.2 Commissioning

Objectives

- 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 will be developed.

Activities

Integrate the role of system 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, tamariki/children and rangatahi/youth
- older people
- cancer
- mental health and addictions
- people with multi-morbidity and long-term conditions
- hospital-based services

Ringfence a Waikato Health System Plan, Te Korowai Waiora 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

Objectives

- Health workers will operate confidently and skilfully with Māori.
- Workforce distribution will be matched to the population need.
- Increasing participation by Māori and Pasifika in the health workforce.
- Leadership, co-design, community development and quality improvement capability will be developed across the health system; this also includes capability to work within interdisciplinary teams.
- There will be 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, such as placements and 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, such as hospital, primary health care, urban and 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 accessing information, it is important that the systems are inter-operable and integrated.

Objectives

- 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 them and authorised members of the health care team.
- A shared strategic approach to technology will be agreed between Māori, consumers and key stakeholders.
- Information will be shared across the sector to enable better targeting of services, monitor and measure 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 under Goal 4 – Improve access to services

8.5 Quality improvement

Objectives

- 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 a quality improvement framework. Initially, focus of quality improvement programmes 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 outcomes performance framework) that can be used to measure and improve health system performance. Performance information will be shared with the public

Prioritise resourcing 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 this plan. Delivering on our strategic goals will require collective action, pooling resource and expertise. Key initiatives will be coordinated 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 work programme. An establishment group will be used to prioritise and set up initiatives. A portfolio steering group will provide oversight after the establishment period.

A single work programme approach means the benefits of the projects and programmes are viewed in their entirety. This 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. Resourcing of initiatives is expected to be through a mix of ring-fenced funding and more efficient provision of services. It is expected that resourcing will initially be skewed to ring-fenced funding and reduce over time as initiatives produce the desired benefits.

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

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

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 Waikato Health System Plan, Te Korowai Waiora, 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 Waikato Health System Plan, Te Korowai Waiora.

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 Waikato Health System Plan, Te Korowai Waiora, 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.

Glossary

Aged residential care (ARC)	<p>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:</p> <ul style="list-style-type: none"> rest home care continuing care (hospital) dementia care specialised hospital care (psychogeriatric care). <p>Short-term respite care and convalescent care may be provided in these facilities. Long-term residential care does not include independent living in a retirement village.</p>
Care coordination	<p>A proactive approach to bringing together care professionals and providers to meet the needs of service users, to ensure that they receive integrated, person-focussed care across various settings.</p>
Care plan	<p>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.</p>
Carer	<p>A carer is either a paid or unpaid family member or other person who regularly helps look after someone who has a long-term need for help.</p>
Continuity of care	<p>Continuity of care reflects the extent to which a series of discrete health care events is experienced by people as coherent and interconnected over time and consistent with their health needs and preferences.</p>
Culture	<p>The way of life, beliefs, customs and arts of a particular society, group, place or time.</p> <p>Culture can also refer to a way of thinking, behaving or working that exists in a place or organisation (such as a business).</p>
Cultural safety	<p>An environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together⁵.</p> <p>An important principle is that it doesn't ask people to focus on the cultural dimensions of any culture other than their own. Culture can relate to more than ethnicity alone, for example socio-economic status, religion, gender, age, sexuality or disability.</p>
Cultural competence	<p>Culture can relate to more than ethnicity alone, for example socio-economic status, religion, gender, age, sexuality or disability.</p> <p>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, consumers and whānau/families.</p>

Disability	<p>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.</p> <p>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.</p>
Engagement	<p>A participatory process where stakeholders are involved in dialogue about their views on a topic.</p>
Equality	<p>Everyone is treated the same based on the assumption that everyone has the same needs.</p>
Equity	<p>Unequal treatment of unequal needs with the aim of achieving similar outcomes.</p>
Health care teams	<p>The collective of health and social services professionals who are involved in the planning and provision of care to an individual or whānau/family. 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.</p>
Healthcare record Electronic healthcare record (EHR)	<p>A health care record is a collection of information from different sources (eg 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 prescribing, hospital admissions and discharges, specialist reports, imaging and lab test reports and wellness plans.</p> <p>An electronic healthcare record collates all this information so that it can be shared electronically between health care providers. Information sharing is governed by strict privacy rules. Patients can specify who can and can't see their information.</p>
Health in All Policies (HiAP)	<p>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 and transport.</p>
Intermediate care	<p>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.</p> <p>Intermediate care helps people avoid going into hospital unnecessarily or allows people to be discharged from hospital earlier and be supported in their own homes or other local facilities.</p>
Model of care	<p>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, intervention, treatment and 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, such as how providers share information between themselves and with people.</p> <p>What is included in a model of care can be variable and ranges from just clinical management in specific areas to more comprehensive clinical and holistic needs.</p>
Navigator	<p>A navigator is a person who supports a person or whānau/family and helps them make their way through the health and social system to get the right services at the right time. The navigator may help the individual or whānau/family act on a health care plan or get through a particularly complex set of circumstances or treatment.</p>

⁵Williams, R. (1999). Cultural safety – what does it mean for our work practice? Australian and New Zealand Journal of Public Health, 23(2), 213-214

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Outcome	A result or consequence. A health outcome is a change in health status as a result of one or several interventions.
Portal	A portal is a website that is a single point of access for many different sources of electronic information. It allows the user to 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, such as pharmacies.
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 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.

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- PP6: Improving the health status of people with severe mental illness through improved access report (12 months to September 2018)
- Waikato District Health Board, Interim Long-term Investment Plan (June 2017)

Appendix 1

Steering group members

- Interim CEO Waikato District Health Board (chair)
- CEO Midlands Regional Health Network Charitable Trust
- CEO Hauraki Primary Health Organisation
- CEO National Hauora Coalition
- CEO Midland Community Pharmacy Group
- Regional Operations Manager, Healthcare of New Zealand
- CEO, Waikato / Bay of Plenty Cancer Society
- Joint CEO, Wise Group
- Co-chair, Consumer Council
- Interim Chief Operations Officer, Waikato District Health Board
- Clinical Director Strategy, Funding and Primary Care, Waikato District Health Board
- Executive Director, Strategy, Funding and Public Health, Waikato District Health Board
- Executive Director, Mental Health and Addictions, Waikato District Health Board
- Executive Director, Te Puna Oranga (Māori Health), Waikato District Health Board
- Clinical Director, Mental Health, Waikato District Health Board





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