Waitemata
District Health Board

Best Care for Everyone

Waitemata Primary and Community Services Plan 2016

Contents

A patient and whanau-centred health system working together to achieve the best outcomes for our population

Welcome to the Primary and Community Services Plan for Waitemata. This plan is vitally important both for describing the future growth and development of primary and community services in the Waitemata district and the actions we will need to take in order to secure these services for the future.

The population of Waitemata experience health outcomes that rank as some of the best in New Zealand and indeed the world and our population are able to access comprehensive health services that are of the highest quality. However, now and over the coming years we face a number of significant challenges. These challenges include our rapidly growing and diversifying population, as well as changes to the burden of chronic disease such as diabetes. We also need to improve health outcomes even further, especially for some population groups such as Māori and Pacific. These challenges mean we must continue to develop our people and the services we offer across the district.

Primary and community services play a pivotal role in responding to the challenges we face. We must work together to address the challenges that will arise. We need to move to one single, integrated health care system, where patients receive the best care in the right healthcare setting whether that be in the home, in the community, primary care centre or, if needed, in hospital. We must work together to develop a sustainable, well-planned responsive and patient/ whānau-centred system that is integrated across the whole care pathway.

This plan contains the agreed set of ideas and actions for moving quickly on today's challenges and to devise and design primary and community services of the future. Our aspiration is that by 2025, 'A patient and Whānau centred single health system will work together to achieve the best outcomes for our population'.

To take us there, we've identified 5 priorities that help us focus our work:

1. **Deliver Better Health Outcomes**
2. **Achieve Equitable Health Outcomes**
3. **Effective and Sustainable Services**
4. **Build Capacity and Capability**
5. **Integrated and Local Services**

The most important aspect of this plan is that it is a joint plan, focused on the need for a single healthcare system across the district. Together this plan has been created and together we will implement this plan. Our healthcare services exist to serve our population. We want those services to be the best they possibly can be.

We strongly believe that together we can support people living in the Waitemata area to live better and healthier lives. Thank you to all of those who participated in the development of the plan.

Dr Dale Bramley – Waitemata DHB CEO

Steve Boomert - ProCare Health Limited CEO

John Ross – Waitemata PHO Limited CEO

Executive Summary

Overview

This *Waitemata Primary and Community Services Plan (PCSP)* outlines a vision to transform our current healthcare system and sets the direction for primary and community services to 2025. The plan has been developed collaboratively with primary and community care partners and signals our collective desire to accelerate progress in primary and community services. Primary and community services will increasingly play a pivotal role in responding to the challenges of a growing and aging population, the need to better manage those with chronic disease and addressing health inequalities. This is against a backdrop of cost and workforce pressures, along with rapid advances in technology.

In order to address these challenges the PCSP:

- Confirms our aspiration for Waitemata 2025, 'A patient and Whānau centred health system working together to achieve the best outcomes for our population', and articulates what this means for primary and community services
- Identifies 5 priority areas and key actions in relation to achieve this aspiration. The 5 priority areas are:
    1. **Deliver Better Health Outcomes**
    2. **Achieve Equitable Health Outcomes**
    3. **Effective and Sustainable Services**
    4. **Build Capacity and Capability**
    5. **Integrated and Local Services**
- Provides a roadmap illustrating the key programmes and initiatives expected to be in place by 2025.
- Outlines the DHBs approach to investment in primary and community services and sets out an initial investment plan for 2016.
- Identifies the key next steps for implementation of the PCSP.

The current state and key challenges we are facing

Our growing and ageing population combined with evolving consumer preferences and technological change is leading to increasing cost and demand pressures. Waitemata's population is the healthiest and longest-lived in New Zealand but there are opportunities to improve health outcomes for our population further. For example, every year around 440 premature deaths occur that are potentially avoidable, mostly through better prevention and chronic disease management. There are also longstanding inequalities for our population – in access and outcomes for our Māori and Pacific populations, as well as for our population living in low decile areas particularly West Auckland. We must also address the barriers to change and the limitations in the infrastructure that supports our services - a lack of connectivity across the system, current provider sustainability issues, workforce and financial issues, and the slow pace of change. Key achievements and challenges within our district are set out in the tables on the following page.

Key Achievements:

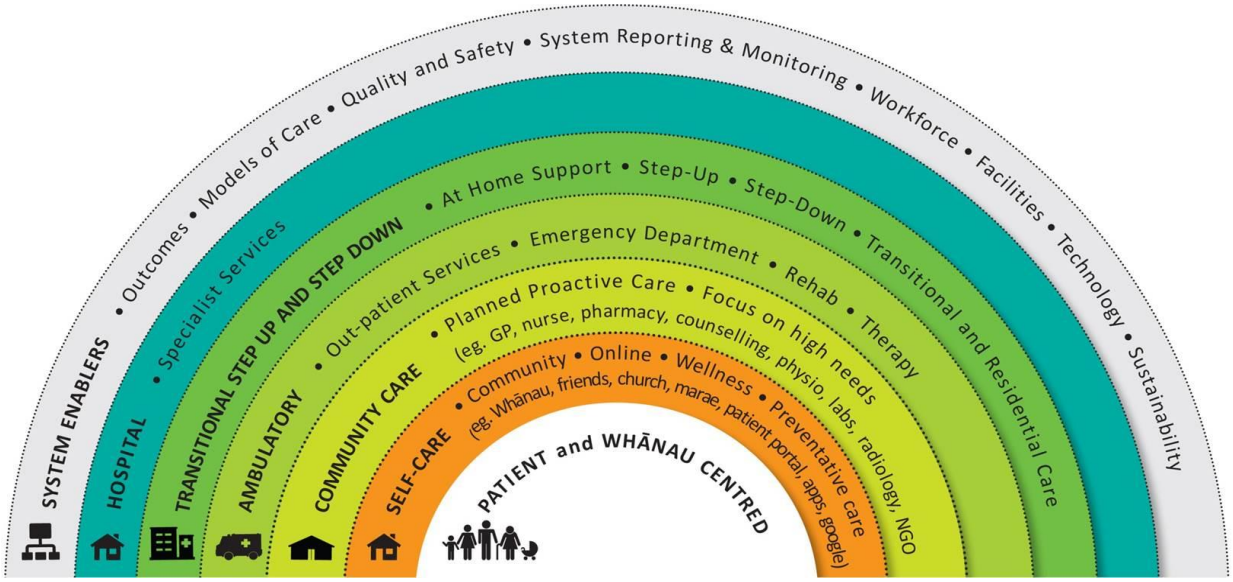
HEALTH OUTCOMES	Highest life expectancy in the country at (83.9 years) Lowest mortality rate from Cardiovascular disease (81.6 per 100,000 population) Lowest rate of amenable mortality (63.7 per 100,000 population) Among the lowest mortality rates from Cancer (104 per 100,000 population) 69% of cancer patients survive five years after their diagnosis, the highest survival rate in New Zealand Among the lowest infant mortality rate (2.3 per 1,000 live births)
SMOKING	Smoking rates are among the lowest and declining (12% adults regular smokers) 89% of smokers in primary care received smoking cessation advice 32% of smokers received cessation support either through a referral to 'quit smoking' services or provided with smoking cessation medication.
PREVENTION AND MANAGEMENT	92% of children are fully immunised by 8-months of age 91% of the eligible population have had their cardiovascular risk assessed over the last five years 93% of children receive a comprehensive before school check 76% of women aged 25-69 are screened for cervical cancer

Key Challenges:

GROWING, CHANGING, AND AGING POPULATION	18% growth rate or 105,000 people to nearly 700,000 by 2025 65% increase in the 75+ population to 53,000 by 2025
HEALTH INEQUALITIES	Life expectancy gap for Māori (6.3 years) and Pacific (5.3 years) Cardiovascular diseases and cancers account for 3.1 years of the gap in Māori and 3.7 years of the gap in Pacific
PREVENTION AND MANAGEMENT OF CHRONIC DISEASE	444 deaths amongst under 75 year olds could be potentially avoided through timely and efficient health care, 75% of these could be avoided through better prevention and management of chronic disease Smoking rates (12%) are decreasing but Māori and Pacific rates (27% and 20% remain high 1 in 4 adults are obese and more than half are overweight Mental ill health affects 1 in 5 of our residents
CAPACITY AND CAPABILITY	Our workforce is aging and we need to increase our workforce numbers and develop our workforce to meet the future needs of our growing population and to improve health outcomes
SUSTAINABILITY AND ADAPTABILITY	The financial challenge facing the health sector is substantial; the current trajectory of cost growth is estimated to outweigh revenue growth by 2025 Change is often slow and difficult in the current environment, new business and funding models will be needed to be developed to accelerate and support the change required. Strong leadership and transformational change will be imperative to ensure change is adopted and sustained.

Waitemata 2025 - 'A patient and whānau centred health system working together to achieve the best outcomes for our population'

Our aspiration is that by 2025 'A patient and whānau centred health system working together to achieve the best outcomes for our population' will operate in Waitemata. Health services will be accessible, understandable and patient and whānau centred. Exemplar care and clinical outcomes will be achieved for all populations through the provision of timely urgent care and structured planned proactive support for those who need it most. A high level of trust will operate across the system. Technology will support greater self-care, and integrated care. Enhanced services will be available in the community with hospital services increasingly focused on acute and specialist services. We will work collaboratively across agencies and with our intersectoral partners to deliver the best outcomes for our population. Barriers between providers will be removed as we work as a single system aimed at improving health outcomes for our joint population. The key features of this system are illustrated in the diagram below.



Our Primary and Community Services Plan

In order to address the key gaps and challenges and create a sustainable community services model for 2025 the PCSP is focused on responding to our growing and changing population, improving outcomes, reducing inequalities, integrating services across the health system and supporting change to happen by creating an environment in which the above can be achieved. The plan is therefore focused on five main priorities and illustrated in the diagram below. Transitioning to new models of care and service delivery will require transformational change and strong leadership and management of this change will be key to successful delivery.

- **Deliver Better Outcomes**

  We will achieve the very best health outcomes for our population focusing on prevention, early intervention and chronic disease management.
- **Achieve Equitable Health Outcomes**

  We will accelerate health gain for Māori, Pacific and vulnerable populations.
- **Effective and Sustainable Services**

  Primary and community services provide world-class care that is patient centred, sustainable, and achieves real improvements in health outcomes
- **Build Capacity and Capability**

  We will develop the workforce, technology and facilities to meet the needs of our changing and growing population.

- **Integrated and Local Services**

  Patients experience co-ordinated, integrated, and seamless services delivered closer to home where appropriate.

Primary and Community Services framework and priority areas:

The strength of our plan lies in us having a collective view of our top priorities, understanding what we need to focus on and the underpinning imperatives we need to support action. These are illustrated in the framework below. The inner part of the diagram is focused on the changes we need to make to improve outcomes and reduce inequalities. The outer ring of the diagram sets out the changes needed within primary and community services to develop effective, integrated and sustainable services and to successfully implement the programmes outlined in priority areas one and two. This represents a transformational change programme that will be supported by investment in change management and underpinned by committed, consistent leadership from across primary and secondary care.

1. Deliver Better Outcomes

Our population already experience very good health outcomes but there are opportunities to do better. To deliver better outcomes we need to increase our investment in prevention, chronic disease management and early intervention and work with other public sector agencies to address the broader determinants of health. Timely urgent care and a greater focus on planned, proactive care, particularly in the management of long term conditions will support better health outcomes and will help to manage demand for hospital services. Our focus in this area is on:

Early Years – accessible and high quality universal services from pregnancy through the first years of life as well as more intensive support and protection for vulnerable children, young people and families
Healthy lifestyles – more smokers receiving support to quit and development of obesity reduction initiatives

Chronic Disease Management – intensive lifestyle support for patients with early stage diabetes, planned proactive management of CVD, diabetes, respiratory disease and other chronic diseases
Mental Health and Wellbeing – improved access to psychological therapies, broader population health strategies to maximise health and wellbeing, improved support for physical health, and employment and housing for people with serious mental illness
Healthy Aging – implementation of the cognitive impairment pathway and falls prevention programme, new models of care in general practice building on the CARE programme, high quality residential care.
End of Life - support the regional palliative care work programme.

2. Achieve Equitable Health Outcomes

We want to ensure that our Māori and Pacific populations achieve the best possible health outcomes. By 2025 we want to see Māori and Pacific people in our region living longer and enjoying a better quality of life. Our aim is to provide services which meet the needs of our patients, support them to achieve their health and wellbeing aspirations and build on the strengths of our patients, their whānau and community. We will achieve this through deliberate and intentional action towards eliminating the life expectancy gap between Māori and Pacific and non-Māori/non-Pacific populations. We will focus on reducing the impact that known modifiable risk factors, including smoking, obesity and alcohol, have on the health of Māori, Pacific and other priority populations. This approach will also support us to identify early and effectively manage chronic conditions whilst ensuring our services are culturally responsive. We will also build collaborative relationships with non-health sector services to support sustainable outcomes for our patients and their whānau.

Whanau ora - expand the current health services provided at Whānau House and support integration between health and non-health services as part of a whānau ora approach, implementing and evaluating the effectiveness of a whānau ora model of care on the North Shore and south Kaipara, and including whanau ora approaches in service delivery models
Engagement – engaging with Māori service users and communities when developing and evaluating services, engaging with Mana Whenua and/or other appropriate Māori representatives when planning, developing and evaluating services
Healthy Lifestyles – provide services which support Māori, Pacific and vulnerable populations to be smokefree, physically active and consume nutritious diets
Screening – implement abdominal aortic aneurysm (AAA) screening, increase uptake of bowel and cervical screening programmes
Chronic Disease Management – implement systems to support early identification and planned proactive management of CVD, diabetes and respiratory disease for Māori, Pacific and other vulnerable populations with a focus on equitable outcomes
Culturally competent workforce: increasing our Māori and Pacific workforce, enhancing the cultural competence of our workforce and better integrating equity into business as usual for all staff
Health-literate services and programmes – support services to be more accessible, understandable and effective for Māori and Pacific patients and their whānau for patients across the range of health literacy levels, and through better use of technology
Advocate, where appropriate, on key upstream drivers of inequity - advocate to central and local government for effective measures that address drivers of inequity both within and outside the health sector
Intersectoral collaboration - building relationships and referral pathways with non-health services to support improved health outcomes for Māori, Pacific and other vulnerable populations, co-commissioning services with Te Pou Matakana and Pasifika Futures that will improve access to services and improve outcomes for Māori and Pacific.

3. Effective and Sustainable Services

This priority area focuses on the system changes we need to make to enable primary and community providers to provide world-class care through proactive, systematic and evidence based approaches and achieve real improvements in health outcomes. Our focus in this area is on:

Outcomes Focused –agree an aligned set of outcomes across the whole system building on the system level measures that address the key health needs of the population and that drives decision making

Models of Care – develop clear and consistent models of care which

- Stream patients efficiently to provide people with consistent, effective and quality management of both timely urgent care and planned proactive care. Care should be delivered in the health care setting that best meets their needs and which is evidence-based and sustainable
- tailor care to the needs of patients and their whānau in the context of the community in which they live based on holistic health pathways
- support links with non-health services where appropriate

Quality & Patient Experience – roll out a robust quality improvement approach such as the Safety in Practice programme

System Reporting & Monitoring - improve reporting and analysis systems to provide intelligence on performance of the system

Sustainability – develop, align and standardise business and financial models and incentives, based on 'Best Care for Life' or 'health care home', to achieve our agreed outcomes.

4. Build Capacity and Capability

In order to respond to our growing and ageing population, rapidly changing technology and to deliver better outcomes, we need to build on and expand the capacity and capability of our existing infrastructure in terms of workforce, technology and facilities. Our focus in this area is on:

Workforce – growing and developing a diverse and culturally competent workforce to meet future population growth and change, extending and implementing new professional roles, setting up professional development programmes, improving clinical leadership in a multi-disciplinary way, creating accreditation programmes

Technology - implementing self-support technology, establishing an Electronic Health Record, establishing Telemedicine in the community (eg E-referrals, remote monitoring; virtual clinics, patient portals); and implementing a culture of testing and adopting innovative technology to enable Model of Care changes

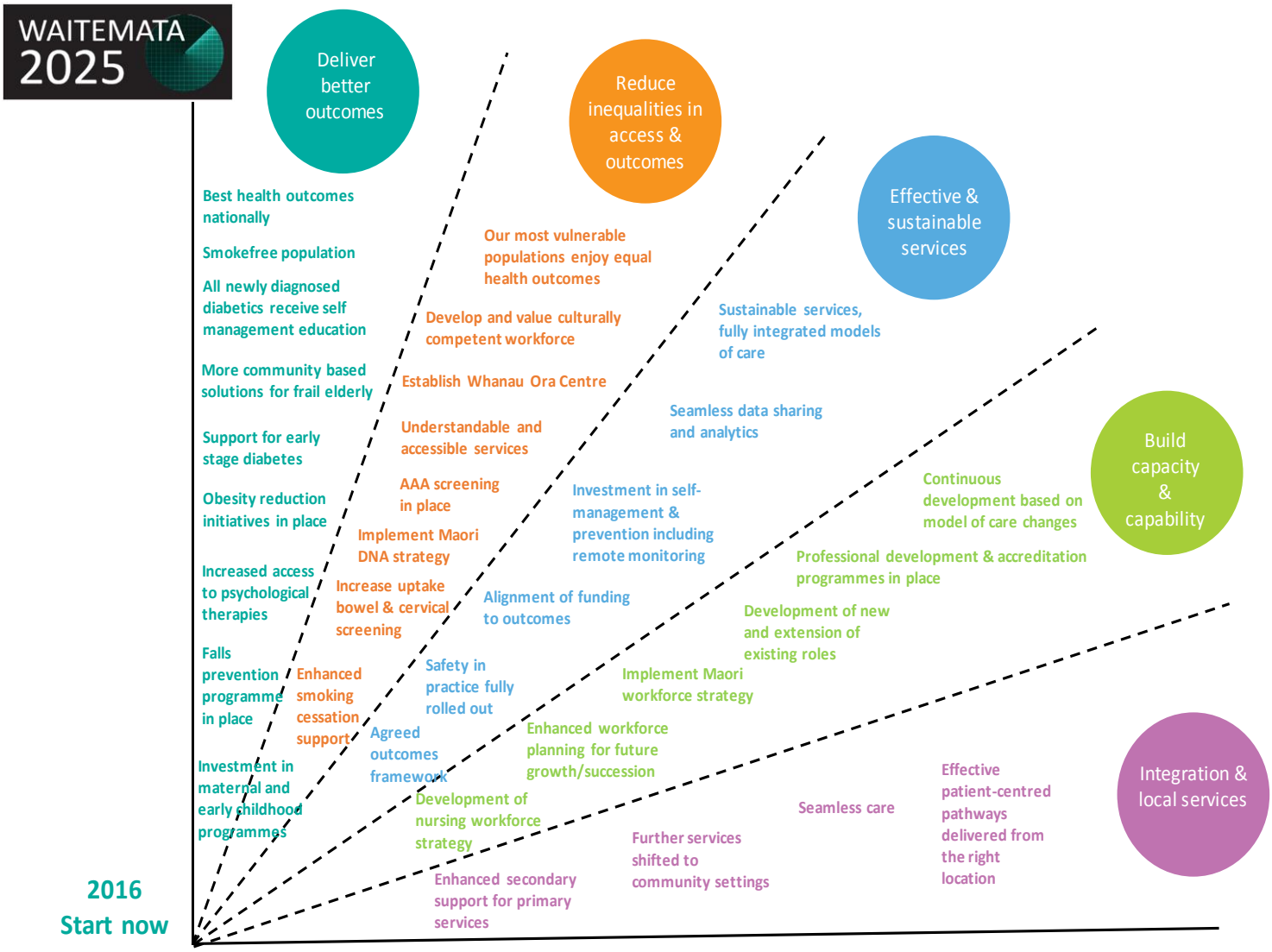
Facilities – identify principles to support facilities development

5. Integrated and Local Services

Well organised collaboration between primary and community services, with multidisciplinary teams working together to optimise patient care, experience and outcomes will help us to have a real impact in our priority areas. Services that are co-ordinated and integrated and that remove and minimise organisational boundaries, should be a central feature for future services. Services should be well placed to deliver high quality care in community settings, with hospitals reserved for more intensive specialist and acute services. This means identifying what we stop doing in hospital settings and what would make most sense to be delivered from primary and community settings with support and advice from secondary specialists (eg through the use of virtual clinics). Getting this right will ensure we can make the best use of our collective resources.

Roadmap to 2025

The diagram below summarises some of the key initiatives and changes that we expect to see through the implementation of the PCSP. These are also set out in the action plan on the following page and described in more detail in section 3.



Investment in Primary and Community Services

In order to achieve our aspirations for Waitemata 2025 the DHB is committed to investing in effective, evidence based interventions that improve outcomes and patient experience and builds the capacity and capability to meet the needs of our growing population. Support for and investment in change management will be included as part of individual business cases. The DHB expects to accelerate this investment over time.

Ongoing financial sustainability is critical if we are to achieve this. We are committed to increasing the transparency of the money invested and the outcomes that are delivered and are working with the District Alliance to achieve this. We are also working with other public sector agencies (such as MSD and ACC) and partners to develop innovative responses that deliver broader social and economic benefits.

Initial areas for investment in primary and community services in relation to the priority areas set out in this plan are shown in the table below. There may also be additional investment required to support the System Level Measures Improvement Plan that will be submitted to the MOH in October. The table identifies those areas

where funding has already been approved by the DHB or is in the process of being approved. Any new investment would need to follow usual DHB processes.

Planned investment in primary and community services	Funding Identified/ Approved	Funding not yet Identified / Approved	Total
1. Better Outcomes			
Healthy Lifestyles (STEP, mental health)		750,000	750,000
Early Years (parenting, living without violence)		500,000	500,000
CDM (CVD and diabetes, early diabetes support, retinal screening)		2,000,000	2,000,000
STEP Initiative Stroke(MSD funded)	690,000		690,000
MH (primary mental health)	1,400,000	1,000,000	2,400,000
Healthy Aging (CARE, cognitive impairment)	1,400,000	1,000,000	2,400,000
2. Reducing Inequalities			
Maori Health (Whanau Ora, AAA screening, workforce)	172,000	500,000	672,000
Pacific Health	72,500	100,000	172,500
STEP Initiative Prisoner Health (MSD funded)		500,000	500,000
3. Effective and Sustainable Services			
Quality Improvement (Safety In Practice)	154,000		154,000
Clinical Leader Quality Improvement	250,000		250,000
4. Capacity and Capability			
Workforce Development (nursing, clinical skills programme)		500,000	500,000
New Business Models (healthcare home, best care for life etc)		500,000	500,000
Leapfrog	500,000		500,000
5. Integrated and Local Services			
POAC	992,000		992,000
Rural Alliance (community ultrasound and radiology)	650,000		650,000
New models of care (falls prevention, avoidable admissions)	1,000,000	500,000	1,500,000
6. Infrastructure			
Whanau Ora Centre		500,000	500,000
Programme Management		500,000	500,000
Total	**7,654,500**	**8,850,000**	**16,534,500**

Leading and Managing Change

This plan outlines a programme of transformational change across primary and community services. This will be supported by strong leadership, a change management approach, and significant new investment within primary and community services as outlined above. Implementation of the plan will be overseen by the CEOs of Waitemata DHB, ProCare and Waitemata PHOs supported by a governance group. A number of the initiatives outlined in the plan such as the health care home / best care for life programmes or Safety in Practice are

fundamentally focused on implementing a change management approach. Other initiatives such as the CARE programme or diabetes and CVD management explicitly incorporate a change management approach within the overall programmes. In addition while individual initiatives may be focused on a particular population group or disease area it is expected that the skills, expertise and approach will be applicable and transferrable to other population groups and disease areas.

Where to next?

There is a significant amount of work required to ensure successful delivery of Waitemata 2025. We need to accelerate progress in those areas already underway and make bolder, faster decisions about new initiatives, adopting a bias for action and a real drive to effect change. This will require further investment and additional programme management support. Some of the key next steps required to deliver upon the PCSP are described below:

1. **Refinement and management of the PCSP:** In order to ensure that this plan is validated and operates as a living document moving forward, forums to enable ongoing consultation/collaboration from community groups (WDHB, Primary Health Networks, ProCare, Waitemata PHO, General Practice, NGOs and other providers, Patient etc.) will need to be established and held. This will likely include regional stakeholders so that there is broader communication occurring.
2. **Integration of the HSP and PCSP:** Both the Health Services Plan (the plan for DHB provided services) and the PCSP provide insight into the future of specific aspects of the WDHB 2025 vision. To ensure effective implementation of both of these plans, there is a need to ensure that the plans are integrated, with initiatives delivered under each plan being complementary, assisting the achievement of health outcomes for the district's population. Detailed investigation into how primary and secondary care will work together will also need to be addressed
3. **Setting up Programmes of Initiatives:**

    I. **Prioritisation and acceleration of initiatives:** The PCSP process has identified a large number of potential initiatives, particularly in the immediate term. Therefore, a prioritisation process will need to be undertaken in order to ensure that the DHB and its partners are investing in the initiatives that are most likely to provide significant gains against the desired outcomes in the short term

    II. **Detailed planning/Business Case of prioritised initiatives:** In order to ensure that the 10 year vision is met, detailed planning will need to be conducted on the prioritised initiatives so that the DHB and its partners can deliver this long term view. These are likely to be grouped into programmes of work and will need to be put through a Business Case process where large investment is required. A timetable for initial business cases is shown in the table below.

Business Case	Board Meeting
MH (primary mental health)	June 2016
STEP programme (Stroke rehab, prisoner health, serious mental illness)	June 2016
POAC	October 2016
Rural Alliance	October 2016
AAA Screening	November 2016
CVD and diabetes	2017
Whanau ora	2017
Workforce development	2017

III. **Process for incorporating new initiatives:** Through the continuous development of the CSP, WDHB is likely to identify additional areas of high need that are not addressed by one of the current initiatives. These will be developed as part of the usual processes

IV. **Adopting a programme management approach:** Ensuring that sufficient resources are in place to design and implement the changes set out in the PCSP.

Beyond these key next steps, there is a need to continually review and update this CSP as WDHB steps closer to 2025.

Introduction

Objectives of this Primary and Community Services Plan (PCSP)

The document presents the Waitemata Primary and Community Services Plan (PCSP) for the next 10 years, and builds upon the WDHB Health Services Plan (HSP). The HSP set the overall direction for health services for the next ten years to 2025 and specified a course of action to deliver WDHBs promise, purpose, priorities and values, and was developed prior to this PCSP. This PCSP identifies the key challenges we need to focus on between now and 2025, where we need to have a real impact and focus on change. It identifies opportunities to work together to improve our performance and sets out a clear plan to respond to these. The focus of the plan is on services in the community including:

- Primary Care (Including; PHOs, general practice, pharmacy, labs etc.)
- Mental Health
- Aged Residential Care
- End of Life (Including Hospice)
- Whānau Ora services
- Children's Health
- NGO provided community services

This PCSP builds upon the prior work done within the HSP and has a focus on;

- Planning and responding to the future growth of community services towards 2025
- Identifying ways to improve patient experience and outcomes for the WDHB population
- Identifying opportunities to better integrate primary and secondary services
    - Supporting accelerated change in an environment that is traditionally slow to respond
    - Implementing sustainable solutions – both operational and financial

The solutions to meet our key challenges are complex and reach beyond health and health care alone. Increasingly the way we work with other agencies and organisations will be key in tackling the multi-faceted determinants of health and wellbeing. This Plan does not attempt to address this, but considers the interface between primary and secondary care[1] as well as primary and community services themselves – within this wider context. It also considers integration with hospital services.

This PCSP has been developed in a collaborative manner with a variety of parties within the WDHB environment. The plan has been jointly sponsored by the DHB CEO and the CEOs of the 2 PHOs in Waitemata – PROCARE and Waitemata PHO. There has also been involvement of community and primary care clinical leaders, NGOs and WDHB providers and consumers.

The timeframe to develop this PCSP was relatively short – approximately 4-5 months; however this plan has incorporated a lot of the prior planning and strategic work already conducted by the community services. This PCSP is to be continually refined and tested on a rolling annual basis so that it can continue to stay relevant and so that feedback from additional stakeholders can be incorporated into this Plan in the future.

The objective of the PCSP is not only to articulate a strategy and plan but to initiate a continuous process of engaging with Community Services and providers. The PCSP has been developed with input from 5 service level workshops, which were attended by a variety of key stakeholders and included representatives from a variety of the NGOs and PHOs in Waitemata.

[1] Primary health care relates to the professional health care received in the community, usually from a GP or practice nurse [Ministry of Health]. Community care is viewed as being broader and includes primary and secondary care, along with other providers, with this care being delivered in a community based setting

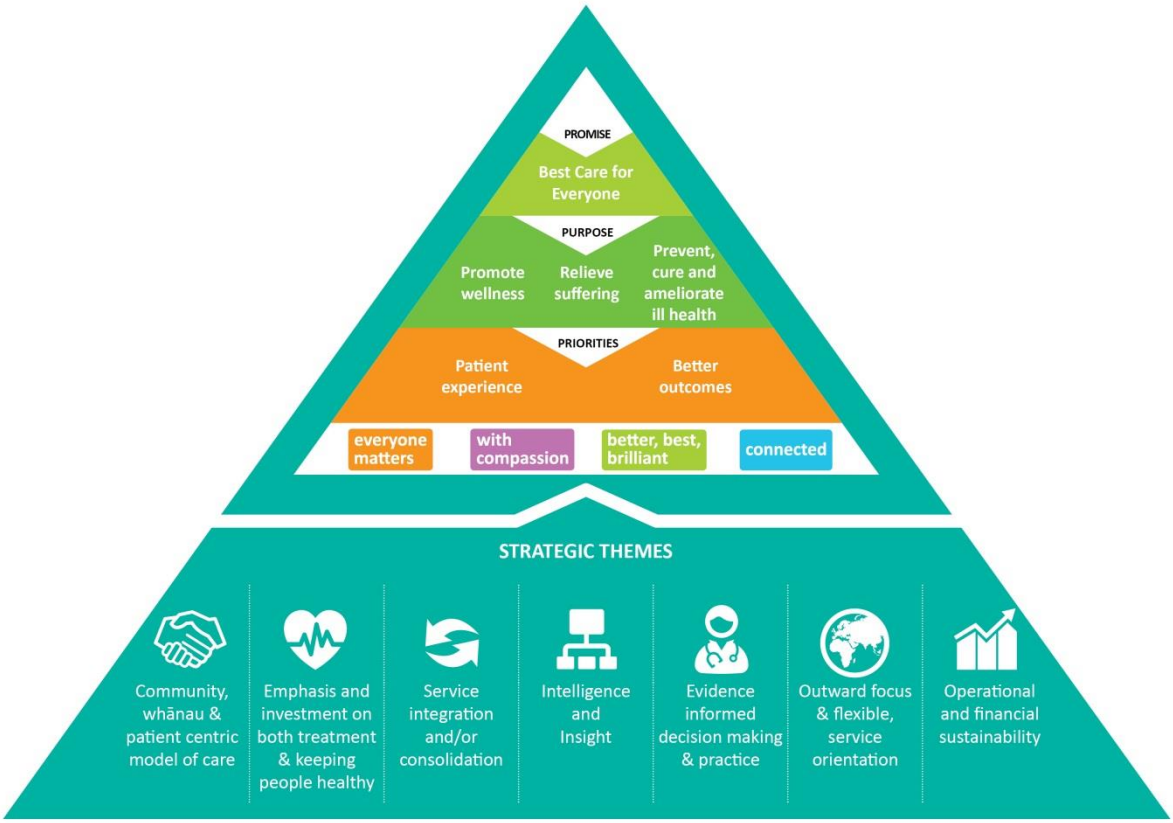
It is noted that this plan will need to be integrated with the HSP in order to create one cohesive plan for WDHB moving forward and has been recommended under the next steps. Additionally, it has not been possible to develop a fully costed plan in the time available and given some of the uncertainties involved some of the financial impacts would be difficult to determine with any confidence. A large amount of work will be required to deliver upon this PCSP and a detailed implementation plan will need to be undertaken along with a change management support structure.

Strategic Direction and Context

The PCSP has been developed in the context of WDHB's strategic direction, the principles agreed by the district alliance, and the recently revised NZ Health Strategy. These are described in more detail below.

WDHB's promise, purpose, priorities and values (shown in the diagram below) are the foundation for all we do as an organisation and have shaped the development of this plan.

WDHB's Strategic Direction – 'Best care for Everyone' and our '7 Strategic Themes'



Strategic Themes

In addition to our promise, purpose, priorities and values, we have identified seven strategic themes. In developing the PCSP, the following seven WDHB Board strategic themes have guided the choices proposed by this Plan:

1. **Community, whānau and patient-centred model of care:** Patients, whānau and our community are at the centre of our health system. We want to see people taking greater control of their health, active partners in their care, and accessing relevant information when they need it
2. **Emphasis and investment on treatment and keeping people healthy:** We are investing in our people, services and facilities across the spectrum of care from prevention, through to treatment and rehabilitation to ensure that they are fit for purpose and delivering the best outcomes

3. **Service integration and/or consolidation:** We need to work collaboratively to ensure that services are delivered by the best provider in the right place to get the best outcomes and patient experience
4. **Intelligence and insight:** The dynamic use of data and information will improve clinical decision making and develop more complete patient and population health insights
5. **Evidence informed decision making and practice:** Our commitment to delivering safe and high quality care is an integral part of our culture. Evidence from research, clinical expertise, patient and whānau preferences and other available resources drive the decisions that we make and the services we provide
6. **Outward focus and flexible, service orientation:** Our purpose, priorities and values require us to develop an organisation-wide culture that puts patient first and is relentless in the pursuit of fundamental standards of care
7. **Operational and financial sustainability:** Operational and financial sustainability is critical to our ability to deliver on our organisational promise and purpose.

Alliance principles

The plan has also been shaped by the principles of our District Alliance, particularly the following:

- We will support clinical governance and leadership and, in particular, clinically-led service development
- We will adopt a patient-centred, whole-of-system approach, and make decisions on a Best for System basis
- We will promote an environment of high quality, performance and accountability, and low bureaucracy
- We will seek to make the best use of finite resources in planning and delivering health services to achieve improved health outcomes for our populations
- We will adopt and foster an open and transparent approach to sharing information
- We will remain flexible and responsive to support an evolving health environment
- We will develop, encourage and reward innovation and challenge our status quo

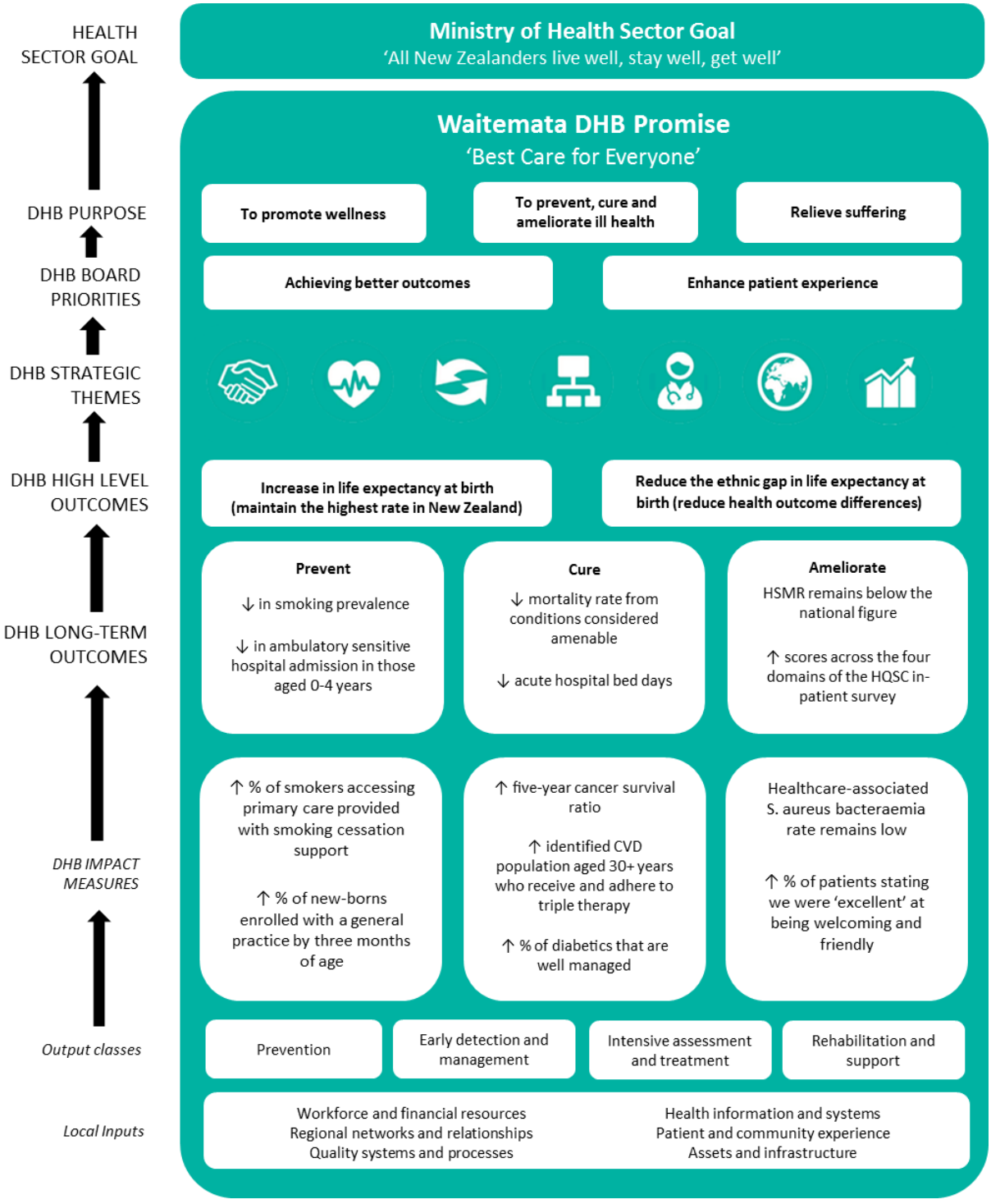
New Zealand Health Strategy 'Strategic Themes'

Lastly, in order to ensure that this Plan is sustainable and in line with national aspirations, this Plan has been aligned to the NZ Health Strategy and its five strategic themes shown below:

The PCSP is aligned to the NZ Health strategy and will seek to leverage the initiatives the Ministry have underway to deliver the above goals.

Intervention and Outcomes Framework

The intervention logic and outcomes framework for Waitemata DHB summarises the key national and local priorities that inform our planning and demonstrates our commitment to an outcome-based approach to measuring performance, including the key measures we monitor to ensure that we are achieving our objectives. Our outcomes framework enables the DHB to ensure it is achieving its purpose and delivering the best possible outcomes across the whole system for our population. The outcomes framework incorporates the new System Level Measures. It is expected that this will be refined further through discussion with the Alliance and other stakeholders.



Methodology and process

Data and research

A Community Services Planning process was conducted over a three month period comprising a review of relevant international and national research and data, relevant policy and strategy, and engagement with key service providers and senior management within WDHB, Waitemata PHO, and ProCare. In addition to this, initial community engagement was undertaken.

A variety of data, including activity-based, population, FTE and financial was sourced from WDHB, Ministry of Health, Statistics NZ and external sources.

Process and Structure

This PCSP has been structured into four sections of work, which are detailed below:

- **Section 1 - Current state definition and overview:** Available data is used to describe the current state of WDHB's population demographics and community service delivery in WDHB – including service provision, metrics, and current initiatives
- **Section 2 - Identification of challenges and opportunities to 2025:** Challenges are identified at two levels – at the WDHB community level (mega-trends which impact all community health systems) and the service specific level. Challenges are identified through analysis of available data and through workshops with WDHB senior management and service providers
- **Section 3 - Definition of strategy and direction to 2025:** This section of work articulates the desired future aspiration for community services at WDHB. This aims to provide overall direction to guide the development of activity and articulates a view of what the health care system will be like by 2025, with a focus on the community system. This direction was developed with the help of the PCSP Governance Group and takes into account mega-trends, policy, and service level feedback and aspirations. It represents a directional view and will need to be frequently visited in order for this to be real and to represent a relevant and shared end state across the district.
- **Section 4 - Roadmap, impacts, and next steps:** Potential actions within the planning period which have been designed to lead the community health service closer to the desired Waitemata 2025 in a manner which is aligned with the core principles and values. Additionally, there is commentary around what some of the impacts could be under this new system, and a set of recommended next steps

This PCSP is another facet of preparing a health system that is fitter for the future. As such, an agile PCSP should seek to delay large scale commitments as long as possible, while seeking to enhance future options through an agile and iterative development cycle. This principle has led to the development of time horizons for the PCSP, with higher certainty and granularity in the immediate term (0-3 years) and directional milestones to achieve the desired end state in 2025 beyond this.

This Plan should be reinforced by regular review and revalidation of direction as Waitemata moves towards 2025.

Section 1: Current State and Challenges

This Section identifies the key challenges that the PCSP seeks to consider and address over the next 10 years, including: population composition and health, growth in demand, financial constraints, and WDHB wide service delivery challenges. A range of service specific challenges derived from the workshops are outlined in Section 3. Further detail is provided in Appendices 4-7.

Population

WDHB contains approximately 600,000 people making it the largest population of all New Zealand's DHBs. The district is ethnically diverse with 10% Māori, 7% Pacific, 20% Asian and 63% European/Other. Nearly one in three of our population was born overseas and 20% of our overseas-born population have lived in New Zealand for less than five years.

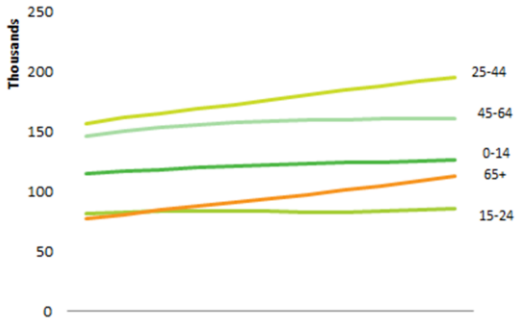
Eight per cent of our total population and 11% of children under five years live in the poorest areas (NZDep13 decile 9 and 10). Māori and Pacific are less likely to live in NZDep13 Quintile 1 and 2 (least deprived) areas, with 40% and 25% versus 58% of European/Others living in the least deprived areas.

The make-up of the population varies considerably across the DHB. One in three of our Māori population and almost one in two of our Pacific population reside in Henderson-Massey board. Henderson-Massey, Whau and Waitakere Ranges boards have respectively 23%, 17% and 10% of their population living in areas with higher levels of deprivation, compared with 5% or less in the other boards.

Growing, ageing and diversifying population

The DHB's population will grow by 18% by 2025, adding 106,000 people. The number aged 75+ will grow by 65% to 53,000. The ethnic mix will also change and we project that one in four of our population will be Asian in ten years' time.

Population growth by age group 2015-2025



Boards with Special Housing Areas are projected to grow in population faster than others. Over 38% of the total growth in the district (39,000 individuals) is projected to occur within ten suburbs.

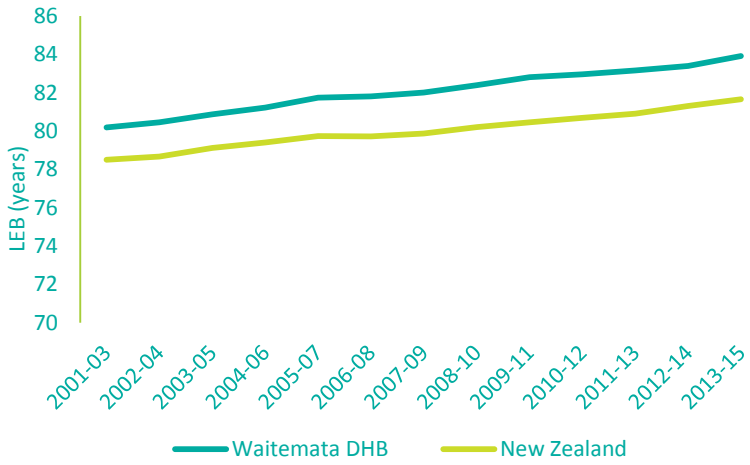
Suburbs with the largest projected growth 2015-2025

Suburb	Number	% of total WDHB growth
Whenuapai West	6,830	6.7%
Hobsonville East	6,750	6.6%
Albany	5,540	5.4%
New Lynn	5,400	5.3%
Silverdale Central	3,920	3.8%
Huapai	2,850	2.8%
Long Bay	2,380	2.3%
Sturges North	2,130	2.1%
Orewa	1,800	1.8%
Takapuna Central	1,790	1.7%

Health Needs

Overall our population enjoys very good health. Waitemata DHB has the highest life expectancy in the country at 83.9 years, 2.2 years higher than the national figure. Most (92%) of our population rate their health as excellent, very good or good. Mortality rates from CVD and Cancer are some of the lowest in the country and infant mortality rate is the lowest in the country (2.3 per 1000 live births compared with the national rate of 5.2 per 1,000 live births).

Life expectancy at birth WDHB vs NZ



In 2013 there were 444 amenable deaths among WDHB residents, comprising 16% of all deaths, and 44% of deaths under 75 years of age. Cancer deaths make up 48% of amendable deaths, and a further 18% are caused by CVD.

Mental ill-health affects one in five people each year, including 2.1% of people who have an intellectual disability. Severe mental illness is associated with a 10 year reduction in life expectancy and intellectual disability with an 18-23 year reduction in life expectancy. Around 6,500 older people have dementia and this is projected to increase to nearly 10,000 by 2025.

Around one in five (19%) of people have a disability, with half of these having multiple impairments; 27% of these disabilities are caused by ageing. People with disabilities are more likely to rate their health as poor (29% vs 4% of non-disabled people.

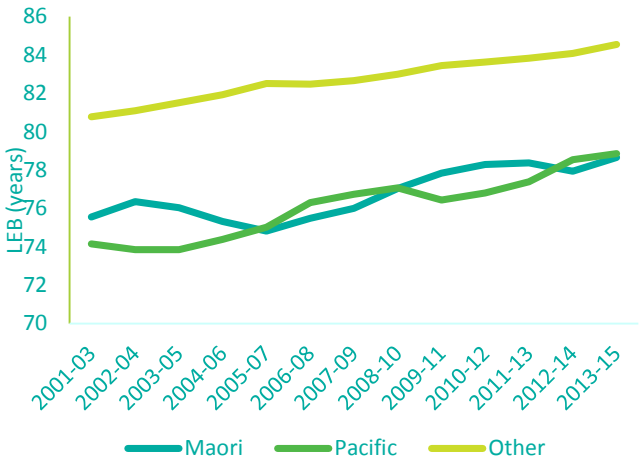
Lifestyle factors

Smoking rates (12% overall) are declining rapidly amongst all ethnicities but remain higher in our Māori (27%) and Pacific (20%) populations. One in four adults are obese and over half are overweight, with little change in the past ten years. The rate of childhood obesity in our Māori (10%) and Pacific (22%) population is higher than for other ethnicities (5%). Approximately half of WDHB's population is meeting daily exercise recommendations and 55% are meeting the daily fruit and vegetable consumption guidelines. One in six adults drinks alcohol in a way that is classified as hazardous.

Health Inequalities

Our Māori and Pacific populations have higher health outcomes than other DHBs but poorer health outcomes than our European and Other population within our district. Māori and Pacific people have a lower life expectancy compared with other ethnicities, with a gap of 5.9 years for Māori and 5.7 years for Pacific. Cardiovascular disease and cancers account for around 3.1 years of the life expectancy gap in Māori, and around 3.7 years of the gap in Pacific. Overall, Māori and Pacific people are 2-3 times more likely to die of avoidable causes, with age-standardised rates of avoidable mortality per 100,000 population of 300 (Maori) and 297 (Pacific), compared with 121 (European Other).

WDHB life expectancy gap Māori and Pacific



There is a 50% variation in the rates of mortality from CVD and Cancer between local board areas. Henderson-Massey and Whau have poor health outcomes with shorter life expectancy and higher rates of avoidable hospitalisation.

Service provision and utilisation

Waitemata DHB contracts with a wide range of providers in the community. These include PHOs, ARRC providers, NGOs and private contractors such as GPs and dentists. We spend around $360m per year on these services, 22% of our budget. This excludes expenditure on community services provided directly by the DHB itself.

Summary of service areas and contracts

Service area	Providers
HOP - ARRC, LTSCHC	60 ARRC facilities
HOP - HBSS	6 household management services, 10 person care services
Māori Health	Whānau Ora and other services
Mental Health	NGOs
Oral Health	107 practices for <18 care
Pacific health	NGOs
Pharmacy	122 pharmacies
Primary Care Services	104 practices
Women, Child and Youth	3 maternity units, 2 fertility services, WTCO providers, school/youth MH services

Summary of growth needs

The following table summarises the current situation and projected growth in demand/capacity across a number of primary and community services. These projections attempt to take account of population growth and ageing and known service trends but assume that models of care are unchanged. However we do expect change, for example we expect that an increasing range of tasks and responsibilities will be assigned to nurses rather than to doctors, which will change the mix of staff required in future from this simplistic projection. Furthermore we have projected that the numbers of GP practices and community pharmacies will not grow, based on an assumption that some of these will expand their staffing levels.

Area	Service	Waitemata Current	Additional requirement in 2025	% change	Average people per unit of service
Primary care	GPs	434	95	22%	1,333
	- lift to NZ average		144	33%	1190
	Practices	104	0	0	
	Practice nurses	420	92	22%	1,388
	increased range of duties			*??*	
	Pharmacies	122	0	0	4,779
	DHB District Nurse contacts 000s	88	35	39%	6,500
Children's Services	Lead Maternity Carers	335	50	15%	23 (births)
	Auckland Regional Dental Service				
	Hub clinics	64			
	Mobile van locations	72			
	Dentists contracted for young people's services	107			

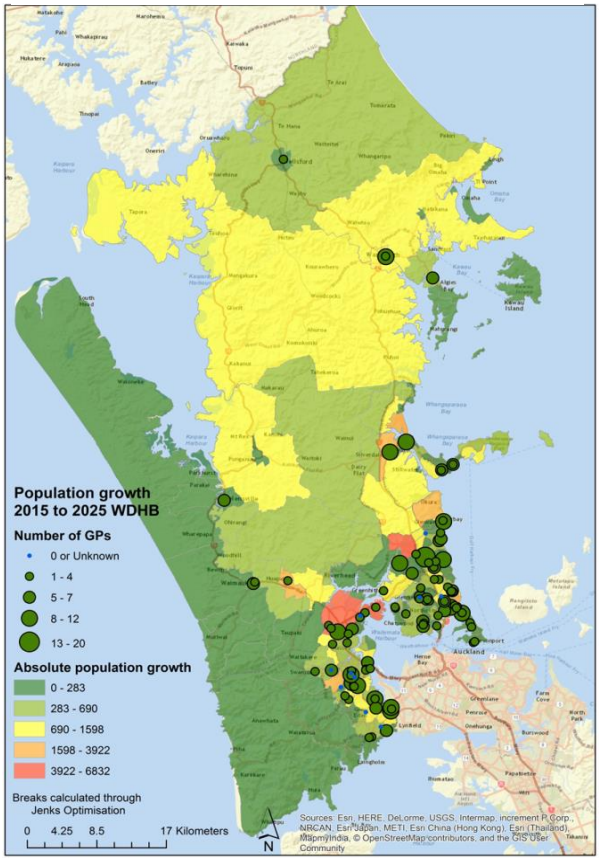
Area	Service	Waitemata Current	Additional requirement in 2025	% change	Average people per unit of service
Mental Health	Mental Health DHB community FTE NGO beds – WDHB Regional FTE – WDHB and Regional	 115 48 156	 18	 16%	 3,721
Older People	ARC beds occupied *Current trends* *Lift to NZ average*	2,836	1,654 1,571 1,803	58% 55% 64%	26 25
	HBSS (000 hrs): Personal care Household mgt *(increase is slower than pop'n growth)*	 781 203	 258 67	 33% 33%	 98.7 379.7
	Hospice contacts beds	 19,000 19.6		 28-34	

Primary care

Waitemata has fewer GPs than the average (75 per 100,000 population vs 84 nationally).There are 22 Very Low Cost Access (VLCA) GP clinics, located in areas with higher levels of deprivation (NZDep 7-10). The population per GP varies more than two-fold across the DHB. Comparing the projected areas of growth with the location of current GP practices suggests that the areas with the greatest projected population increase (predominantly special housing areas) may be underserved in the future.

While we have high rates of enrolment with GPs (96%) and of annual consultation (76%), 17% of our residents report difficulty accessing GP care due to cost, availability or transport. The proportion is higher for Māori (30%) and Pacific (32%). One in eight adults has a community services card (CSC). For adults without a CSC, just over one in four are enrolled with VLCA GPs who charge $18 or less. One in five (21%) are enrolled with GPs charging $50 or more. Amongst adults with a CSC, 45% are enrolled with VLCA practices and 10% are enrolled with GPs charging $50 or more.

GP practices and practice size and population growth



Primary care delivers very well on the Health Targets including brief advice to quit smoking, CVD risk assessment and immunisation. However, there are areas, particularly in the management of chronic disease, where improvement has the potential to bring about significant gains in population health status.

Currently 54% of our CVD population receive triple therapy (target 70%) and 28% of smokers receive cessation support. Only half of our people with diabetes are having an annual review. Seven in ten diabetics having their annual review are known to be managing their diabetes well, but this is lower for Māori (63%) and Pacific (60%).

The medical workforce overall is ageing. The General Medical Council (GMC) workforce survey reported that from 2011, the largest group is doctors aged 50–54. Comparing this with the data from 1980 and 1990 when the

largest group of doctors were aged 25–29 and 30–34 respectively, the average age of the current medical workforce is higher than it used to be, and this trend is continuing. However, over the whole country the number of GPs working in general practices increased by 19% between 2013 and 2014.

Primary care nursing

Approximately one in four of our population report seeing a practice nurse without seeing a GP during a clinic visit. This is lower than the national figure of one in three (NZ Health Survey). Primary care nurses have begun to take on responsibility for a wider range of activities such as managing warfarin dose, thus freeing up GPs. This trend is expected to continue and the services provided by practice nurses are expected to increase.

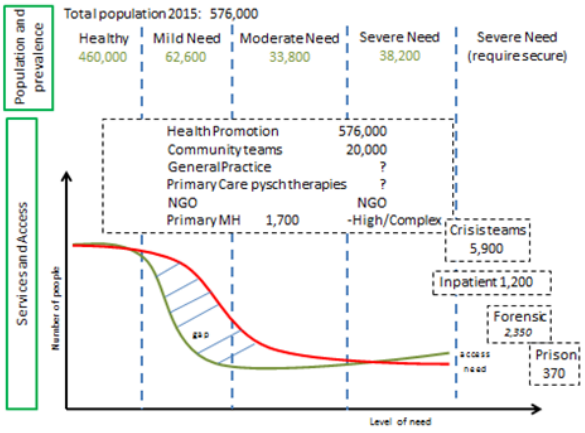
Community pharmacies

The DHB spends 8% of its budget on community pharmacies (including drug costs). Over one in ten (12%) of Māori and 11% of Pacific adults report that cost has prevented them from filling a prescription. Around 2,000 people have a high user card.

Mental Health Services

Mental ill-health and addiction problems affect around one in five residents (133,000) each year. A study in 2001[2] found that GPs identified a mental health component in around 21% of consultations and recognised that 17% of their patients had a mild, moderate or severe psychological disorder. The DHB-funded primary mental health and addiction (MHA) services are delivered by teams employed by PHOs and are targeted at high needs patients. The DHB also funds extended consultations with GPs and practice nurses.

Mental Health access and need



NGOs

The DHB funds a number of NGOs to provide mental health services, including 166 beds and approximately 156 FTE, although 48 of these beds and a proportion of the FTE serve the whole Northern region, providing alcohol and other drug (AOD) and forensic services. Clients using these beds often stay for more than a year. In part this reflects the long-term nature of mental ill-health for some people.

AOD services are delivered mainly from DHB-provided community based services or NGOs. Around 42% of all clients accessing AOD are aged 20-64 years. The proportion of 0-19 year olds who are AOD clients (of all 0-19 year olds accessing both AOD and other mental health services) has increased over the past three years from 12% to 19%. In the 12-19 year age group, AOD clients accessing both NGO and DHB services have not changed much over time, except for Māori where this type of access has risen from 23% to 28%.

Children's services

Overall, outcomes and performance for children's services are good. However, Māori and Pacific children do worse than European and Other ethnicities on many key indicators.

Three out of four children visit a GP in any 12 month period.

[2] Bushnell,J et al, 2001, Psychological problems in New Zealand primary health care: A report on the pilot phase of the Mental health and General Practice Investigation (MaGPIe), NZ Medical Journal 114, 11-13,

Lead Maternity Carers (LMCs)

Ninety-five per cent of women giving birth in WDHB register with a private LMC and 65% register in the first trimester. There are three primary birthing facilities in WDHB, all in Rodney board. These facilities provide after-care for many more women who deliver in Waitakere and North Shore. The DHB is currently consulting the public on the need for primary birthing facilities located in Waitakere and the North Shore.

Well Child/Tamariki Ora

Just over two-thirds (68%) of new-borns are enrolled with a general practice by three months of age, one of the lowest enrolment rates in the country. Only 47% of Māori and 52% of Pacific children are referred to WCTO within 28 days of birth compared with 71% of Asian and 61% of European children. Similarly, only 72% of Māori and Pacific children receive their first three core checks within 134 days from birth, compared with 89% of Asian and 87% of European children. At a community board level, Rodney has the lowest percentage of children referred to WCTO within 28 days at 54% and the lowest percentage of three core check completeness at 74%. Mothers in poorer areas are less likely to be breast-feeding their children at three months.

Rates of immunisation are relatively high with 93% of children fully immunised by 8 months of age (target 95%). Ninety-four percent of 4-year-olds receive a Before School check. For older children, the DHB provides 8.9FTE school nurses in 6 schools, covering two-thirds of secondary school children from the most deprived areas.

Children's dental services

Among pre-school children, 84% are enrolled with DHB-funded oral health services, against a target of 86%. This figure is much lower for Māori (67%) and Pacific children (73%). Five year olds have an average of 4 decayed, missing or filled teeth (dmft), but again Māori and Pacific children fare worse, with 4.3 and 4.8 dmft respectively.

Community Services for Older People

Age-Related Residential Care

We have seen a steady decline in the percentage of our 65+ years population receiving funded HBSS (9.0% in 2010 to 7.0% in 2015) and a stable proportion (3.6%) living in age-related residential care (ARRC). Based on past trends and other factors, the rate of demand for rest home beds is likely to decline, while the rate of demand for hospital beds and dementia care beds will rise. The net effect is projected to result in a similar rate of demand overall in future, but a different mix of beds. As of May 2016, 634 additional beds were planned to come online before mid-2018. This leaves a shortfall of 937 beds if no more come online before 2025.

Home-based support services

Delivery of home-based support services to people aged over 65 reduced by 48% over the five years to 2014/15. All the decrease was in hours of household management, while the hours of personal care remained about the same. Similarly, looking at the access rate in terms of client numbers, the access for those aged under 80 years has decreased over the past five years, while access for those aged 80+ has increased.

Palliative care

The Palliative Care Council estimates that almost two in three (62%) of those who die can benefit from palliative care at the end of their life (National Health Needs Assessment for Palliative Care, Phase 1 Report: Assessment of palliative care need, 2011). Hospice services provide 19.6 beds and 19,000 contacts annually, but 13% of patients referred acutely for hospice admission waited more than 48 hours for a bed.

Many hospital staff are now trained to assist patients to discuss, with their whānau and their doctors, what constitutes a worth-while life for them. This can include the level and timing of interventions that they want at the end of their life, and the setting for care. An Advance Care Plan records these preferences and provides guidance for services looking after the patient.

Hospital services

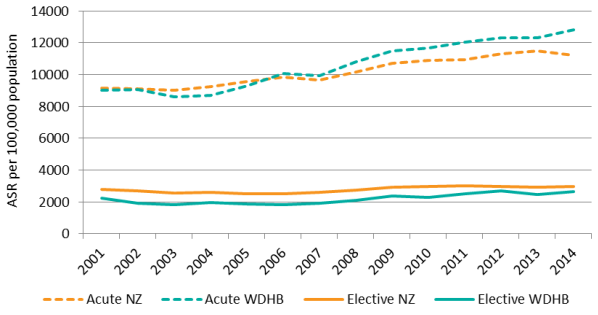
Our hospitals perform well across health and quality safety markers; surgical mortality rates are declining and cardiac performance is improving, including direct access to cardiac catheter lab.

Between 2001 and 2014, acute admissions for Waitemata DHB residents have grown faster than the rest of the country. Acute bed-days per capita are falling, although still 4.9% higher than the national average. Age-standardised attendance rates at emergency departments increased by 2.5% in 2015/16 compared with the previous year, after remaining stable for the previous four years. Conversely, the rate of elective service delivery, though increasing, is lower than the national average. The ambulatory-sensitive hospitalisation (ASH) rate is above the NZ average for adults 45-64 (4,227 vs 3,808 per 100,000) but below average for 0-4 year olds (5,273 vs 6,816 per 100,000). Rates of hospital admission vary two- fold across practices and localities.

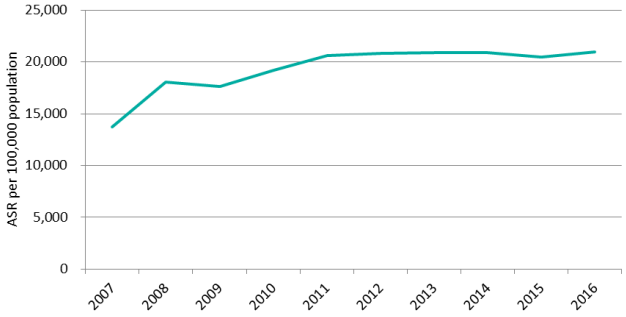
People aged 65 years and over use around 45% of medical/surgical bed days. As this group increases from 13.5% of the population now to 16.7% in ten years' time, we can expect demand for beds to increase rapidly. In 2015, 16% of hospital bed days in WDHB were used by patients in their last year of life (*Source: WDHB data warehouse*).

Length of stay in Waitemata hospitals is high. If national length of stay were used as a benchmark, up to 55 beds could be released. The average length of stay in AT&R beds has increased by 0.7 days per year and is now 4 days longer than in 2010. Efforts to reduce length of stay need to focus on evidenced based initiatives that show length of stay can be reduced without impacting on health outcomes. Given Waitemata has such high health outcomes in some cases, it may be that length of stay is not the best metric to measure effectiveness and efficiency of care.

Demand for acute hospital services is increasing

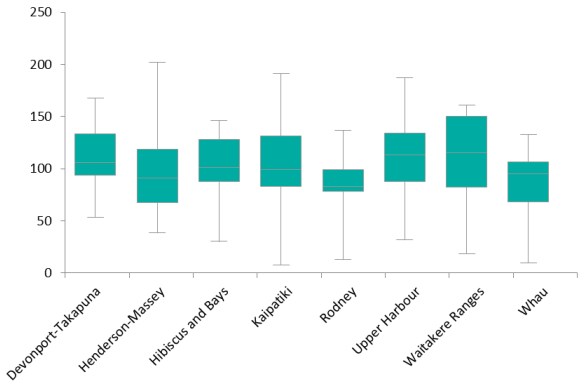


Rates of ED attendance are increasing but more slowly

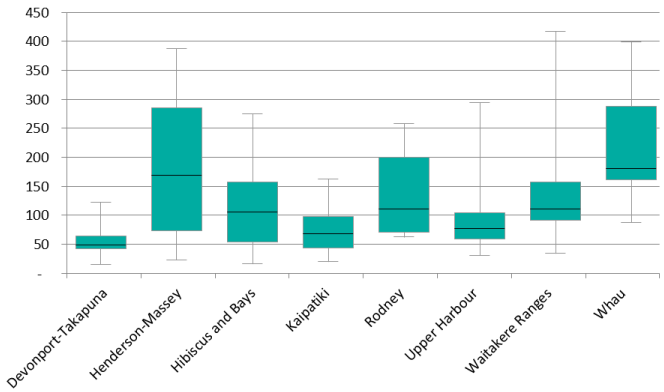


Acute admissions per head vary across local boards and by practice.

Standardised rate of acute admissions by community board and practice, 2012/13



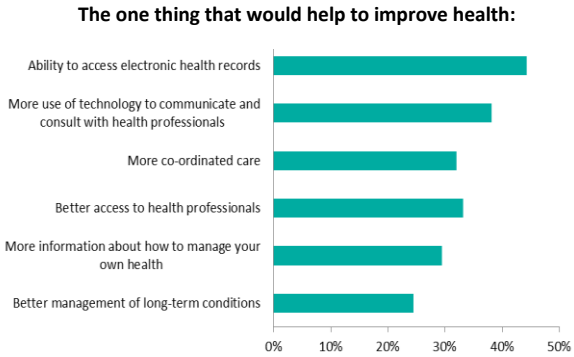
Number of ASH admissions per practice in each community board 2012/13



Community Views

We used an online survey to seek our community's views in the development of the plan. The survey focussed on the use of services, barriers to access; opportunities for improving individual and family/whānau health; DHB focus areas; and the use of digital technology. Three hundred individuals participated.

Accessibility



Three key messages from respondents were:

- Cost of appointments is a barrier
- Waiting time for appointments can be long
- More out-of-hours services are needed

Nearly half of responders (47%) said that cost prevented them from using healthcare when they needed it, particularly dental services. The 'inability to make an appointment at a suitable time' was also a strong theme (37%) and 29% stated 'they were too busy with work or family commitments'. A number of respondents commented on the length of time they had to wait to obtain an appointment with their regular GP, in some cases between three and seven days. Others stated that there was a shortage of clinics that operated out of normal working hours.

What should Waitemata DHB focus on to improve health services for the Waitemata community?

Respondents wanted the DHB to address the issues above, and also to develop more services outside of hospital (42%). They also wanted DHB to play a more active role in promoting healthy lifestyles. Growing and developing the health workforce was also suggested as focus area.

Respondents expressed concern about the rapid population growth in Rodney and the ability of the services in the region to cope with the growth. Residents from the north also noted that many services take place at the hospital and travel can be difficult.

Use of digital tools and technology

Seven out of ten respondents (70%) said they were very likely to use digital technology to access health records and 65% were very likely to book appointments. Respondents said they would also be very likely to use technology to remind them of appointments (55%) and for accessing health information (61%).

Respondents were least likely to use digital technology to communicate online with their health care provider. They preferred a face to face contact and there were concerns with the potential for miscommunication. Other comments were that technology would make it easier to share with others involved with an individual's care. Some respondents raised concerns regarding mobile phone and internet coverage, particularly in rural areas.

Section 2: Our Key Challenges and Opportunities to 2025

This section describes the opportunities for change required to respond to the main challenges we face. We need to focus on working towards better outcomes for our population while ensuring we have the right infrastructure and supports in place to make sure we can accomplish our goals.

WDHB key health challenges

Area	*Challenge*	*Opportunity*
Growing population	Growth rate of 18% or population of nearly 700,000 by 2025	Need to grow, people, services and facilities and at same time change delivery to manage demand
Tackling inequalities	Gap in life expectancy between Māori and Pacific and other ethnicities is 6.3 and 5.3 years respectively Difficulties with cost and access for those living in lower decile areas	Better targeting of population groups More intensive support to support healthy lifestyles and management of chronic disease Addressing cost and access issues Embedding health literacy work
Early years	Māori and Pacific children do worse on most indicators Breastfeeding rates need to improve	Targeted and tailored programmes to achieve equality for infants, children and young people and ensure the best start to life
Prevention and management of chronic diseases	1:4 adults obese, 11% of Māori and 23% of Pacific children obese Diabetes estimated to affect 31,000 people 60% of people with diabetes have well managed diabetes 793 CVD deaths in 2011, 54% of CVD patients on triple therapy	Innovative prevention and health promotion programmes Enhance support to practices to provide structured planned proactive care Earlier, targeted treatment options Patient and family-centred, tailored solutions
Mental health	GPs identify around 21% of consultations with a mental health component AOD service use is increasing, particularly for youth	Support GPs to manage patients with mental health issues – appropriate referral pathways and a range of options Improve access to psychological therapies Develop more easily accessible AOD services
Caring for our frail elderly	75+ population will increase by 65% to 53,000 by 2025 Home based support services may need to increase by 33% over the next 10 years 45% of our medical beds are occupied by over 75s	Aligned, streamlined and well-resourced home-based support services, targeted to the areas of greatest need Hospitals deal with complex high-need care only More proactive support and integrated care at the end of life Early, supported discharge development

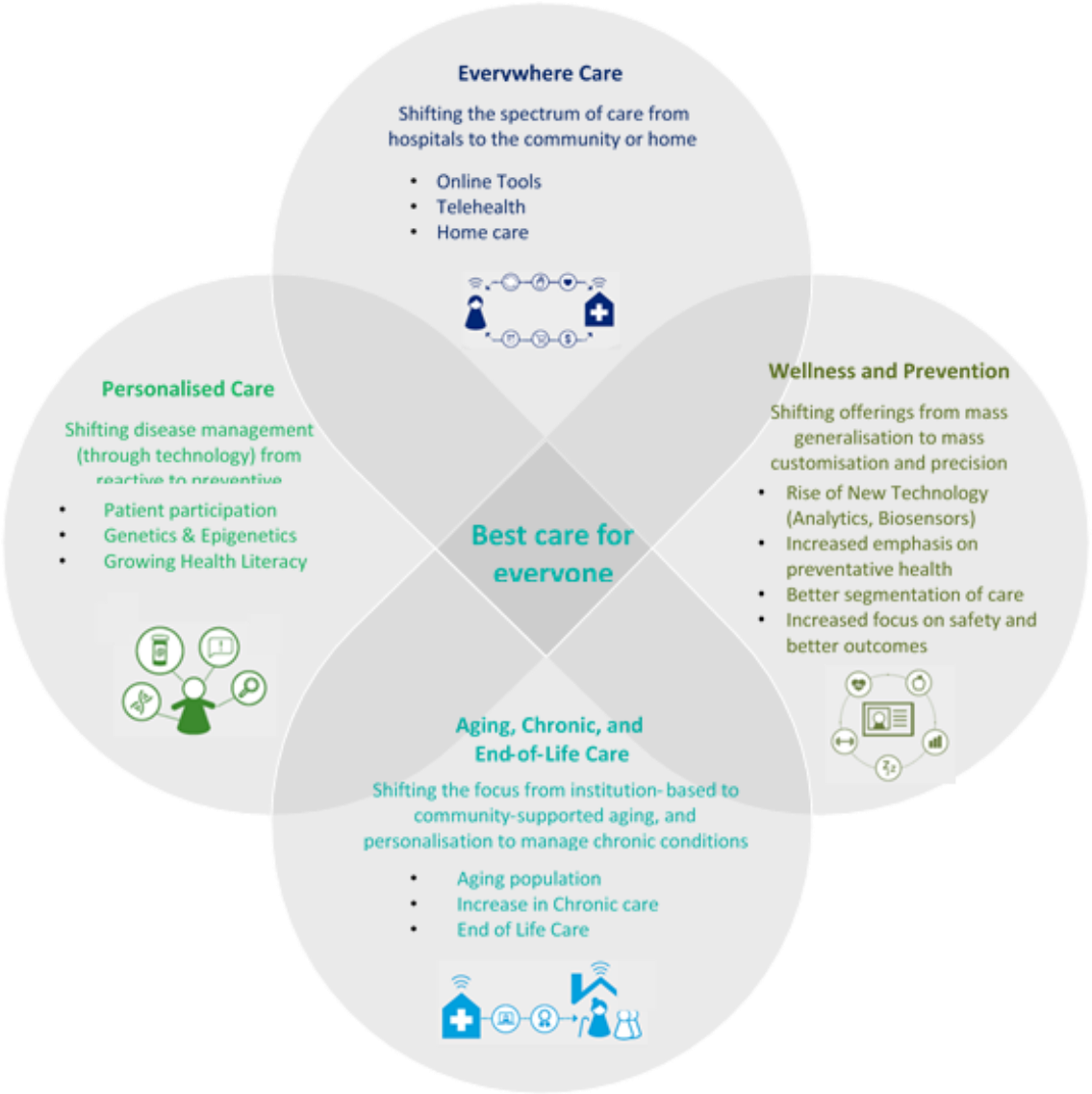
Waitemata community specific challenges

The Community faces a number of challenges in its service provision. While some of the challenges are being addressed, the majority still require detailed planning and thought. The key challenges identified through the development of the CSP are set out below:

Enabler	WDHB community specific challenges
Outcomes	• **We need to focus on the outcomes that matter most:** There are a variety of quality and outcome frameworks across the system which need to be streamlined to enable one shared view • **The current funding models do not always incentivise the right outcomes:** The population based funding formula (PBFF) and capitation models of funding may not always produce the right mix of incentives to improve health outcomes
Models of Care	• **There are opportunities to improve connectivity and communication both within the sector (i.e. DHB, NGO, PHO) and across other sectors (i.e. Housing NZ, ACC):** There is a lack of connectivity and communication across the DHB and system due to the siloed nature of the services which makes it difficult to enable change and consistency
Quality & Patient Experience	• **Access and service provision varies across the district:**. This can be evidenced by over-servicing in some areas (i.e. Takapuna) and a lack of service provision in others (i.e. Henderson-Massey) • **Due to the complexity of the health system, it can be hard to navigate for patients and staff:** Due to the system, processes, and multiple providers, patients and staff can find it hard to navigate the complex system, resulting in duplication of effort and detract from an ideal patient experience
System Reporting & Monitoring	• **Relevant population data and analytics are not distributed in an efficient manner to providers:** The DHB has a large amount of data at its disposal and conducts a large amount of data analytics, however there is no system that allows for it to be shared with relevant providers who would benefit from this information. Providers also have a large amount of data at hand that is not effectively utilised or shared.
Workforce	• **The current community workforce model needs to be strengthened moving into the future:** The community workforce is facing a variety of challenges. The workforce in general is ageing, hospital roles are seen as more valuable, and there is a lack of consistent long term training programmes, and a lack of visibility of future workforce numbers and pipeline across all disciplines
Facilities & Services	• **Large capital investment costs for community providers are a barrier to change:** For large providers the investment required to change their model of care to deliver upon targets and outcomes can be significant and may be a barrier to change
Technology	• **Appropriate technology is difficult to effectively leverage:** Although there are technologies that can assist in the delivery of effective community services it is difficult to identify what this is, and enable it across all providers in a consistent, effective, and timely manner
Sustainability	• **The short term contractual arrangements between the DHB and Providers do not allow for long term planning:** This can make it difficult for providers to plan for and invest in the long term • **Cost will exceed revenue:** There will be an increasing financial gap between costs and revenue moving into the future • **Business models in the community do not always have the ability to support the clinical demands**

Global Models of Care

In response to these changing patient needs, new models of care are developing. These predominantly focus on four key areas: Wellness and Prevention, Everywhere Care, Personalised Care, and Ageing, Chronic and End of Life Care. Key trends in each area are outlined below. The focus for community services is to see how to apply technology and resources to enable our population to be healthier, with lower risk lifestyle and living in a healthier environment.



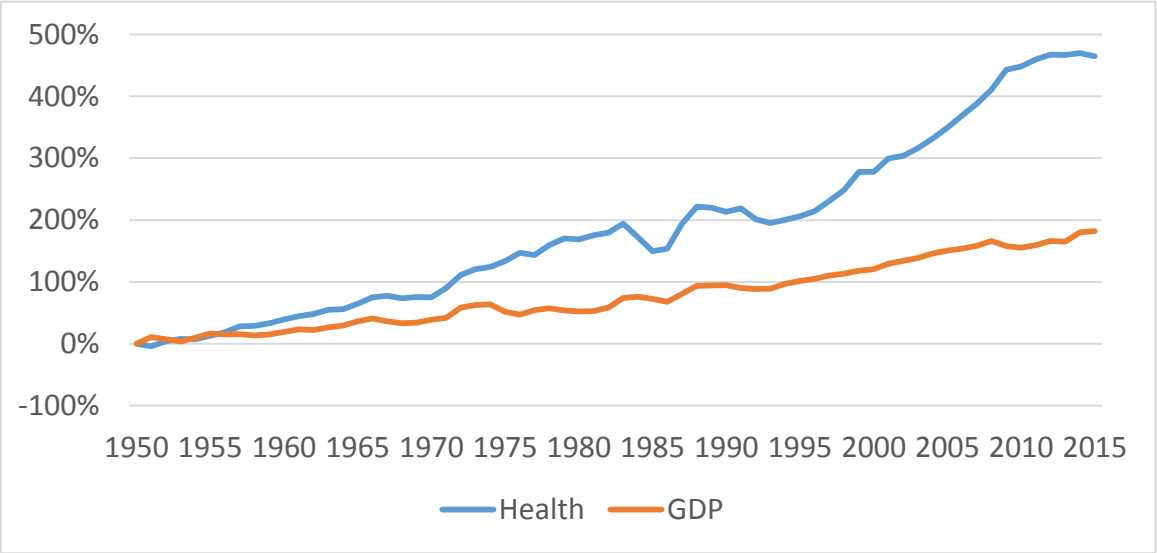
Megatrend	Sub trend	Description
Personalised care – *Shifting offerings from mass generalisations to mass customisation and precision*	Patient participation	Increasing focus will be given on delivering individual patient experience and co designing care based on patient journeys rather than service needs. Patients will expect 'choice' in their healthcare experience
	Growing health literacy	Linked with the growing availability of health information, patients are increasingly informed and seeking collaborative solutions
	Genetics & epigenetics	Exponential decrease in genome sequencing cost and breakthroughs in epigenetics has led to increased use of targeted therapies
	Rise of new technology (Analytics, Biosensors, etc.)	Many of these are already present globally and will include: new diagnostics, devices and wearables, additive manufactured 3D products such as organs, nano-medicine, pharmaceuticals, robotics (e.g. robots that care for the elderly), and artificial intelligence such as the recently physician certified IBM machine - 'Watson'

Megatrend	Sub trend	Description
Preventative care – *Shifting disease management from reactive to proactive*	Increased emphasis on preventative health, wellness and self-care	Providing appropriate primary and community based services to increase wellness and reduce the need for hospital interventions will become increasingly important over the next 10 years to address growing demands
	Better segmentation of care	Boundaries between care settings will be increasingly disrupted becoming more highly specialised in relation to clinical case mix and need
	Increased focus on safety and better outcomes	There is a growing movement towards continuous quality improvement and reduction in variation of clinical practice
Everywhere care – *Shifting the spectrum of care from hospitals to lower-cost sites and in the patient's home*	Online Tools	Availability of information and health solutions are increasingly delivered online or via online communities
	Telehealth	Healthcare provision and access increasingly transcends physical location to meet the needs of patients
	Devolution of Care to Other Practitioners and non-traditional specialists	GPs, Nurse Specialists/Practitioners and other Clinicians are increasingly delivering care that is traditionally completed by secondary care specialists. This has been required to address specialist shortages and demand growth
	Home care	With technology and advances in monitoring, home health care may reach the levels of monitoring precision associated with inpatient ward hospital level care. Therefore, patients could be discharged earlier when monitoring and timely home care response / support are available
Aging, chronic, and end-of-life care – *Shifting end of life care from inpatient to outpatient*	Aging population	65+ population size doubling by 2034 and will form 20% of Waitemata's total population
	Increase in chronic care	Correlated with aging population and growing burdens of disease (e.g. diabetes), there will be an increase in chronic care presentations
	End of life care	Increasing importance placed on palliative medicine and ensuring appropriate settings for end of life care

Financial sustainability challenge

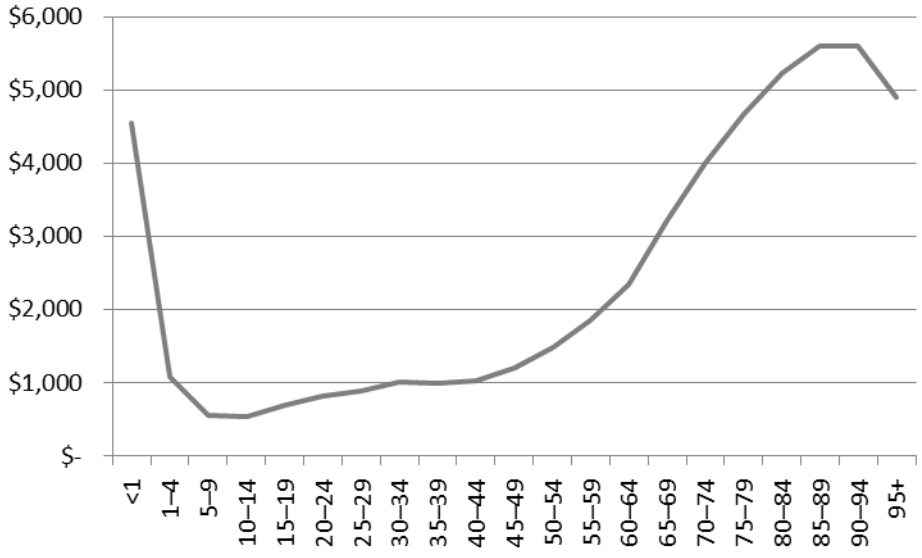
Over the last decade and across most developed countries, healthcare costs have outstripped both demographic and inflationary rates, driven primarily by healthier, longer living patients who consume exponentially increasing amounts of medical resource as they age[3]. The same pattern is true in New Zealand, where healthcare expenditure per capita is growing at a much faster rate than GDP (see the Treasury's graph below).

Core Crown health expenditure per capita and GDP per capita, indexed real growth, 1950-2015



The graph below from Otago University illustrates one of the major (although not the only) drivers of this cost growth, with those above 75+ years incurring on average 10 times more cost than the 5-15 year age group.

Estimated health system costs attributable to specific health events for New Zealand citizens from Health Tracker (per person-year during 2007/08 to 2009/10, in 2011 NZ$ inflation-adjusted values).



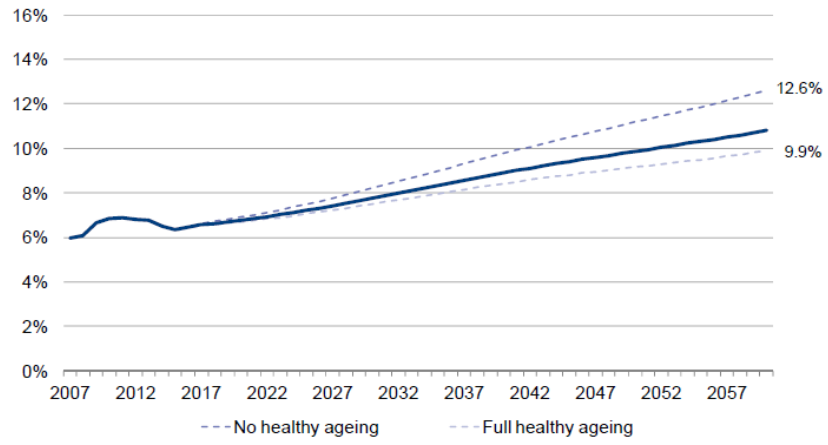
Blakely, T et al, 2015, ***Updated New Zealand health system cost estimates from health events by sex, age and proximity to death: further improvements in the age of 'big data',*** *NZMJ 25 September 2015, Vol 128 No 1422 ISSN 1175-8716*

[3] http://www.treasury.govt.nz/government/longterm/fiscalposition/2013/pdfs/ltfs-13-bg-lhppo.pdf

Given that, as noted above, WDHB's 65+ population will double over the next 20 years and the 85+ will increase by over 150%, this trend is unlikely to abate over the next 10 years, even considering ameliorating factors such as improving technology, outcomes, and interventions. Inevitably therefore prioritisation and effectiveness will become an increasing prerogative in healthcare management, as will demonstrating value for money and outcomes.

The Treasury's series entitled 'Affording Our Future' illustrates the sector wide challenge, with medical costs estimated as growing from just over 6% of GDP currently to somewhere between 9% and 12% by 2050. The 3% difference demonstrates the potential impact of an aging population, with a higher range representing an 'expansion of morbidity' scenario (no assumption of 'healthy' aging) and the lower range representing a 'compression of morbidity' scenario (assumes that growth in costs associated with an aging population will be offset by improved outcomes). While there is a clear imperative to streamline healthcare services and contain growth, there is also a real opportunity to make best use of the technology and advances in healthcare and medicine to deliver better outcomes for people more effectively and more efficiently.

Healthcare spend as a % of GDP changes significantly based on healthy ageing assumptions



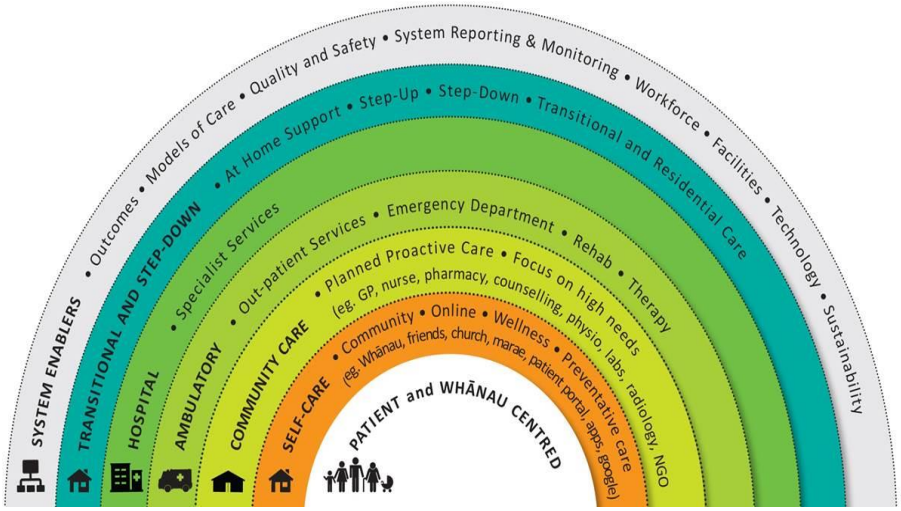
Section 3: Direction to 2025

‘A patient and whānau centred health system working together to achieve the best outcomes for our population’

Our aspiration is that by 2025 ‘A patient and whānau centred health system working together to achieve the best outcomes for our population’ will operate in Waitemata. Health services will be accessible, understandable and patient centred. Exemplar care and clinical outcomes will be achieved for all populations, through timely urgent care, planned proactive care and more intensive support for those who need it most. A high level of trust will operate across the system. Technology will support greater self-care, virtual care and integrated care. Enhanced services will be available in the community with hospital services increasingly focused on acute and specialist services.

PATIENT & WHANAU CENTRED CARE
Patients and their Whānau are at the heart of this system. Services focus on the patient experience and journey and are integrated so that the patient will have a personalised and patient centred experience

SELF CARE
Patients and their Whānau would make much greater use of technology to access health information, connect with others who are experiencing similar health challenges and engage in preventative care.



COMMUNITY & PRIMARY CARE
Community and Primary care services consist of a multidisciplinary team of health providers coordinated by general practice. Services such as radiology, physiotherapy, pharmacy, district nursing, age related residential care and NGOs are digitally connected and where necessary, co-located. Practices will provide timely urgent care, planned proactive care and more intensive support for those who need it most. They will also perform more services that have traditionally been conducted in a hospital setting, while being supported by secondary care specialists. There will be unique models of care supported by technology which will enable better care connectivity available for at risk, complex, and high needs patients, helping to navigate the system and ensuring outcomes are met. There will be greater focus on multiagency and inter-sectoral coordination

AMBULATORY
The first of three specialist orchestrated levels of care. This level includes emergency medicine and ‘one stop shops’ established around particular conditions with diagnostic and treatment capability in a single site. These services may be accessed physically or through virtual methods. This level of care will refer to intervention or community care services as appropriate and support primary care providers to manage the patient back to a state of self-care.

HOSPITAL
Hospital services would increasingly focus on more intensive specialist services. They will provide care that is acute, with concentration of specialisation and assets. These services may be offered at a DHB or on a regional level, depending on volumes or level of specialisation required. Where more intensive interventions are required, services will be organised by ‘routine’ and ‘niche’ patient flows. Routine services will be high volume relatively standardised interventions, whereas niche services would require a greater degree of expertise or support (e.g. cancer treatment for frail and elderly patient with mental health disease).

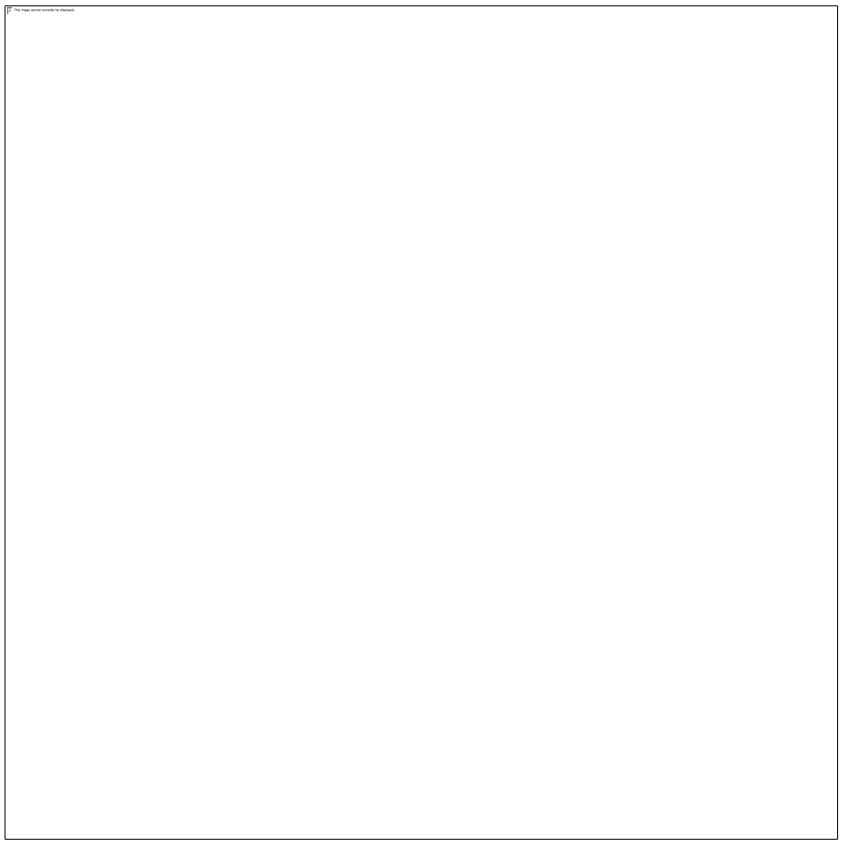
TRANSITIONAL AND STEP DOWN
Following intervention, the specialist will work with the GP to orchestrate any community based care to support the transition back to a state of self-care. These include facilities offering rehabilitation, transitional and aged care as well as at home care services.

How to operationalise the WDHB 2025 Vision for the Community

The success of the PCSP will be measured by how effectively it is operationalised – the impact and speed it has on the achievement of the outcomes defined. The operationalising of the PCSP has been considered from two directions, firstly identifying the right things to do – the initiatives or specific services to be delivered, and secondly, identifying the right way to do them – how the DHB and its partners will work together to support the Community Services system to best enable these services. The plan is therefore focused on five main priorities and illustrated in the diagram below:

- **Deliver better outcomes**
  Achieving the very best health outcomes for our population through prevention, early intervention and chronic disease management
- **Reduce inequalities in access and outcomes**
  Services are focussed on reducing gaps in access and outcomes between socio-economic groups, ethnicities and the population living in the most deprived areas.
- **Effective and sustainable services**
  Primary and community services provide world-class care that is sustainable and achieves real improvements in health outcomes.
- **Build capacity and capability**
  Build and develop the workforce and adopt new ways to meet the needs our changing and growing population
- **Integrated and local services**
  Equitable access to services that are co-ordinated, integrated and seamless and where appropriate are delivered closer to home.

Community Services framework and priority areas:



1. Deliver Better Outcomes

Our population already experience very good health outcomes but there are opportunities to do better. To deliver better outcomes we need to increase our investment in prevention, chronic disease management and early intervention and work with other public sector agencies to address the broader determinants of health. Effective management of acute presentations in primary care and a greater focus on planned, proactive care, particularly in the management of long term conditions will support better health outcomes and will help to manage demand for hospital services. Our focus in this area is on:

These areas are described in more detail in the table below.

Priority Area	Description of Priority Area
1. Healthy Lifestyles	• **Intensified smoking cessation support:** Improve uptake and access, focusing particularly on high needs populations and aiming to eliminate smoking in pregnancy. Continue work to achieve Smokefree 2025 goals for the district • **Improved access to healthy nutrition and promote physical activity:** improve information related to healthy nutrition choices, continue to develop programmes such as Enola Ola and other community based initiatives. • **Increased investment in reducing childhood obesity:** continued support and collaboration through the Healthy Auckland Together partnership and Healthy Families Waitakere to address the obesogenic environments including implementation of a new family based intervention for very obese children.
2. Early Years	• **Improved connectivity with Primary Care:** Develop relationships and connections with Primary Care and Early Years • **Maternal and infant mental health:** Develop tools for universal service providers and increase the range of intervention options available to pregnant women and new parents • **Intensify universal services for vulnerable children, young people and whānau:** Improve quality of services and equity of coverage for vulnerable groups, e.g. social worker support for pregnant women. Facilitate service enrolment and access • **Further improvements in immunisation systems:** Increased timeliness of immunisation for high-need populations, and increased immunisation uptake for pregnant women • **Improved support for breastfeeding mothers:** Programmes to increase knowledge about introduction of solids, leading to increased breastfeeding prevalence and duration • **Support for healthy lifestyles in pregnancy:** Supporting healthy eating and activity to reduce obesity, complemented by improved screening and intervention for gestational diabetes. Aim to eliminate smoking in pregnancy and encourage healthy environments for children
3. Chronic Disease Management	• **Expanded screening and intervention programmes for pre-diabetes:** Community-based support for improved nutrition and physical activity. Supported by more effective screening, under guidance of diabetes service alliance. Prioritise high-needs populations for greatest cost-effectiveness • **Timely intensive interventions for people with poorly controlled diabetes:** Development and implementation of the diabetes alliance workplan. • **Planned proactive cardiovascular disease management:** Support practices to provide structured planned proactive management of patients with cardiovascular disease and all patients who have a CVD risk assessment receive lifestyle advice and treatment appropriate to their estimated risk, • **Planned proactive management of respiratory disease and other chronic diseases:** Support practices to provide planned proactive management of respiratory disease and other chronis diseases • **Improve access to cardiac rehabilitation after myocardial infarction:** these services potentially have strong cost-effectiveness and population health impact. Access needs to be further

Priority Area	Description of Priority Area
	improved to minimise unmet need and improve equity
4. Mental Health and Wellbeing	• **Increasing ability to deal with complex presentations:** Improved support and resources in the community for those people with high needs including more complex and severe presentations • **Implement the Our Health in Mind strategy:** Ongoing development of specific actions under this strategy to improve mental health and address addiction. Emphasise effective actions for high-need populations, and actions to reduce inequalities for people with serious mental illness, including those of affordability • **Broader population health strategies to support mental health:** Improve ease of navigation of mental health services. Increase mental health literacy in workforce. Address hazardous drinking, especially in high-need populations • **Improve access to effective therapies:** Build capability and capacity for early identification and treatment, and improve access to psychological therapies. Strengthen self-management approaches • **Support physical health and other needs of people with serious mental illness:** Better support for employment and housing. Improved monitoring of physical health in mental health services and primary care.
5. Healthy Aging	• **New models of care in general practice:** Develop and implement new general practice models of care for older people with complex long term conditions and frailty – progressing from the CARE programme • **Addressing cognitive impairment and falls prevention:** Ensure services are in place to meet the needs of frail older people, particularly people with cognitive impairment and those who are at risk of falls • **Improving community-based management of acute severe illness**: Develop approaches for acutely unwell older people that avoid hospitalisation or allow for early and safe transition from hospital back into the community – e.g. Step home, EDAR, rapid response teams • **Reduce impairments, enabling aging in place:** Provide support to older people with disability to reduce impairments and improve their ability to stay in their own homes – e.g. HBSS review • **High-quality residential care supporting quality of life:** Ensure that when older people require residential care, high quality clinical care and a pleasant home are provided • **Prevention targeting priority conditions**: Identify the conditions that create the largest burdens of disease for older people and ensure that there is good access to prevention and treatment that maintains health and function
6. End of life	• Develop and implement a regional palliative care work programme

2. Achieve Equitable Health Outcomes

We want to ensure that our Māori and Pacific populations achieve the best possible health outcomes. By 2025 we want to see Māori and Pacific people in our region living longer and enjoying a better quality of life. Our aim is to provide services which meet the needs of our patients, support them to achieve their health and wellbeing aspirations and build on the strengths of our patients, their whānau and community. We will achieve this through deliberate and intentional action towards eliminating the life expectancy gap between Māori and Pacific and non-Māori/non-Pacific populations. We will focus on reducing the impact that known modifiable risk factors, including smoking, obesity and alcohol, have on the health of Māori, Pacific and other priority populations. This approach will also support us to identify early and effectively manage chronic conditions whilst ensuring our services are culturally responsive. We will also build collaborative relationships with non-health sector services to support sustainable outcomes for our patients and their whānau. These areas are described in more detail in the table below.

Priority Area	Description of Priority Area
Reduce Inequalities	• **Whanau ora** - expand the current health services provided at Whānau House and support integration between health and non-health services as part of a whānau ora approach, implementing and evaluating the effectiveness of a whānau ora model of care which supports integration between health and non-health services on the North Shore, implementing and evaluating the effectiveness of a whānau ora model of care in the South Kaipara, include whanau ora approaches in service delivery models • **Intersectoral collaboration** - building relationships and referral pathways with non-health services to support improved health outcomes for Māori, Pacific and other vulnerable populations, co-commissioning services with Te Pou Matakana and Pasifika Futures that will improve access to services and improve outcomes for Māori and Pacific, • **Engagement –** engaging with Māori service users and communities when developing and evaluating services, engaging with Mana Whenua and/or other appropriate Māori representatives when planning, developing and evaluating services • **Healthy Lifestyles –** provide services which support Māori, Pacific and vulnerable populations to be smokefree, physically active and consume nutritious diets • **Screening –** implement AAA screening, increase uptake of bowel and cervical screening programmes • **Chronic Disease Management –** implement systems to support early identification and improved management of CVD and diabetes for Māori, Pacific and other vulnerable populations with a focus on equitable outcomes • **Culturally competent workforce:** increasing our Māori and Pacific workforce, enhancing the cultural competence of our workforce and better integrating equity into business as usual for all staff • **Health-literate services and programmes** - make services more accessible, understandable and effective for Māori and Pacific patients and their whānau particularly through better use of technology • **Advocate, where appropriate, on key upstream drivers of inequity** - to central and local government for effective measures that address drivers of inequity both within and outside the health sector

Effective and Sustainable Services

This priority area focuses on the system changes we need to make to enable primary and community providers to provide world-class care and achieve real improvements in health outcomes. Central to this is achieving a much stronger relationship between resource allocation and outcomes. In order to do this we need to agree and focus on the outcomes that matter most, develop clear and consistent models of care, focus on interventions that are highly effective, ensure we all align to the same high quality standards and align financial models to incentivise improved health outcomes. We also need to be able to monitor and evaluate our success along the way and be committed to making change and improvement when it is clear that it is required. These areas are described in more detail in the table below.

Enabler	Features
Outcomes Focused	• **Outcomes Framework:** Ensure an aligned set of outcomes across the whole system building on the system level measures that address the key health needs of the population and that drives decision making

Models of Care	• Development of a standardised urgent care model including call management and triage
	• Planned proactive patient-centred care model development, focused on those with highest need/greatest risk. Models would consider a broad range of professional input and would encourage and promote self-care
	• **Health Pathways:**
	  ○ Localisation and socialisation of the Canterbury pathways prioritising the pathways that contribute the most to health outcomes.
	  ○ Ensuring integration with eReferrals
	• **Self-management and preventative care:** Invest in and support patient education, remote monitoring and data collection for highest impact population groups (e.g. patients with cardiovascular disease and diabetes), with a focus on wellness
	• **eReferrals:** With the web based portal in place turning off the paper referrals. Continuing to roll this out in secondary care to ensure sector wide consistency for referrals
	• **New Programmes and Initiatives:** Development and implementation of new programmes and initiatives to support the models of care (e.g. CARE programme, falls prevention, community health and social care team)
	• **Integration across the system:** Models of care will be integrated across the entire health system (Primary, Secondary, Consumers, NGOs, PHOs, Pharmacies etc.) and eventually include broader social sector partners as well
	• **Business models:** appropriately designed to support new models of care, based on the Health Care Home or 'Best Care for Life' models

Quality & Patient Experience	• **Learning and responsive culture:** A learning and responsive culture will be supported so that providers are constantly adapting and refining their methods to ensure that patients receive the best experience and quality of care of care available in a sustainable way • **Models of care:** Feedback mechanisms for both consumers and providers to ensure constant refining of the patient journey. • **Safety in Practice:** Roll out of the Safety in Practice programme across all general practices and other community based providers with a wide menu of care bundles • **Learning Networks:** Providers will be better connected through attending relevant Networks/forums (virtual or physical) to ensure that trust is built up within the system and to ensure that successes and difficulties are shared
System Reporting & Monitoring	• **Improved reporting and analysis:** Will have the required systems to capture and report against outcomes and targets • **Social Listening:** Building on the Healthpoint consumer feedback mechanism by developing a system reporting dashboard across the whole health sector • **Minimum performance requirements**: Will have a set of minimum performance requirements, which may be relative to past performance, to ensure that there is improvement across the system • **Culture of sharing and transparency:** Will share data and analytics at a practice/pharmacy level to ensure that the system is informed and transparent. The sharing of data and information between primary and secondary care will improve quality of care and patient outcomes

Enabler	Features
Sustainability	• **Alignment of funding to outcomes:** Funding will be aligned to the meeting of outcomes, so that the system is working together to ensure that the best outcomes for the population are met • **Longer term provider contracts:** Provider contracts will have longer terms to provide Providers with some assurance and allow them to undertake larger investments • **Set up sustainability programme:** There will be an ongoing sustainability programme established that will focus on ensuring that the system is operating and planning in a way that ensures sustainable practice, business efficiency and continuous improvement moving into the future

Build Capacity and Capability

In order to respond to our growing and aging population, rapidly changing technology and to deliver better outcomes we need to build providers capacity and capability in terms of workforce, technology and facilities. We need to support and grow our workforce, training and developing a growing number of staff as well enhancing roles and supporting new roles. We want to make best use of current and emerging technologies and we need to ensure that we have the right facilities in the right place in order to provide the services we need. These areas are described in more detail in the table below.

Enabler	Description
Workforce	• **Focus on workforce growth and sustainability:** We will understand what mix of workforce is operating within the system currently and will understand the requirements moving into the future so that adequate planning and preparation can be undertaken to broaden workforce capability and capacity (based on exemplar Model of Care requirements). All aspects of the pipeline require attention and consideration as to how we optimise our staff mix through 'growing our own' and 'buying in' workforce – to best meet the needs of patients. • **Institute of Innovation and Improvement facility:** a source of expertise and resource to support the development of an integrated workforce. • **Professional bodies:** such as the Goodfellow Unit, RNZCGP, NZNO, Pharmacy Guild and the Pharmaceutical Society to develop and manage an integrated workforce development plan, providing the learning and development pathway across the workforce to optimise patient care • **Safety in Practice initiatives:** these will be closely linked to workforce development activities to ensure patient safety and also workforce safety via clinical quality improvement measures • **Nursing Strategy:** Implement the vision and direction of the Primary Health Care Nursing Strategy and Development Plan • **Professional Roles:** Maximising the potential of existing clinical roles via workforce growth and sustainability, such as GPs with special interest (GPSIs), Practice Nurses with special interest (PNSIs), nurse specialists, nurse practitioners along with the development of new roles as required when co-design and model of care changes embedded • **Professional development calendar**: Sharing of professional development activities across all stakeholders in a single calendar • **Professional Development programme:** Through improved cross-working and joint-working, an integrated approach to the development of a continuous interdisciplinary workforce skills programme will support clinicians to enhance and maximise their role potential and work to the top of their scope. This would involve webinars; GP, practice nurse or pharmacist shadowing; skills labs and teaching. • **Clinical leadership:** Leadership courses will be integral to the professional development programme and pivotal to workforce strategy development in order to ense succession planning for the district's workforce. Joint working will enable an integrated and supportive framework for interdisciplinary exchange of knowledge and learning to create coalitions of experts who can inform and lead health care improvement into the future • **Accreditation Programme:** Accreditation of practitioners will ensure a level of credibility of our programmes with both internal and external stakeholders e.g. the WDHB skin lesion service. This could be extended to include Gynaecology, ORL and General Surgical procedures. This will help decongest secondary care services and provide rewarding career paths for GPs • **Continuous development based on Model of Care changes:** Feedback loops will ensure the workforce mix, scope, and responsibilities will continually be refined based on exemplar Model of

Enabler	Description
	Care changes • **Primary Care Clinical Directorate:** Development of the clinical directorate within WDHB through a collaborative approach to grow coalitions of experts such as GPs, practice nurses and pharmacists which will in turn aid integration activity • **Communication framework:** An intranet communications framework for inter-professional communications will support integration activities. • **Primary Care Connections:** Twice yearly inter-professional meetings around specific services rotated between North Shore Hospital and Waitakere Hospital
Facilities & Services	• **Principles for facilities development:** There will be a set of principles for the system to use when considering facilities development in the sector. These will include guidelines around layout and composition of facilities, based on best evidence and may include virtual facilities. The Community Services Plan will give confidence to funders looking to invest in infrastructure development.
Technology	• **Established Electronic Health Record (EHR):** An Electronic Health Record will be established, which will connect the entire system together (including the patient) • **Development of a single platform referral:** Extending eReferral platform to include POAC and ATD with the ability to offer more targeted options such as rural Primary Options • **TeleMedicine:** The enabling technologies such as eReferrals, Telehealth, remote monitoring, , virtual clinics, and patient portals (including web and smart phone based) will continue to be established within the community • **Continuous adoption of innovative and proven technology:** Proven technology will continually be tested, piloted and implemented across the system to enable Model of Care changes and ensure the best outcomes for the population

Integrated and local services

Well organised collaboration between primary and community services with multidisciplinary teams working together to optimise patient care, experience and outcomes will help us to have a real impact in our priority areas. Services that are co-ordinated, integrated, patient-centred and that remove and minimise organisational boundaries should be a central feature for future services.

The health system in Waitemata already has many of these components in place and a number of successful models such as the skin lesion service and virtual clinics operating in gynae services have already been developed, but there are opportunities to do better. The changes outlined in priority areas 1 to 4 will address these through the agreement of a common outcomes framework, clearly specified models of care and supporting infrastructure particularly in terms of technology.

In addition to these changes there are some systems and tools, model of care changes and support and development outlined in the table below that will support integrated and local services.

Enabler	Features
Integrated models of care	• See models of care actions under priority area 3 above
Integrated systems and tools	• **Integrated e-referrals system:** that links to other tools (eg. Auckland Regional Health Pathways) to create an adaptable demand management and decision support tool. Extension of this to other community based providers such as LMCs via the new web portal. • **NEXXT tool:** complete pilot of this dynamic decision support tool across 92 practices with 10 pathways, then develop link to e-referrals • **E-Lab demand management tool:** develop with LabTests for community providers to ensure more effective laboratory use • **POAC:** look at incorporating features (such as a funding mechanism) into the integrated e-referrals system, expanding for other activities such as Ferinject, venesection, ATD, GPSI referrals and primary mental health services. • **Online booking system –** to enable clinicians to book and manage outpatient appointments

Enabler	Features
	directly • **Smartphone app implementation:** allowing primary care physicians to connect with patients to deliver care eg. for palpatations, to conduct an audiogram • **Leveraging technology:** further development of virtual clinics, telehealth and remote monitoring

Local Service Delivery	Setting up the models, structures, training, support and evaluation to enable primary and community providers to deliver services currently provided in the hospital:
	• **Cardiology:** minor procedures that do not require follow ups in a secondary setting
	• **Children's Health:** providing services to children in their home or supporting an earlier discharge so children can recover at home
	• **Gastroenterology:**
	  ○ providing GPs and primary providers with training and support to manage low acuity cases at a primary level (e.g. irritable bowel)
	  ○ nurse run clinics with hepatologist support in the primary setting
	• **General Surgery:** movement of low risk procedures back to Primary care by educating or consulting with GPs to perform procedures (e.g. skin is well down this path)
	• **Gynaecology:** GPs doing more gynaecological work in a primary care setting, reducing the demand for simple gynaecological procedures
	• **Laboratory and Pharmacy:** more testing work will be done within the community. (e.g. finger prick, shining light on the skin, and readings etc.)
	• **Mental Health:** potential to shift relevant mental health care from an outpatient to a community setting eg. Virtual clinics, inreach services, nurse led clinics
	• **Respiratory:** rural respiratory rehabilitation services could be better delivered by moving them to the community, chronic obstructive pulmonary disease clinics could be run in the community with nurse support, provision of spirometry testing in the community by GPs as part of regular health checks

Support and Development	• **Communication strategy and framework:** to ensure wide knowledge of the model of care framework for both consumers and for primary and community services and to promote relationship building between clinicians • **Rural access:** development of a rural POAC to improve access/services eg. For ultrasounds and point of care testing • **Clinical skill programme:** developed as part of multidisciplinary Continuing Professional Development strategy/programme (see Workforce section above), informed by analysis of the learning needs associated with new models of care and provided through a range of mechanisms eg. Webinars, skills courses, videos etc.

Section 4: Roadmap, Impacts, and Next Steps

This Section consolidates the above described principles and priorities, health needs, WDHB challenges, mega trends, and community aspirations into an overarching plan for the next ten years.

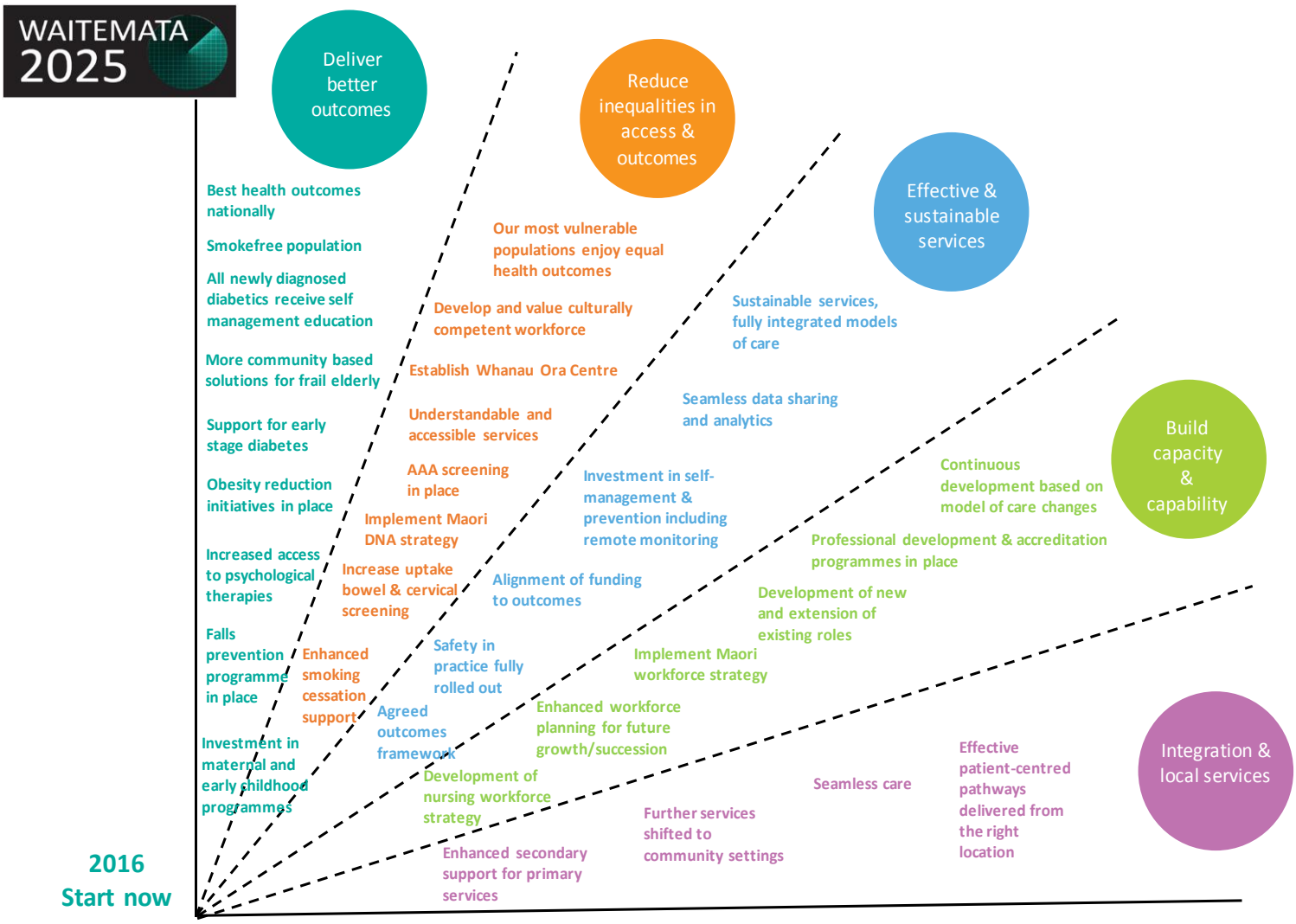
Priorities towards 2025

As highlighted in the previous sections, there are gaps from the current state to Waitemata 2025 across primary and community care, and a variety of priority areas which have initiatives currently underway or which plan to address these gaps. The growth path below summarises these and describes what success in 2025 looks like. This PCSP:

- The **'immediate term'** is classified as 0-3 years following the commencement of the PCSP. The focus is on accelerating current initiatives, engaging with a broader set of stakeholders, and setting up the required enablers to achieve the first stage of maturity towards the 2025 vision. This timeframe has a relatively high degree of certainty and measurable impacts compared to the medium and longer term time horizons.
- The **'medium term'** is classed as 3-5 years following the commencement of the PCSP. Actions in this period are addressing the need to extend successful programmes across the system with a focus on improving patient and clinical integration. Actions in this timeframe are considered to be achievable (from planning through to execution) within this period, although they are associated with less certainty and limited ability to measure outcomes.
- The **'longer term'** is classed as 5-10 years following the commencement of the PCSP. Actions addressed in this period require longer lead-times and look to operationalise the WDHB vision. The focus in this timeframe is to build on prior successes to ensure that an accessible, understandable and patient centric system is operating that is providing exemplar care for all populations within WDHB. This timeframe has the least certainty and no little material measurability, but is essential to establish the desired end destination for WDHB services.

Roadmap to 2025

The diagram below summarises some of the key initiatives and changes that we expect to see through the implementation of the PCSP. These are also set out in the action plan on the following page and described in more detail in section 3.



Waitemata 2025: A Patient and whanau centred health system focused on the best outcomes for our population.

	Better health outcomes	Reducing Inequalities
Immediate Term (2016-2018)	• Programmes to ensure babies live in smokefree households • Improved screening and intervention programmes for CVD and diabetes • Intensive support programme for managing early stage diabetes developed • Access to psychological therapies increased • Obesity prevention initiatives implemented • Falls prevention programme implemented • CARE programme & dementia pathway roll out • Effective community based cardiac rehab programmes	• Targeted programmes to improve health outcomes for Māori – AAA screening programme implemented, HPV self-sampling implemented, Hohourongo Service implemented • Smoking cessation service development • Targeted self-management/prevention programmes – focused on diabetes, CVD, obesity • Establish Whānau Ora Centre on the North Shore, in partnership with Te Puna Hauora • Increase uptake of bowel and cervical screening • Further development of programmes to grow the Māori and Pacific health workforce and enhance workforce cultural competency
Medium Term (2019-2021)	• Development of further community based options for mental health services – including high and complex needs • Development of community based solutions for frail elderly patients – early discharge pathways and enhanced primary care capacity	• Health Literacy strategy – actions rolled out • Health literate services and programmes – development of principles and evaluation tools • Evaluate and expand services delivered as part of the Whānau Ora approach
Longer Term (2022-2025)	• Full rollout of Our Health, Our Mind Strategy and actions • Embedded community based management of unwell frail elderly that avoids hospitalisation	• Integrated health and social service contracts – built on demonstrated examples of diminished health inequality • Programme development tools with include knowledge from Whānau Ora evaluations

	Effective & Sustainable Services	**Build Capacity & Capability**	**Integration & Local Services**
Immediate Term (2016-2018)	• Collectively agree on an outcomes framework • Full rollout of the *Safety in Practice* Programme across all providers/practices • Development and roll out of *Health Pathways* • Complete eReferral and eTriage rollout out and aim for 100% eReferrals utilisation • Patient experience measures used and reported on • Development of structured, consistent learning networks • Develop consistent reporting frameworks for evaluating and sharing performance data and information	• Development of further virtual clinics and opportunities to support primary care through secondary care advice • Telemedicine enablers – e-referrals, eVitals, patient portals etc • Implementation of nursing strategy • Development of comprehensive workforce plan to address gaps and growth • Professional development programme developed • Accreditation programme development • Develop principles for facility development	• Further development of services in community based settings, currently delivered in hospital settings, including rural based • Increased access to diagnostics and interventions to rural and other priority communities • Evaluation/learnings from service shifts that have already occurred • Develop secondary care comprehensive support networks that enable piloting of new services in primary care • Enhanced after hours services • Build systems and frameworks for data sharing and analytical support • Develop funding pathways that follow patients
Medium Term (2019-2021)	• Alignment of funding to outcomes • Collaborative plan for addressing primary care cost for patients • Longer-term provider contract pilots • Provider sustainability programme set up	• Nurse led clinic development • Further rollout of follow up or alternative to hospital care delivered from primary care settings • Development of new and extended roles roles to support new models of care	• Full roll out of clinical pathways • Further development and reconfiguration of services via integration framework • Embed redeveloped funding pathways
Longer Term	• Demonstrated and evaluated integrated models of care operating with extension to broader social sector partners	• Establishment of integrated electronic health record • Workforce model that can flex to enhanced models of care	• Complete service development to achieve optimum mix of primary and secondary based delivery – evaluate and refine pathways

Investment in Primary and Community Services

In order to achieve our aspirations for Waitemata 2025 the DHB is committed to investing in effective, evidence based interventions that improve outcomes and patient experience and builds the capacity and capability to meet the needs of our growing population. The DHB expects to accelerate this investment over time.

Ongoing financial sustainability is critical if we are to achieve this. We are committed to increasing the transparency of the money invested and the outcomes that are delivered and are working with the District Alliance to achieve this. We are working with other public sector agencies (such as MSD and ACC) and partners to develop innovative responses that deliver broader social and economic benefits. Initial areas for investment in primary and community services in relation to the priority areas set out in this plan are shown in the table below. There may also be additional investment required to support the System Level Measures Improvement Plan that will be submitted to the MOH in October. The table identifies those areas where funding has already been approved by the DHB or is in the process of being approved. Any new investment would need to follow usual DHB processes.

Planned investment in primary and community services	Funding Identified/ Approved	Funding not yet Identified / Approved	Total
1. Better Outcomes			
Healthy Lifestyles (STEP, mental health)		750,000	750,000
Early Years (parenting, living without violence)		500,000	500,000
CDM (CVD and diabetes, early diabetes support, retinal screening)		2,000,000	2,000,000
STEP Initiative Stroke(MSD funded)	690,000		690,000
MH (primary mental health)	1,400,000	1,000,000	2,400,000
Healthy Aging (CARE, cognitive impairment)	1,400,000	1,000,000	2,400,000
2. Reducing Inequalities			
Maori Health (Whanau Ora, AAA screening, workforce)	172,000	500,000	672,000
Pacific Health	72,500	100,000	172,500
STEP Initiative Prisoner Health (MSD funded)		500,000	500,000
3. Effective and Sustainable Services			
Quality Improvement (Safety In Practice)	154,000		154,000
Clinical Leader Quality Improvement	250,000		250,000
4. Capacity and Capability			
Workforce Development (nursing, clinical skills programme)		500,000	500,000
New Business Models (healthcare home, best care for life etc)		500,000	500,000
Leapfrog	500,000		500,000
5. Integrated and Local Services			
POAC	992,000		992,000
Rural Alliance (community ultrasound and radiology)	650,000		650,000
New models of care (falls prevention, avoidable admissions)	1,000,000	500,000	1,500,000
6. Infrastructure			
Whanau Ora Centre		500,000	500,000
Programme Management		500,000	500,000
Total	**7,654,500**	**8,850,000**	**16,130,500**

Measuring Success

A number of outcome, contributory, and process measures have been identified to enable us to measure the success of the PCSP. These measures will enable us to monitor whether or not we are moving in the agreed and planned direction as the plan progresses. The initial process measures are:

- Community Service Plan is approved by both PHOs and the DHB by 1st October 2016.
- Quarterly 'governance' meetings scheduled to monitor progress in place by 1st October 2016
- Formal launch by 1st October 2016.
- The following prioritised business cases are to be completed in 2016/17 financial year: Business cases 1 & 2 Our Health in Mind, Business case 1 Diabetes/CVD, Expansion of POAC, Rural Alliance Point of Care Testing, Rural Alliance Imaging, Cognitive Impairment, AAA Screening.
- Approved business cases implementation initiated during 2016/17.
- Further business cases prioritised for 2017/18 by 1 July 2017.
- Agreed outcomes framework, measures and data collection agreed with quarterly reporting from 1st April 2017. This will need to be cognisant of System Level Measures, Health Targets, and Better Public Service Targets.
- Enhanced General Practice/ Healthcare Home & Safety in Practice work programme(s) initiated.

The high level outcome measures are the overall outcomes the DHB aims to achieve and that the activities within the CSP will contribute to. These reflect the new system level measures. The desired direction of travel is specified with an exception where national targets/aspirations exist. The set of system and contributory measures will contribute to the overall outcomes of the DHB and also measure the success of the CSP. It is expected that these will be refined through discussion with the Alliance and other stakeholders. It is intended that specific measures, baseline performance and levels of improvement will be agreed as part of the business cases for each initiative.

DHB High level outcomes	
An increase in life expectancy	A reduction in the ethnic gap in life expectancy
A reduction in mortality from conditions considered amenable	A reduction in ambulatory sensitive hospital admission in those aged 0-4 years
A reduction in smoking prevalence (<=5% by 2025)	A reduction in acute hospital bed-days

Contributory measures	Desired outcome
Deliver Better Outcomes	
Healthy Lifestyles • Percentage of smokers identified in primary care that receive smoking cessation support or referral to cessation services • Percentage of children identified as obese at their Before School Check offered a referral to a health professional for clinical assessment and nutrition, activity and lifestyle interventions • Family based intervention for very obese children	Increase >=95% Implemented
Early years • Percentage of mothers registering with an LMC in the first trimester • New-borns enrolled with a PHO by 6 weeks of age • Percentage of children fully immunised by 8 months of age • Percentage of infants receiving all core well child/Tamariki Ora core contacts in their first year of life	Increase Increase >=95% Increase
Chronic Disease Management **Diabetes** • Percentage of enrolled patients with diabetes (aged 15 to 75 years) who have good or acceptable glycaemic control (HBA1C ≤64) • Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest	>=80% >=80%

systolic blood pressure measured in the last 12 months is <140 • Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have microalbuminuria and are on an ACE inhibitor or Angiotensin Receptor Blocker **CVD** • Percentage of enrolled patients with known cardio-vascular disease who are on triple therapy (Statin + BP lowering agent + Aspirin) • Percentage of enrolled patients with 5 year cardio-vascular risk ever recorded >20%, (aged 15 to 74 years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent)	>=90 >=70% >=70%
Mental Health and Wellbeing • Access to psychological therapy • Programme to support those with serious mental illness into employment and housing	Increase Establish
Healthy Ageing • Percentage of 65+ population receiving seasonal influenza vaccination • Community based solutions for frail elderly patients – early discharge pathways and enhanced primary care capacity • Falls prevention programme	Increase Established Implemented
Achieve equitable health outcomes	
Reduce Inequalities • Percentage of Maori and Pacific smokers identified in primary care that receive smoking cessation support or referral to cessation services • Percentage of Maori children fully immunised by 8 months of age • Percentage of Maori, Pacific and Deprivation Quintile 5 that are enrolled with a PHO • Additional services provided at Whanau House • AAA screening programme	Increase >=95% Increase Increase services Established
Effective and Sustainable Services	
Models of Care • % or Number of Practices taking up Transformational Model of Care change accredited to the New Zealand Health Care Home Standard or Waitemata PHO's Best Care for Life • Models of care are evaluated	Year on year increases Evaluations completed
Quality and Patient Experience • Number of practices participating in the Safety in Practice programme • Average scores in overall patient experience with GP or nurse clinic	Increase Increase
System Reporting and Monitoring • System Level Measures and contributory measures agreed and reported against • Systems to capture and report against outcomes and targets • Systems to allow data sharing at a practice/pharmacy level • Frameworks for consistent reporting and evaluating of performance information	Agreed Established Established Established
Sustainability • New contracts established have longer terms • Sustainability programmes for all providers • % and number of practices that have adopted a new business model that supports new models of care, based on the Health Care Home or 'Best Care for Life' models	Increase length Established Year on year increases

Build Capacity and Capability	
Workforce • Increase in new graduate nurses employed in Primary Care • Primary Care Diabetes Nurse Prescribers engaged in the diabetes prescribing pathway • Regional system for sharing professional development activities	Increase Increase Established
Technology • Percentage of medical out-patients appointments provided virtually with the person supported by their general practitioner or practice nurse • Percentage of practices where patients are able to access patient portals	Increase Increase
Integrated and local services	
Integrated systems and tools • Online system enabling clinicians to book and manage out-patient appointments	Established
Local service delivery • Low risk procedures in primary care (eg skin lesions) • Home-based children's services • Cardiology work that does not require follow up in secondary care undertaken in primary care • Minor gynaecological procedures in secondary care	Increase number and type of procedures Reduced
Support and development • Clinical skills programme • Clinical staff engaged in professional development and clinical skills programmes	Established Increase

Where to next?

There is a significant amount of work required to ensure successful delivery of Waitemata 2025. We need to accelerate progress in those areas already underway and make bolder, faster decisions about new initiatives, adopting a bias for action and a real drive to effect change. This will require further investment and additional programme management support. Some of the key next steps required to deliver upon the PCSP are described below:

1. **Refinement and management of the PCSP:** In order to ensure that this plan is validated and operates as a living document moving forward, forums to enable ongoing consultation/collaboration from community groups (WDHB, Primary Health Networks, ProCare, Waitemata PHO, General Practice, NGOs and other providers, Patient etc.) will need to be established and held. This will likely include regional stakeholders so that there is broader communication occurring.
2. **Integration of the HSP and PCSP:** Both the Health Services Plan (the plan for DHB provided services) and the PCSP provide insight into the future of specific aspects of the WDHB 2025 vision. To ensure effective implementation of both of these plans, there is a need to ensure that the plans are integrated, with initiatives delivered under each plan being complementary, assisting the achievement of health outcomes for the district's population. Detailed investigation into how primary and secondary care will work together will also need to be addressed.
3. **Setting up Programmes of Initiatives:**
    a. **Prioritisation and acceleration of initiatives:** The PCSP process has identified a large number of potential initiatives, particularly in the immediate term. Therefore, a prioritisation process will need to be undertaken in order to ensure that the DHB and its partners are investing in the initiatives that are most likely to provide significant gains against the desired outcomes in the short term

b. **Detailed planning/Business Case of prioritised initiatives:** In order to ensure that the 10 year vision is met, detailed planning will need to be conducted on the prioritised initiatives so that the DHB and its partners can deliver this long term view. These are likely to be grouped into programmes of work and will need to be put through a Business Case process where large investment is required. A timetable for initial business cases is shown in the table below.

Business Case	Board Meeting
MH (primary mental health)	June 2016
STEP programme (Stroke rehab, prisoner health, serious mental illness)	June 2016
POAC	October 2016
Rural Alliance	October 2016
AAA Screening	November 2016
CVD and diabetes	2017
Whanau ora	2017
Workforce development	2017

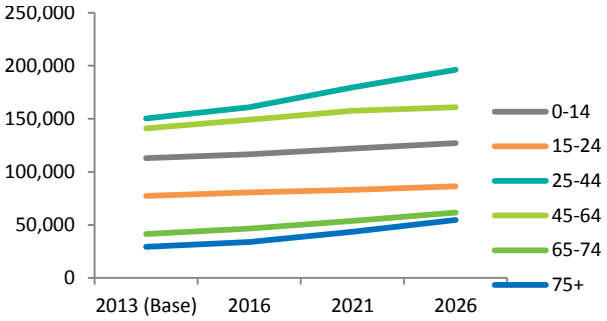
c. **Process for incorporating new initiatives:** Through the continuous development of the CSP, WDHB is likely to identify additional areas of high need that are not addressed by one of the current initiatives. A process needs to be put in place to prioritise and incorporate these into a programme of work

d. **Adopting a programme management approach:** Ensuring that sufficient resources are in place to design and implement the changes set out in the PCSP.

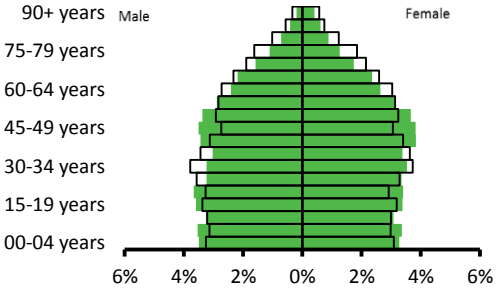
Beyond these key next steps, there is a need to continually review and update this CSP as WDHB steps closer to 2025.

Appendix 1 – Population Growth

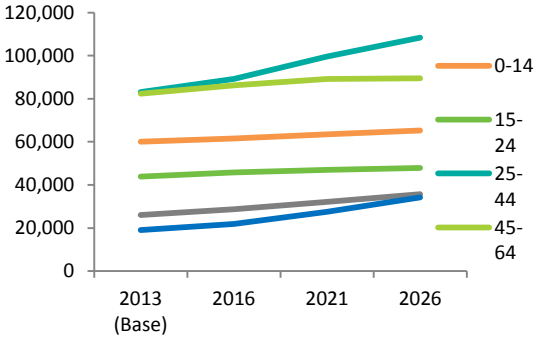
WDHB's total population is expected to grow 24% by 2026 with the largest growth in the 25-44, 65-74 and 75+ age groupings



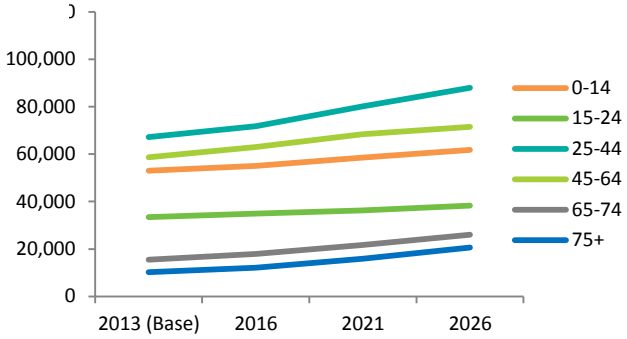
There will be a large shift in the age profile through to 2025



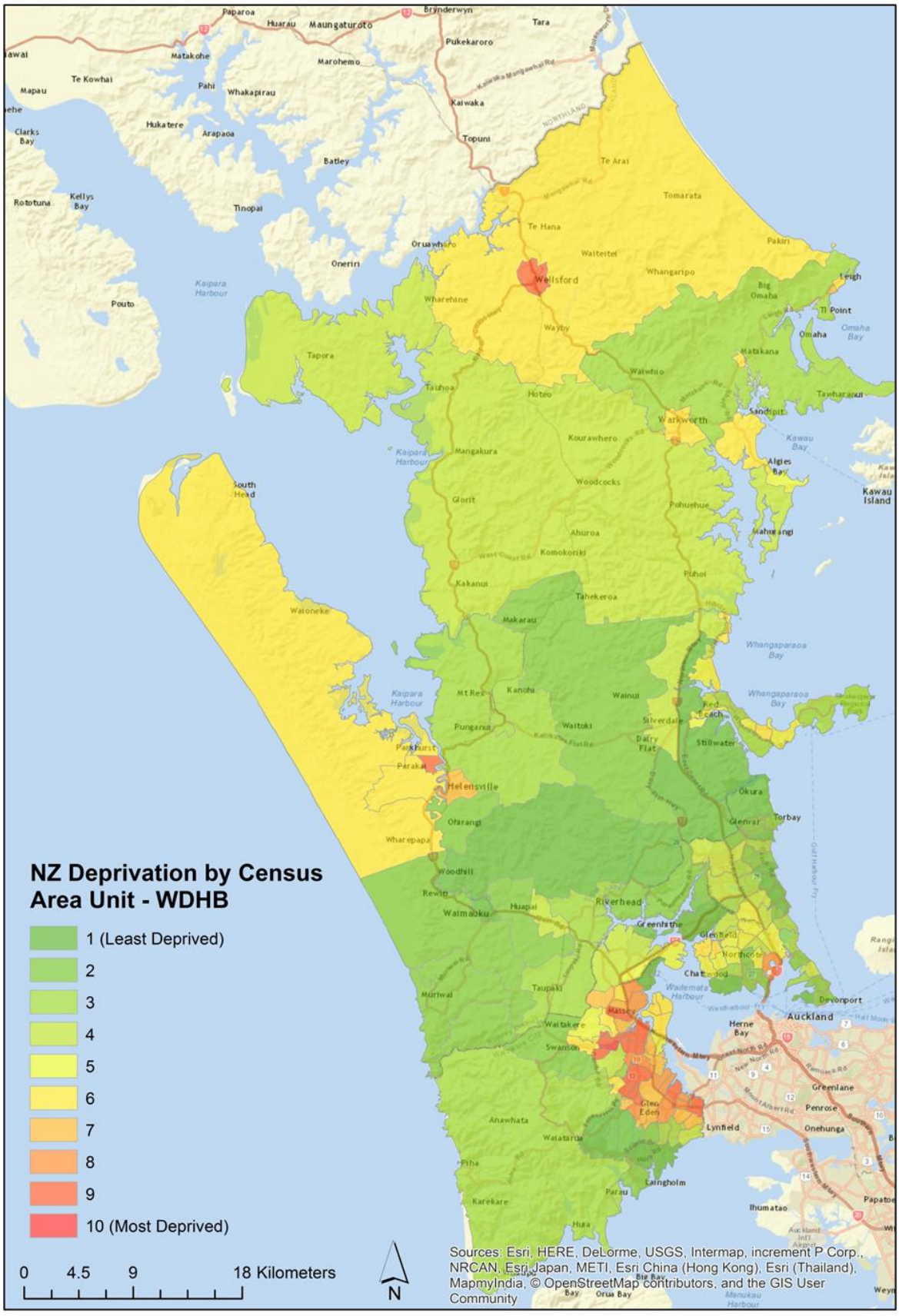
The population is expected to grow by 21% by 2026 in the North region of WDHB with large growth in the 25-44 and 75+ age groups



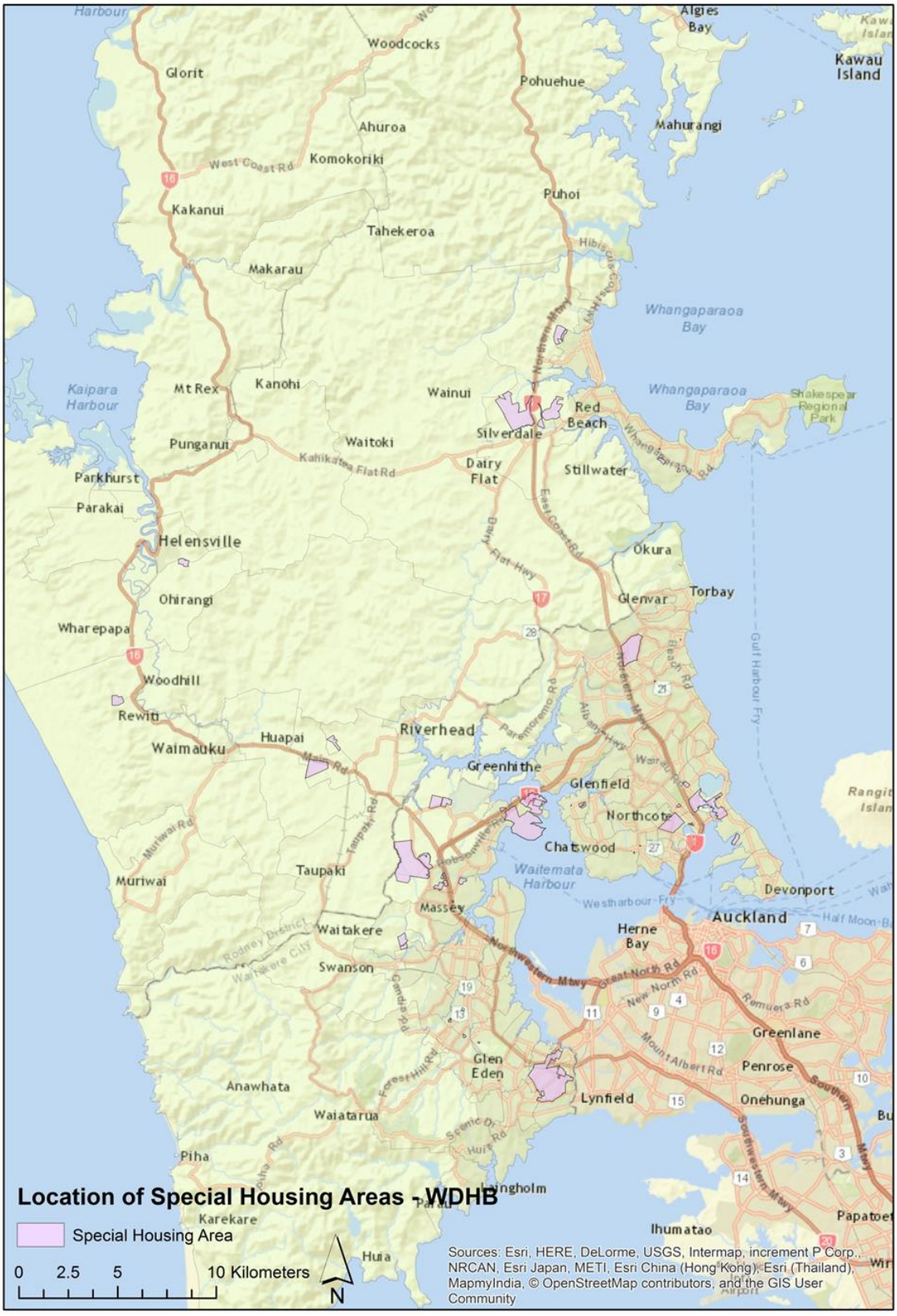
The population is expected to grow by 29% by 2026 in the West region of WDHB with large growth across all age groups (except 15-24)



Appendix 2 –Waitemata region and New Zealand Deprivation Index by Census Area Unit



Appendix 3 – Location of planned special housing areas in Waitemata DHB region

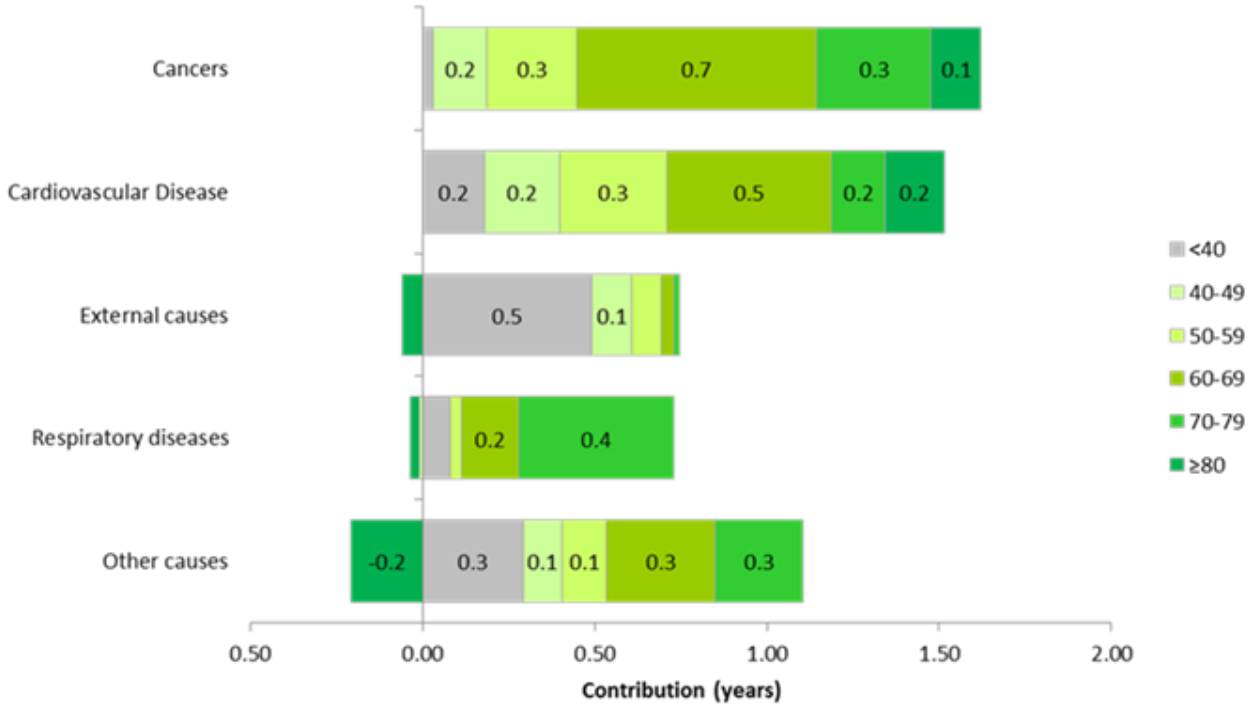


Appendix 4- Population and services by Board

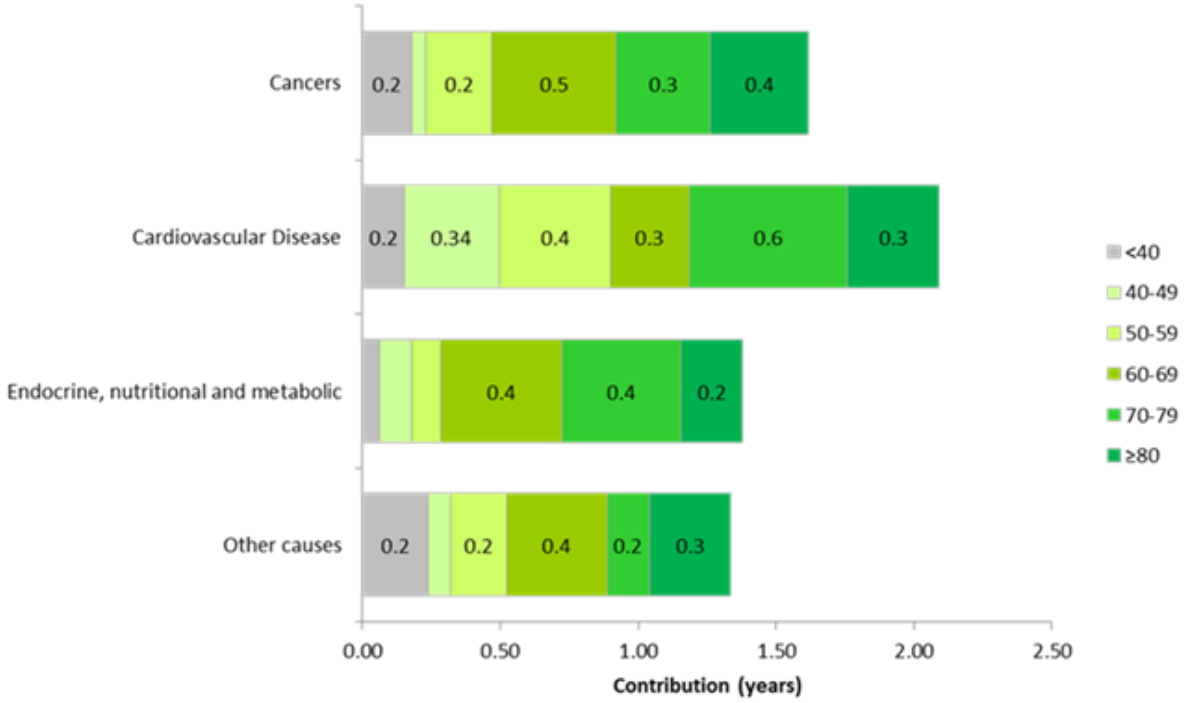
		Rodney	Hibiscus & Bays	Upper Harbour	Kaipatiki	Devonport-Takapuna	Henderson-Massey	Waitakere	Whau	Waitemata DHB
Population	Population 2015/16	63,289	103,437	64,629	92,820	63,289	123,382	54,682	17,863	583,390
	0-14 yrs	23,930	35,720	23,290	35,245	21,565	54,530	22,905	14,785	231,970
	75+ yrs	7,455	16,370	5,840	8,650	8,420	11,095	3,705	4,485	66,020
	Projected pop 2025/26	78,520	122,681	83,734	100,887	70,387	146,665	59,855	22,511	685,240
	Increase 15/16 to 25/26	15,231	19,244	19,105	8,067	7,098	23,283	5,173	4,648	101,850
Socio-economic ind	NZDep2013 Quintile									
	Q1 (least deprived)	24%	43%	47%	20%	39%	4%	35%	8%	26%
	Q5 (most deprived)	5%	1%	0%	4%	1%	23%	10%	17%	8%
	Number in Q5	3,388	637	150	3,972	481	28,709	5,433	3,092	45,862
	People in crowded households (needing 1+ bedrooms)	5%	4%	5%	11%	6%	17%	10%	19%	10%
Health outcomes	Life Expectancy, 2012-14	84	84	83	83	85	81	83	82	84
	Cancer mortality ASR per 100,000 population	121	109	109	101	94	139	112	110	
	CVD mortality ASR per 100,000 population	90	80	114	98	82	107	112	118	
	Avoidable hospitalisation ASR/100,000	2,100	1,800	1,600	2,400	1,900	3,400	2,500	3,200	
	ASH 0-14 ASR	2,108	1,623	2,020	2,148	1,482	2,975	2,711	2,510	
	ASH 45-64 ASR	1,885	1,893	2,339	2,198	1,631	4,382	2,652	3,257	3,808
Services	GPs	57	65	63	73	56	74	11	35	434
	Patients per GP	1,053	1,518	957	1,232	1,073	1,585	2,486	1,247	1,341
	Pharmacies	9	16	16	21	18	24	3	12	119
	People per pharmacy	6,667	6,169	3,769	4,281	3,339	4,888	17,400	3,097	4,838

Appendix 5 – Life expectancy gap decomposition Māori and Pacific

Contribution of the leading causes of mortality to the life expectancy gap (5.4 years) between Māori and non-Māori/non-Pacific ethnicity by age – Waitemata DHB (2010-12)

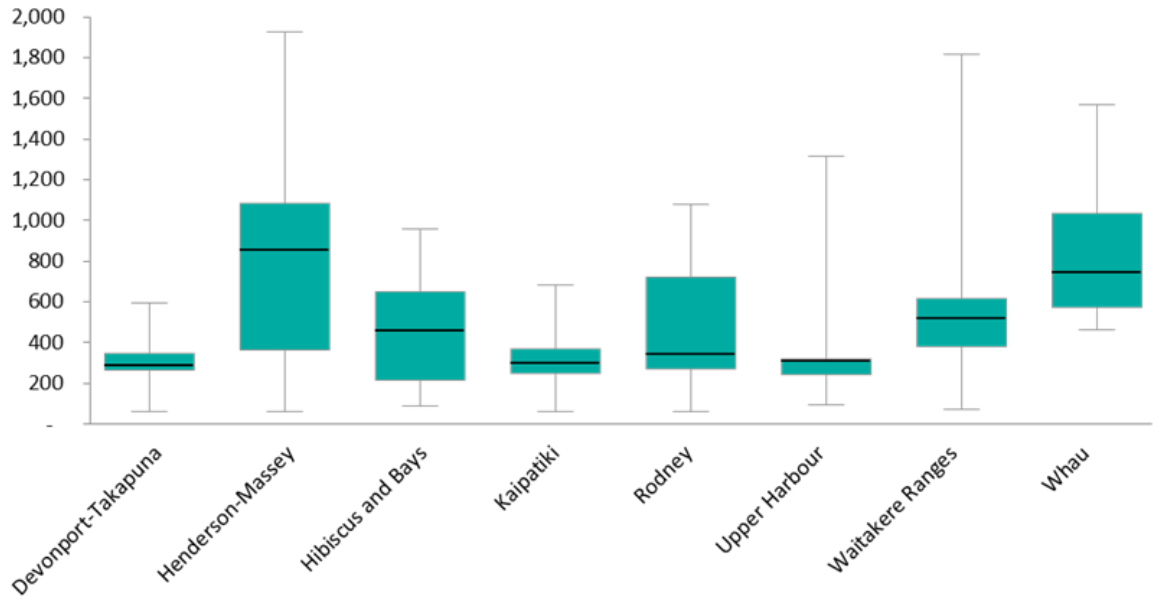


Contribution of the leading causes of mortality to the life expectancy gap (6.4 years) between Pacific and non-Māori/non-Pacific ethnicity by age – Waitemata DHB (2010-12)

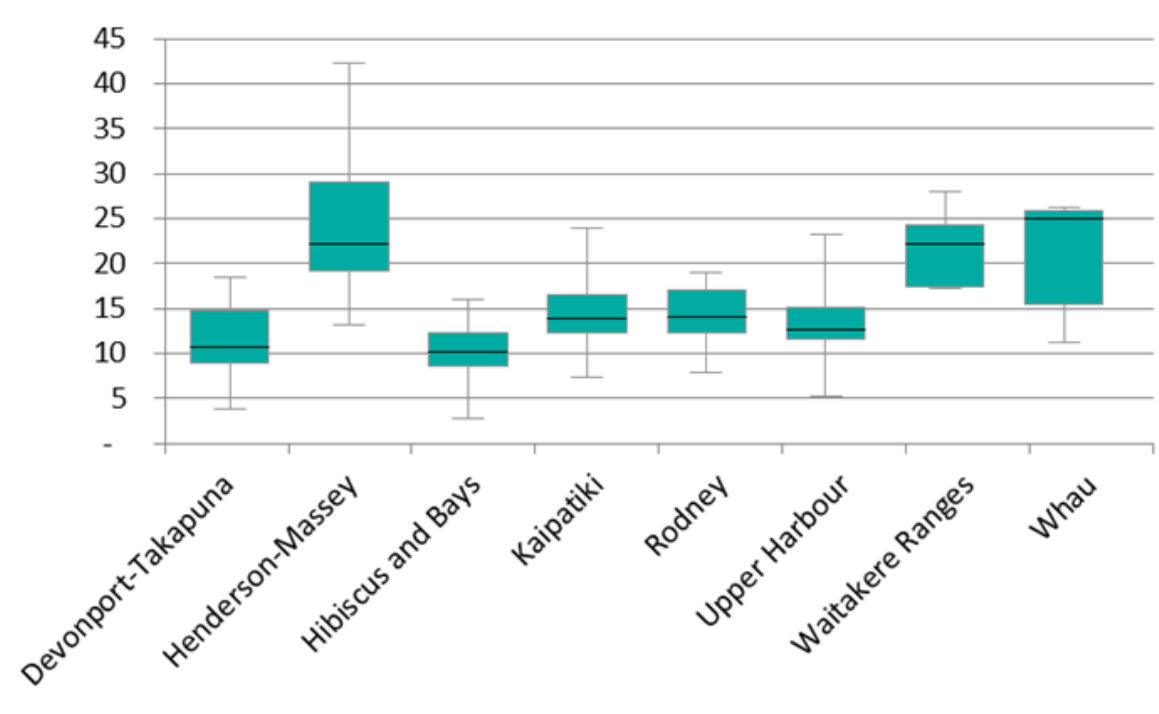


Appendix 6 – Variation in ED attendance and acute admissions by local board practices

Variation in ED attendance rate for practices within specific local boards



Standardised percentage of total acute admissions that are ASH admissions by community board and practice



Appendix 7 –Key indicators by ethnicity (where available)

Section	Indicator	Waitemata Total	Māori	Pacific	Asian	European/Other	NZ
Health services							
Access	GPs per 100,000 population	75					84
	% enrolled with PHO	96%					
	% of adults who visited GP in last 12 months	76%	82%	76%	69%	80%	77%
	% of adults unable to visit GP (due to transport, cost, availability)	22%	30%	32%	17%	23%	27%
	% of adults unable to visit GP due to cost	14%	18%	21%	13%	14%	15%
	% of adults unable to visit GP due to transport difficulty	3%	6%	10%	4%	2%	4%
	% of adults unable to get GP appointment within 24 hours	11%	12%	13%	9%	11%	15%
Health Status							
Smoking	Current smoker status -GP	13%	33%	20%	7%	12%	18%
	% of smokers receiving advice to quit	83%	82%	84%	79%	83%	
	% of smokers referred to cessation services	28%	26%	31%	28%	28%	24%
CVD	% eligible adults having CVD risk assessment in past five years	90%	86%	88%	91%		90%
	% of pop'n with IHD on triple therapy (target 70%)	55%					
	% with risk score > 20 on dual therapy (target 70%)	41%					
Diabetes	Estimated population with diabetes	31,000					
	% of population with diabetes	5.5%	4.0%	10.3%	Indian: 11%	5%	5.5%
	% of diabetics having annual check	32%	33%	37%	31%		
	% of diabetics having annual review well-managed (HbA1c <64 mmol/mol) Target 75%	70%	60%	59%	74%		
	% of diabetics receiving retinal screening	72%					
Screening	Breast screening uptake (% of eligible women)	67%	61%	78%	67%		71%
	Cervical screening uptake (% of eligible women)	77%	57%	73%	64%	84%	77%
	Colorectal screening uptake (% of eligible people)	53%	48%	38%	50%	53%	
Immunisation	% fully immunised at 8 months Q2 2015/16	93%	87%	96%	98%	92%	95%
	% fully immunised at 24 months Q2 2015/16	93%	94%	94%	98%	90%	93%
	% immunised against HPV	43%					
Hospitalisation	Ambulatory sensitive hospitalisation rate: 0-4 yr olds	5,273	5,478	10,369	4,460		6,816
	45-64 yr olds	4,227	7,356	10,463	3,594		3,808

Appendix 8

Stakeholder workshops

The below tables were created through engaging in workshops with the relevant Primary and Community services in order to understand where they saw the key challenges in the future and potential service directions that could help address these key challenges. Throughout these workshops the responses were collated and mapped across the timeframes (Short, Medium and Longer term) and theme type (Workforce, Services & Facilities, Technology, and Sustainability). These tables highlight the service direction of the services within each Division and have been used to develop the Community Services Plan.

List:

- Children's Health
- Health of Older Persons
- Primary Care
- Palliative Care

1. Children's Health:

Trends: What are the key trends that will impact the delivery of Children's Health in Waitemata in the next 10 years?

1. Discussed trends in CH

a) Population Trends

- **Changes at home:**
    - **Single parent families/busier/more complex families (time and/or resource poor):** Continued increase in single parent families is expected
    - **Poverty:** It is expected that in certain areas, levels of poverty will continue to increase, resulting in increases in poor health outcomes – and these areas don't attract HPs
    - **Isolation:** Technology and housing style may increase this
    - **Housing issues:** With housing becoming more expensive, there is a risk the population may become more transient
    - **Substance abuse:** Expected increase in the prevalence of substance abuse (particularly meth) as a result there is likely to be an impact on children' health
    - **Family violence:** Family violence expected to continue as a factor impacting children's health
- **Mental health:** Increasing prevalence of mental health issues and increasing recognition of the impact of these issues on children
- **Chronic conditions:** Increasing prevalence of chronic conditions at younger ages
- **Inequality:** Expectation that Māori and Pacific women continue to have children at younger ages, while the rest of the population has children at older ages – driving an increase in inequality

Gaps: What are the gaps in the Children's Health services currently provided?

a) Services

- **Maternal mental health:** Mental health support for mums seen as an ongoing issue that impacts children and that is not currently a focus. Could have a significant impact on improving the outcomes for children
- Perceived need to intervene with high needs children earlier and more effectively
- Potential to move toward Proportionate Universalism – some services for all, more services for these that need them

b) Model of Care

- **Increased connectivity:** View that patient needs are becoming more complex and as a result, the need for interconnected, interagency responses is increasing
- **Design of services:**
    - View that currently services are designed, based on the population average – resulting in services don't always effectively target 'high need' patients, and as a result increases in inequality
    - Potential to reconsider how children's health care is provided. Views were expressed noting that the current model of the 15 minute block with a GP isn't meeting the patients' needs as well as it might for adults

c) **Technology**
    - **Balance technology with face to face:** An increase in the use of technology has been observed. The requirement for face to face interaction remains as isolation continues to be a risk factor

d) **Facilities and Assets**
    - **Geographic gaps in service provision:**
        - Perceived low healthcare availability in poorer areas (i.e. Ranui) while a 40 min drive away its saturated with availability (i.e. Takapuna)
        - Perception that infrastructure development in not keeping up with population needs in high growth areas

Aspirations: What are your long term aspirations for Children's Health? What would you want Children's Health to look like in 2025?

- **Increased connectivity:** Increased integration across all Children's Health services, including sharing of health records and other relevant information, to ensure a positive patient experience, including transitions across different services/models of care/geographies/primary and secondary – other agencies (e.g. Social Services)
- **Outcomes focused**: outcomes should be targeted around longer term population health improvements rather than short term targets, with responsive and continuous monitoring of these outcomes
- **Model of Care utilising the community:** Services are part of the community – integrated into where people live, work and play (schools, supermarkets, sports team, virtual portals) with expert advice targeted to the communities that need it most
- **Patient Experience:** Co-designed with the community to make the patient experience easy, accessible, simple and easy to navigate, with patients and their whānau feeling comfortable (i.e. not 'shamed'), and with interventions occurring at the earliest possible point

Responses: What are some potential changes we could make to current service provision to help us achieve our aspirations?

Identified service challenge	Potential service response	Time Frame
Models of Care		
There is a lack of community involvement in model of care planning	• Incorporate patient representatives in model of care planning, particularly for areas of high need/inequity of outcomes	Short Term
Method of designing, delivering and funding children's health services could be more connected across providers and targeted more for children to deliver better outcomes	• Convene a group of service providers with a special interest in children's health to help them develop a pilot approach to address these service delivery challenges	Medium term
There are a variety of high need patient groups that are not getting access to the right services	• Investigate boundary around what's community/secondary as some primary occurs in hospital settings and vice versa • Develop closer relationships and collaborate with other social services (i.e. MSD, Ministry of Education) • Develop services for those who are not accessing care based on where they are spending the most of the time (i.e. school kids may need services in schools, preschoolers require different access points)	Medium term
Services and Facilities		
Service delivery not always aligned to children's and young people and their families health needs (e.g. difficulty getting to appoints due to transport/work/other family commitments)	• Use DHB data to understand where children's health services should be targeted and how service provision could be targeted more effectively • Develop methods to collect non DHB data where useful in order to utilise big and better understand where and how people are accessing services in order to direct services appropriately (e.g. supermarket planners know where the flow is and build accordingly)	Short term
Workforce		
The current workforce cannot adequately identify the children and young people in greatest need	• Develop based on model of care changes	Medium term
Sustainability		
Lack of service focus for maternal mental health	• Develop a working group for improved non-acute maternal mental health (we have concept in development through PFYOL – will need to have funded interventions), identifying the desired outcomes and how these could be delivered	Short term

2. Health of Older Persons:

Trends: What are the key trends that will impact the delivery of Health of Older Persons in Waitemata in the next 10 years?

1. Discussed trends in HOP

b) Population Trends

- **Increased population:** Expected population increases, particularly in the group of older people, will increase the need for Health of Older people services
- **Comorbidity on average will continue to increase:** Expectation that as patients live longer and have better care, on average the population will have a higher comorbidity which will put further strain on primary care
- **Changing demographics of aging:** Expected increases in cohorts that are becoming older that we haven't dealt with before, or haven't dealt with in these numbers/volumes:
    - Older people with mental health issues
    - Older people with addiction issues
    - Older people with obesity issues
    - Older disabled people
    - Older people from overseas (less family in the country etc.)
    - Older people with co-morbidities
    - Older people who are well (as a result their main need may be addressing social isolation)
    - Younger people with dementia who will need to be treated via the dementia pathway

c) Facilities and Assets Trends

- **Aged Residential Care:** View that increases in population and aging population will drive increased demand for Aged Residential Care beds

d) Workforce Trends

- **Consumerisation of HOP Care:** View that Baby Boomers are far more demanding and this increase in service expectations could impact the level of service and types of service that need to be delivered
- **Workforce:** The current workforce described as 'aging and low paid'. Perceived need to address this by making the industry more attractive. View that this could be done through pay increases, coupled with other efforts to make team members feel more valued such as training opportunities

e) Information Technology Trends

- **Use of technology:** Expectation that technology will continue to improve at a pace faster than WDHB's approval cycle (i.e. apps are outdated by the time they can be approved). There is a need to start utilising tech and having shared info systems

Gaps: What are the gaps in Health of Older People services currently provided?

2. Gaps Identified in HOP Services

a) Model of Care

- **Navigation:** Perception that it is currently difficult for a patient to navigate through the services or potential services that can address their care needs. This could be improved through an increased focus on 'navigation' of health of older people services
- **Definition of 'Older People':** View that considering only 65+ only can be too restrictive. Expectation that there are significant numbers of 50+ patients with needs that are typically seen as 'older people' type needs, as well as 70+ patients who are fit and well and have different needs
- **Cognitive Impairment:** The need to provide support to patients with mild cognitive impairment (that is not quite at the standard of dementia) is seen as increasing. Currently, there is a lack of services targeting this specific group

b) Facilities and Assets

- **Emergency housing:** Perception that there are currently very few options for emergency housing for older people – i.e. the refuge may not take over 65s and mental health beds can sometimes be used, but this is not their purpose and they are very scarce
- **Funding:** The view is that there is currently inequity in asset testing and co-payments. There is a need to enable new and different ways to fund so that there is flexibility. Funding needs to follow the patient

Aspirations: What are your long term aspirations for Health of Older People services? What would you want Health of Older People services to look like in 2025?

3. Aspirations Identified in HOP Services

a) Model of Care

- **Older people service portfolio:** We understand the types of needs that older people typically need care services to address and the 'care pathways' for this portfolio of services. This view helps us better identify gaps in the services, development areas and the accountabilities of different groups
- **Integration:** We treat the Older Person as a person and not just as a series of medical issues to be addressed in a silo through an 'Older Person Whānau Ora' style approach, where service providers share information about the patient, including a patients needs and goals, as detailed in an advanced care plan
- **Mobile workforce and models of care:** More care delivered closer to people's homes/ rest homes

b) Information Technology

- **Leveraging of telehealth:** Increased range of telehealth services targeted specifically for older people – reducing the burden on the current system and delivering an improved patient experience
- **Data and analytics:** Service delivery is more efficient and with the right care delivered at the right time, driven by smarter insight on patient needs driven by improved data and analytics

c) Workforce

- **Increasing Diversity:** A more diverse workforce that takes into account both ethnic and age appropriate access points and needs

Responses: What are some potential changes we could make to current service provision to help us achieve our aspirations?

Roadmap Area	Potential service Direction	Time Frame
Models of Care		
A need to understand how to deliver services in the community	• Investigate potential 'mobile model of care' options to enable the delivery of more services in the community. I.e. mobile x-ray that can go to patients homes/rest homes	Short Term
A need to understand the types of needs that older people typically need care services to address	• Understand the profile of needs that older people typically need care services to address. • Once these needs are defined, develop the equivalent of the 'care pathways' for this portfolio of services.	Short - Medium Term
A lack of integration between service providers, resulting in a siloed approach to service delivery, a lack of understanding of the services available, who is accountable for these services and difficulty in 'navigation' of these services	• Investigate the development of a system that would provide improved connectivity between HOP and the DHB and HOP and other providers/health participants in the sector (i.e. NGO, PHO)	Medium term
Services and Facilities		
Lack of assurance from the DHB to providers as the contracts are not long enough	• Investigate the potential for WDHB to provide longer term provider contracts to enable greater provider funding certainty	Short Term
Lack of short term Emergency Care	• Identify potential locations/facilities that could provide short term emergency housing for older people	Short term
Information technology		
Lack of data and analytics	• Investigate ways to improve the collection of data in relation to the provision of health services to Older People • Investigate potential data analysis solutions	Short Term
Lack of use of telehealth	• Determine how the provision of Health of Older People services could be improved through the utilisation of Telehealth • Pilot then roll out extended telehealth services	Medium Term
Lack of older people with health literacy	• Develop additional information that can be shared with older people and their families and carers in order to increase their levels of health literacy, especially in regards to the health of older people	Short term
Workforce		
Lack of people entering into the Health of Older People workforce	• Understand the Health of Older People workforce in order to be able to better focus the improvement initiatives and increase the value that is placed on working in HOP services	Short term
Lack of diversity in the Health of Older	• Based on our understanding of the Health of Older	Short term

Roadmap Area	Potential service Direction	Time Frame
People workforce	People workforce, identify the ethnicities that are underrepresented and target recruitment in these areas, to ensure ethnically appropriate services can be provided	

3. Primary Care:

Trends: What are the key trends that will impact the delivery of Primary Care in Waitemata in the next 10 years?

1. Discussed trends in PC

a) Population Trends

- **Increased population:** Projected population increases need to be matched by increased level of primary care services targeted in the growth areas
- **Migrant population:** Likely to mean that changes will need to be made to primary care services to ensure culturally appropriate care is provided
- **Increase in chronic care:** Given the increase in life expectancy, it is expected that there will be a need for primary care to be able to deal with/provide support to patients requiring chronic care in larger volumes

b) Workforce Trends

- **Aging workforce of GPs** – perceived need to bring more GPs through the system to meet the demands of the increasing population
- **Increased stratification of services:** Trend towards clinicians focussing more on the 'higher skill services', with other services being delegated to nurses, and non-clinical staff

Gaps: What are the gaps in the Primary Care services currently provided?

2. Gaps Identified in PC Services

a) Services

- Public dental
- Skin legions
- Neurology
- Endoscopy
- Dermatology

b) Model of Care

- **Role of the DHB**
  - Perception that there is no meaningful partnership currently between the DHB, PHOs and GPs and that changes could be made to improve this. Noted that other DHBs have made improvements in this area such as through the Primary Care Directors/GP Liaisons at ADHB
- **Current model of care under pressure**
  - Noted that patient expectations, growing patient numbers, increasing costs, increased devolution of traditional secondary services to primary care and the current funding approach are placing the current model of service delivery under significant pressure.
  - All these changes are expected to continue and the view is that the current model of primary care service provision is unlikely to be able to address these
- **Integration**

- Feeling that the primary care sector is constantly reactive – they do not have a joined up view of the sector, its services, goals, progress against goals and best practice
- Diagnostic led access
- Physiotherapy in public
- Mental health support in general healthcare

c) Workforce

- **Up-skilling:** Identified that there is a need for clarity on what services should be delivered at the differing skill levels within Primary Care, how quality can be maintained and how the workforce can be up-skilled to deliver these services
- **Nursing:** Noted that Nurses are playing an increasing important role in primary care. However, there is an undersupply of primary care specialised/qualified nurses and no effective, consistent programme to train them. On the job training is expensive, varies in effectiveness and consistency of skill development

d) Funding

- **Sustainability of GP model is under threat**
  - View expressed that the co-payment model "does not bear any relation with reality." Rising costs across the board, and asking to change models of care - but unsure where can get the money to do this. Need to work under a commercial model and charge appropriately to fix this.
  - Moving to larger centres working longer hours. Capitation does not enable the right change
- **Policy can conflict with sustainability**
  - Policy changes can impact on the sustainability of the business model

e) Facilities and Assets

- **Space:** Finding space to deliver the required services – and funding the development of the required additional space is becoming increasingly challenging for private practice

Aspirations: What are your long term aspirations for Primary Care? What would you want Primary Care to look like in 2025?

Model of care

- **Role of the DHB:** A view that the DHBs role should be to act as a hub to:
  - Be a guiding voice on policy and sector direction (particularly where this will effect investment decisions by primary care providers)
  - Share information on the population (demographics etc.)
  - Share best practice (the most effective interventions)
  - Share resources to smooth out short term demand increases, and
  - Increase the capability of the sectors resources through training
  - Ensure that the right relationships are being built within the primary care sector
- **Current model of care under pressure:**
  There is effective alignment between the services, the funding and the desired outcomes, to deliver a high quality, sustainable model of care
- **Integration:**
  Clinicians are sharing with each other and with secondary care, with a view to the long term rather than feeling like a divided group

Practices will have identified and grouped with other 'like' practices, into something that "looks like locality planning" helping develop greater understanding across the sector

i. Not just Doctors and nurses, also pharmacists, physios, NGOs and any other organisations providing primary care

Workforce

- **Planning:**
  - Planning process that is supported by the DHB and is across the whole system (Incl. pharmacy and nursing)

Technology

- **Data sharing:** Increased trust and communication in data sharing between the DHB and the sector as well as parties within the sector, delivering a more effective patient experience

Facilities and Assets

- **Space:** Space found to deliver the required services – and funding the development of the required additional space is planned and accessible (where appropriate)

Funding:

- Outcomes based funding that is more closely linked with provider effectiveness while producing better patient outcomes. Supported by increased social investment approach

Measurement of outcomes

- Outcomes measured by the delta (i.e. the level of change that is delivered by a service) as a more effective approach than measuring an absolute value. Practices/Providers target their own outcome areas (aligned to the DHB and National health outcomes). Ensuring provider buy in and drive a culture of improvement, rather than a culture of busy-ness

Sustainability

- Sustainable business model driven through longer term provider contracts

Responses: What are some potential changes we could make to current service provision to help us achieve our aspirations?

Identified service challenge	Potential service response	Time Frame
Models of Care		
Lack of integration within the primary care sector, as well as between primary care/secondary care and DHB	• Increase integration: Consider ways to enable primary care providers to self-organise into groups that can address the issues caused by lack of integration, whilst potential linking outcomes measurement and funding to these groupings	Short term
The current primary model of care is under pressure from a range of factors – changes need to happen to ensure the level of service quality is maintained	• Primary Care Model of Care review: Convene a Primary Care team to undertake a review to determine the key pressure points in the model of care and develop solutions to address the challenges causing these and identify the short term/medium term/long term responses	Medium term
Lack of clarity of the role in the DHB in primary care	• Clearly define the role of the DHB as a "hub" for the primary care providers, identifying the services the hub can provide and how the DHB can change its people, processes and technology to deliver these	Medium Term
Services and Facilities		
Ability to invest to develop the required primary care capacity	• Determine the WDHB strategy for co-investment in primary care facilities	Short term
	• Work with providers to address capacity issues	Medium term
Information technology		
Need for trusted and integrated data sharing within primary care and between DHB and primary care providers	• Review the proposed Electronic Health Record programme to understand how effectively this will meet the needs of the primary care providers	Short term
	• Identify any gaps, and tactical or strategic ways the DHB can address these	Medium term
Workforce		
Increased stratification of primary care services	• Within the Waitemata DHB region, work with primary care providers to identify a stratified service catalogue – those services that can be delivered by GPs/Nurses/or other to help drive consistency and efficiency across the sector, supported by a centralised training and capability development programme	Short term
There is a lack of workforce planning at the system level	• Develop a workforce planning strategy that takes into account the entire workforce (i.e. Pharmacy, GP nurses)	Medium term
Lack of nurses skilled and experienced in primary care	• Develop a specific 'primary care nurses' training programme within the DHB that can be used to develop a pipeline of specialist nursing resources	Medium term
Other		
Funding Review	• Review of the WDHB approach to funding primary services to consider how funding can: ○ Better align to the outcomes that need to be achieved ○ Better ensure sustainability for the primary sector	Medium term

4. Palliative Care:

Trends: What are the key trends that will impact the delivery of Palliative Care in Waitemata in the next 10 years?

- **Population changes**
  - Increasing population
  - Increase in aging population
  - Increase in migrant population
  - Increasingly urbanised community
- **Perceived increase in need for integration across relevant services** (both health and social services)
- **Increasing number of patients with Dementia, which is presenting at a younger age**
- **Need for a stronger patient advocate/navigator system**
- **Consumerisation of Palliative Care:** Baby Boomers are far more demanding and this is impacting the level of service and types of service that need to be delivered – i.e. people are more likely to exert their wish to die in their place of choice

Gaps: What are the gaps in the Palliative Care services currently provided?

1. Gaps identified in Palliative Care

- **End of life advanced care planning:** There are initiatives in place with staff to educate them on having end of life care planning conversations. But there is a view that these conversations are not as effective as they could be – noting that it is an extremely sensitive area
- **Compartmentalisation:** Strong feeling that within palliative care there is a need to "protect your own patch" resulting in siloes of information and services between primary/ secondary care and palliative care, as well as between the different providers of palliative care, including:
  - Integration of hospital palliative care teams
  - District nurses
  - Gerontology Nurse Specialists
  - Palliative Nurses Specialists
  - Carers
  - GPs
  - Hospices
  - ARC
  - Social Support services
- This lack of clarity on accountability and inconsistency in services is perceived as impacting negatively on the patient experience
- **General Palliative Care:** Current perception is that the focus is on specialist primary care – the experts who provide support in extreme palliative cases. But there is a need to be integrated with more general or primary palliative - taking the rigidity out of the distinction between care and palliative care
- **GPs role in palliative care:** View that there are not enough GPs providing support and guidance/advice in palliative care

- **Facility and workforce planning:** There is a lack of understanding in the palliative care sector around what facility/ bed requirements and workforce numbers are needed moving into the future

Aspirations: What are your long term aspirations for Palliative Care? What would you want Palliative Care to look like in 2025?

2. Aspirations Identified in Palliative Care

a) Model of Care

- **Improved patient planning/communication:** Greater efficiency in service delivery driven by more effectively prepared and planned end of life care. Better capability across the sector to have these conversations that count with people at end of life and their families and build this into our advanced care planning – better enabling the right to a good death
- **Service Integration and Patient Experience -** Patient experience improved by increased connectivity of palliative care – namely clinical staff and other carers having increased understanding of and visibility to the Palliative Care services that are delivered within WDHB

b) Information Technology

- **Patient Information:** Patients and their families have more ownership of their health information and give more direction to carers on their desired end of life care. Carers provide the assistance required to help patients, their families and carers understand and navigate the potential services

c) Workforce

- **Community volunteer workforce:** Rising demand partially met through an effective community volunteer workforce providing a consistent level of care and quality.
- **Improve interactions between types of workforce:** Increased understanding between the Palliative care workforce as to roles and responsibilities – a workforce that is operating well together at the top of their scope with minimal repetition

Responses: What are some potential changes we could make to current service provision to help us achieve our aspirations?

Roadmap Area	Potential service Direction	Time Frame
Models of Care		
There is a lack of care planning towards end of life	• Improve the implementation and uptake of advanced care planning, to assist patients in planning for their end of life – helping the patient and family understand how healthcare will assist them in this journey	Short Term
There are a lack of training programmes for non-specialists or where there are programmes not enough staff are utilising them	• Increase non-specialist care providers ability to more effectively include palliative care in their activities by delivering palliative care training programmes to wider groups of DHB staff • Investigate how to ensure that identified clinical staff undertake the: ○ Carer Training programme ○ Patient Support programme ○ Bereavement follow up programme	Short term
There is a lack of GP availability within Hospices and their roles are unclear	• Review how to increase GP availability within the Hospices • Review the role of an individual patient's GP vs the Hospice GP to determine how GP resources can be better allocated to ensure effective and responsive care for patients	Short term
Roles for nurses are unclear, which often results in gaps in service	• Define the role of GNS' and nurse practitioners – including the specification of accountabilities and responsibilities – and how they provide an interface between primary care and palliative care	Short term
Discharge and patient co-ordination occasionally does not flow well, resulting in a poor patient experience	• Discharge improvement – smooth the transition between hospital and palliative for patients in need of palliative care by ensuring that all records are shared, and that there is accurate co-ordination of all logistical issues	Short Term
There is a stigma around palliative care which makes patients avoid the topic until late in the process	• Enable people to understand and engage more effectively with Palliative Care – removing the stigma around palliative care, and making it easy to understand the decisions that should be made. This could include the increased use of: ○ Information therapeutics ○ E-triage ○ E-learning ○ E-therapies	Short Term
Services and Facilities		
There is a lack of understanding of what bed and facility requirements are needed	• Conduct bed modelling and investigate need in the future, to ensure that the appropriate level of supply is available to meet future demand	Short Term
Information technology		
There is a need to improve the ability to share health information across providers	• Ensure that all relevant parties have the ability to view the required electronic records of care planning for patients entering or currently in palliative care	Medium Term
Workforce		
There is a need to conduct workforce planning across Palliative Care	• Conduct workforce planning or engage more closely with the DHB in order to direct improvement investments more effectively and ensure an appropriate and sustainable palliative care workforce	Short Term
There is a need to have a more diverse and ethnic workforce to cater to our ethnic population needs	• Investigate the need in the community for specific language support to be provided by Palliative carers • Determine whether technology could assist, or whether training is required in order to meet this need	Medium Term