

‘Health & Healthcare Where it Matters’

A locality approach for Auckland & Waitemata DHBs

1. Introduction

Through 2008 and 2009 both Auckland and Waitemata District Health Boards (DHBs), together with primary care, consulted extensively on their respective Primary Health Care Plans (ADHB 2009, WDHB 2009). Both Boards achieved a high level of cross sector and community support for their plans and they were signed by all the Primary Health Organisations (PHOs) in each district and by Te Runanga o Ngati Whatua.

Both Plans made a commitment to a neighbourhood/locality approach.

Such an approach was to respond to the desire of communities for a more locally nuanced approach to health service planning and delivery than the existing district wide model. They wanted to feel more involved in decisions and see local services being provided to meet local needs.¹ From an organisation point of view, the approach is an opportunity to partner more closely with patients, families, communities and providers across the system to improve health and the quality of healthcare through reducing variation and a whole of system focus.

Since that time, significant progress has been made in refining the approach in both DHBs including the development of the West Auckland Health Network and associated entities, and the development of a locality based community engagement model in ADHB.

This plan consolidates activity to date and sets our locality approach squarely in the context of ‘self directed care’ as we plan for 2013/14 and beyond.

2. Purpose & Approach

“Working together we will create the conditions in which individuals, families/whānau and communities can take greater control over their lives to maximise their health & wellbeing”.

This plan acknowledges that achieving our vision will take time. Our intent in the 2013/14 year is to build on the foundation of work already developed to deliver a series of key projects that moves us clearly in this direction. It is important to note that our locality approach is just one way for us to maximise the health and wellbeing of our communities. There will still be a need for broader district or regional activity, for example the regional clinical pathway work through the Greater Auckland Integrated Health Network (GAIHN).

The locality approach will see enhanced community engagement, clinical leadership, and use of health information, with a sharp focus on putting individuals, their families/whānau and communities’ front and centre.

Supporting the people of Auckland & Waitemata to maximise their health and well being we will ensure:

- people will be empowered to control and maximise their own health and well being, and enhance the quality of their life
- peoples different beliefs about their health or their role in care will be respected
- services will be prioritised based on patient / whānau need and we will work with the community to deliver services that meet their expressed health needs
- people will have rapid and convenient access to high quality cost effective evidence based services
- a focus on reducing health inequalities

¹ Feedback received during consultation on the Auckland DHB Primary Health Care Plan, 2008

- responsiveness to the aspirations of Māori and other ethnic communities such as Pacific and Asian peoples
- a focus on whānau ora approaches

People will see:

- Health care that is adapted to their needs - as they see themselves
- Where possible a choice of services which are efficient and provide value for money
- Delivery of seamless, integrated, individualised or whānau based care, no matter where they touch the system
- Person centred (rather than disease centred) case management of individuals /whānau within a whole health system with the Medical Home (General Practice) as the central care provider
- Improved quality of care, reduced variation and achievement of the National Health Targets

The high level approaches that will deliver these outcomes are:

- **Partnership with local communities** including deliberate strategies to connect with local populations in a continuous rather than episodic way to facilitate shared health service planning & delivery;
- **Meaningful engagement with providers** across the whole spectrum of care;
- **Enhanced local government engagement** through structured links with elected Local Boards; and
- **An inter-sectoral approach** with other government and non-government agencies who have an influence on health and its broader determinants

Appendix 2 contains more information about the principles that underpin the locality approach.

3. What is a 'locality'?

Definitions

A **locality** is defined as one of the Auckland Council Local Board areas. These are geographically defined and encompass all people usually resident in the area.

Our **locality approach** has two related but distinct features:

Locality planning is a population health approach which puts communities and their experiences of health and healthcare at the centre of planning decisions and, crucially, engages those communities in action to improve health. This concept goes further than consulting local people on planned changes or development instead seeking to actively engage them to shape and define the public value, that is, what matters most in terms of health priorities. In general, locality planning is tightly bound to locality boundaries to allow for meaningful population data analysis and intersectoral working, and is part of our broader community engagement strategy.

Locality provision is the better co-ordination and integration of health and related services at the locality level. Importantly this encompasses more than traditional primary care, representing instead a microcosm of *all* health service activity, inclusive of hospital and primary care and other health and social sector services, operating at a local level. Locality provision is **not** tightly bound to locality boundaries to allow the development of functional networks around existing or potential provider relationships and to accommodate known movements of patients.

For operational purposes the localities may be aggregated.

The infrastructure and governance that is planned to support the approach is outlined in Section 6.

Table 1: Auckland DHB & Waitemata DHB Localities

Locality	Population *	District Health Board
Rodney	54,100	Waitemata DHB
Hibiscus Coast	88,800	Waitemata DHB
Upper Harbour	49,000	Waitemata DHB
Kaipatiki	85,900	Waitemata DHB
Devonport-Takapuna	57,300	Waitemata DHB
Henderson-Massey	109,600	Waitemata DHB
Waitakere Ranges	49,000	Waitemata DHB
Whau	76,400	Waitemata and Auckland DHB
Albert / Eden	98,800	Auckland DHB
Puketapapa	56,100	Auckland DHB
Waitemata	70,000	Auckland DHB
Waiheke Island	8,420	Auckland DHB
Great Barrier Island	820	Auckland DHB
Orakei	81,100	Auckland DHB
Maungakiekie Tamaki	73,000	Auckland DHB
Mangere-Otahuhu	75,900	Auckland and Counties Manukau DHB

Rationale for taking a geographic approach

Whilst community based care must care for multiple different populations, (such as communities of ethnicity, age, etc), there are a number of reasons why we should *also* focus on locality populations:

- “Localities are strong natural communities of interest;
- Health services are by their nature geographically located and deliver services within a locality;
- Primary care is by its nature generalist and comprehensive and tends to provide these services within a limited geographic area rather than providing services to more specific groups over a larger area;
- Primary care is strongly linked with local communities. Enhancing this linkage can lead to better involvement with the community and improved access;
- Primary care clinicians need to work closely with other people caring for their patients. This is most easily enhanced through a locality population. Organising primary care, secondary care, and other health providers around the same local populations will greatly assist integration of services.”²

A focus on geographic localities enables us to better understand and address health priorities from local communities’ perspectives. We are able to partner directly with patients families/whānau and the public in the design and ultimately the delivery of health services in defined areas. Existing approaches, such as to diseases (e.g. diabetes) and to whānau ora and the aspirations of Māori can also be interwoven into a locality approach.

* Population numbers are rounded estimates based on Statistic NZ 2009 projections

² Discussion Paper on Locality Planning. Tom Robinson and Vanessa Selak. Waitemata District Health Board, 2010

The locality approach does not replace existing relationships, such as with our iwi partners; existing community networks or programmes such as HVAZ³; or existing disease specific planning, such as for diabetes or cardiovascular disease.

A locality approach seeks to complement them, where appropriate, to further improve health outcomes and reduce inequalities.

Rationale for using local government boundaries

Localities with a population of between 50,000 - 100,000 people are estimated to be required to gain the full benefits of a locality approach⁴. This population size aligns well with the Local Board areas defined for the Auckland Council which has advantages in being able to work closely with our local government partners with common populations.

In determining local government boundaries the Local Government Commission identified three communities of interest: perceptual (a sense of identity with an area); functional (reasonable economy of scale to meet requirements for physical and human services); and political (ability of elected body to represent interests)⁵. These communities of interest are also relevant to achieving an integrated health system.

We have elected to use Local Board areas rather than Wards, as the Local Boards provide a ready community interface for locality planning. In many cases there is a single Local Board for a Ward but where they have been split, the separation also makes sense from a health perspective. For example, this would mean considering the ward of 'Waitemata and Gulf' as three localities (Waitemata, Waiheke Island and Great Barrier Island) [refer Table 1].

5. How are we going to do this?

Delivering our vision will require the integration of activity internal *and* external to the DHB across three broad areas:

1. Better use of health information;
2. Enhanced community engagement (including iwi and MoU partners); and
3. Local service provision & development

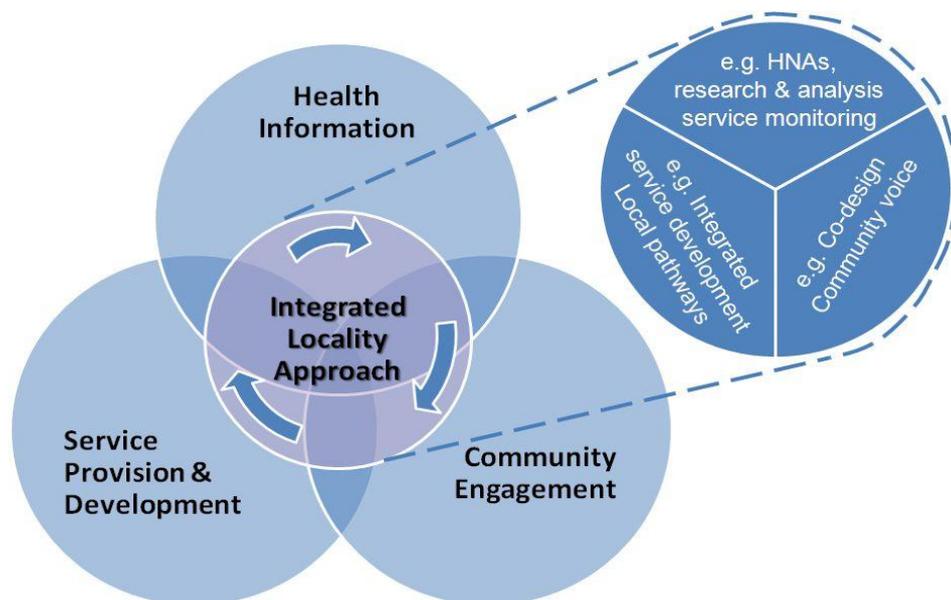
As shown in Figure 1, the three areas overlap, for example the use of community engagement tools to provide health information, but they are a useful frame for grouping action.

³ Healthy Village Action Zones

⁴ Discussion Paper on Locality Planning. Tom Robinson and Vanessa Selak. Waitemata District Health Board, 2010

⁵ Tasks and Approach on Auckland Governance Reforms, Local Government Commission, 2009

Figure 1: Functional components of the locality approach



Health Information

We are awash with data across the health sector but relatively little is translated into meaningful information and less still into a form that is able to inform decision making.

In a locality context the functional component ‘health information’ refers to two broad areas.

1. The first is at a **population health** level where we are working to gain a better understanding of health need and utilisation patterns of our resident population at a locality level. To enable integration with other sectors we are using Auckland Council Local Board boundaries as the functional unit. To do this it has been necessary to reconstruct existing datasets and as part of this process we have been working to make the information more accessible and dynamic (as presented to the March 2012 CPAHC meeting).
2. The second area is data about **enrolled populations** held within primary care, at both practice and PHO levels. Emerging analysis is providing valuable insights into health variance across providers within similar areas and with similar populations. Targeted data analysis will be used to inform specific quality improvement activity. This will reduce avoidable admissions and improve service delivery in key areas such as diabetes management, CVD risk management, smoking cessation and child health.

A number of uses for information in a locality context have been identified, including:

1. **Individual patient management:** Sources include disease registers and/or population registers for preventive and long term condition proactive care.
2. **Improving practice/ practitioner quality:** Focus could start with regional network KPIs first, data sources vary but include individual practice and PHO registers
3. **Local service delivery & integration (community):** There is a need to stocktake services including defining GPs with special interests (GPWSIs), specialist nurses and the need/demand for such, primary care allied health, self-management support – group or otherwise, Family Planning, sexual health, After-hours, youth, community pharmacy etc
4. **Local service delivery & integration (hospital):** There is a need to understand current volumes of service delivery, scale required for efficient service, current local provision, and alternative models
5. **Health promotion / community development:** Need to identify local issues & local resources. Community engagement activity is key and needs to be driven “bottom up”
6. **Inter-sectoral understanding and synergy:** Starting with Auckland Council and MSD (including CYFS), but useful to build and include others e.g. ACC, Housing, Education, Justice, Police etc

7. **Funding and planning:** Provision of information for health needs assessment to guide locality planning processes at Integrated Health Network level.
8. **Wider community understanding & engagement:** Sharing of locality level information with Local Boards and community groups is already proving a welcomed engagement mechanism as we seek to work more closely across the system.

Improving the utility of health information will ensure that DHBs and service providers have more precise information about service access, health need, and variance in service delivery and at a finer level of detail than previously. This will enable us to better forecast demand and more accurately tailor our service planning and improvement activity.

Analysis will be focused to ensure all localities can answer:

- **How healthy?** Reducing health inequalities and improving health outcomes now and in the future. How healthy /unhealthy is my population in relation to my benchmarks?
- **What is really happening in this system?** Information at the right time and to the right person to protect the vulnerable and to ensure the right care is given
- **How much?** improved financial information including budgeting and planning so we know we are spending on the right things with the right provider
- **How do we compare?** challenge the current state through benchmarking and comparison in order to improve clinical outcomes
- **Are the providers who serve our population delivering quality care?**
- **How could things be better?** What are our patients telling us? Focus on patient stories – and keep the focus on what it feels like and what people want for themselves, keep the moral high ground and the shared objective.
- **What difference have we made?** Have we improved health outcomes? Have we reduced inequalities?
- **Responsiveness to Māori?** How are localities working with iwi and MoU partners to maximise Māori Health Gain?

Community Engagement

Community engagement is a very broad concept and we already have numerous mechanisms for engaging with our community and gaining information to inform healthcare planning decisions, service provision and how to improve the patient experience. However many of these activities occur in an ad hoc, or project specific way.

A key feature of the locality approach is planned and proactive ongoing partnership with patients, whānau, iwi and community networks and representatives resident in a geographic locality. The value that the locality approach will add is that it will enrich the relationships and information flow between those who use services and those who develop and provide them. It will facilitate genuine conversations with our stakeholders/NGOs and public (consumers) that is appropriate to each locality.

The locality approach acknowledges communities of individuals as equal partners in service planning.

The key enablers for enhanced community engagement are:

- **Knowledge** of community leaders, networking meetings and appropriate access pathways for minority communities.
- **Good will:** intention of all parties to share, consider and utilise information.
- **Health Literacy** as two way, culturally appropriate, verbal and written communication.
- **Sector leadership** identified and known, available and accessible.
- **Communication:** Transparency and consistent communication between all parties, including the agreement of a specific communications strategy.

- **Collaboration** with local government, other Government organisations (MSD, Housing etc).
- **Co-ordination** of touch points with individuals (consumer voice), NGOs, communities (public voice) and ensuring the feedback loop is managed.
- **Accountability** mechanism/ indicators of genuine conversations.

The locality approach provides a rigorous framework and enduring connections to engage patients, whānau and representatives and leaders of local communities in three distinct areas:

1. Local perceptions of health status

Such an assessment will be used to inform the qualitative component of local health needs assessments/profiles. Engagement in this area could also be used to help us understand variability in health status between and within localities.

2. Patients', families and communities experience of service delivery.

This topic area would usually be explored at the service level.

From a patient/family point of view:

- a. what's working well?
- b. what needs to be improved?
- c. how can we best do that?

This information will directly influence service re-design. The degree of involvement could be extended to directly involving patients and community representatives in the design of local services (ie: "co-design"). Engagement in this area could also serve performance monitoring purposes: we will draw on service users' experiences of service delivery to help us understand the reasons for service performance variability between and within localities.

3. Patients', families and communities understanding of value⁶.

This topic area would usually be explored at the level of planning and strategy in the Integrated Health Networks. From patients and communities' points of view:

- a. what matters most for patients, families and communities?
- b. for what health conditions is the system delivering value for patients and where is it not?
- c. what maximises outcomes (including the sustainability of health benefit) for patients and their families/whānau?

Engagement in this area will influence decision-making at the system-wide level, for example, sector integration and strategy.

Patients will see the DHBs and PHOs keeping in touch with their views and experiences across these three topic areas and, where appropriate, their input factored into service development and improvement activity.

Service Provision & Development

The service provision & development component of the approach is where the health system responds to the signals that have been generated through looking at the available health information and engaging communities in conversations about their health, priorities and value. It is where the 'rubber hits the road' in terms of service integration and a locality approach offers real potential to allow a significant departure from current models of service delivery, including the potential to 'co-produce' services with communities⁷.

⁶ Defined as the health outcomes achieved per dollar spent. *A Strategy for Health Care Reform - Toward a Value-Based System* (Porter 2010).

⁷ *Co-Production in Public Services: A New Partnership With Citizens* (UK Cabinet Office: The Strategy Unit, 2009); *The Challenge of Co-Production* (NEF, The Lab, NESTA, 2009).

Co-Production goes beyond factoring community input/ feedback into service design and improvement. It involves designing *and* delivering services collaboratively. There is a growing body of evidence to show that such an approach can deliver benefits across service accessibility, quality, outcomes and costs in a range of settings and service areas. While true co-production will take time, antecedent concepts such as co-design⁸ are an achievable first step.

It is through this function that we will begin to describe the role and function of primary care practices as access and care coordination points. Such functions may include:

- Population focus with targeted population based interventions
- Locality linkages to ensure population access to extended services and subspecialisation within primary care
- Care navigation based in primary care
- Services accessed via primary care or direct access eg access to talking therapies
- Attached staff e.g. district nurses, rapid response services
- Access to diagnostics and near patient testing
- Telecare and telehealth
- Extended access
- Multi modal consults (video, phone, email)
- Interdisciplinary practice and model
- Extended team eg, clinical pharmacist, health care assistants, extended scope nurses.
- Clinical partnership with community pharmacy
- Partnership with residential homes
- End of life care

It is also here that we will explore how hospital provided care may evolve, for example:

- What needs to be different in secondary care initially and how secondary care services are to be accessed by localities and how secondary care will support localities?
- How do we create a system instead of secondary and primary care?
- How to we monitor & evaluate services?
- Staff trained in supporting 'my plan' and motivational approaches
- Open referrals and follow up
- Services close to me (e.g. telecare and telehealth)
- Two way digital communication
- How will Whanau Ora be realised?

6. Form to deliver function

Implementation of the Locality Approach described will require the formation of new groups based around new partnerships and ways of working. Form should however follow function and an evolutionary approach to the required structures is suggested. As a principle, existing structures and groups will be utilised where practical. As noted, each Auckland Council local board area will be designated a locality. For operational efficiency these may be aggregated into groups.

Governance

The overall approach will initially receive its governance from a Locality Establishment Governance Group (LEGG). Each locality will develop its own clinical governance process which will be linked to a system of broader clinical governance (to be established).

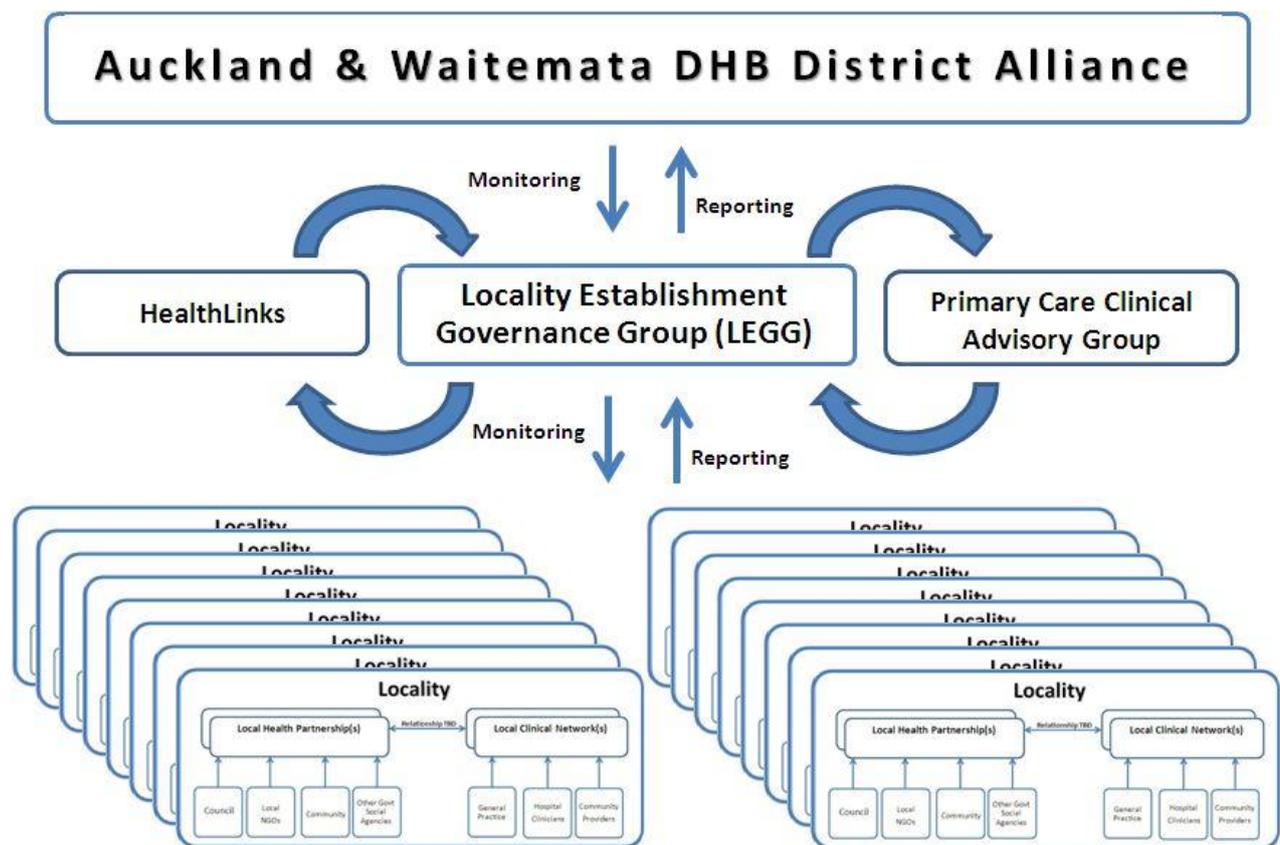
⁸ Within a health context, co-design (also known as experience based design) is "... a method of designing better experiences for patients, carers and staff". It involves patients and staff exploring the care pathway and the emotional journey patients experience along it, capturing experiences, then working together to understand these experiences and improve them. (NHS Institute for Innovation and Improvement, 2009).

Structures

Within each locality we will develop separate vehicles for locality planning – **Local Health Partnerships** (LHPs), and locality provision – **Local Clinical Networks/Clusters** (LCNs). At least one Local Health Partnership and one Local Clinical Network/Cluster will be established in each locality with. While in most cases we expect LHPs to exist within locality boundaries, exceptions will be made where these boundaries are not sensible (e.g. Rodney and Hibiscus & Bays). Local Clinical Networks/Clusters will focus on the enrolled populations of their constituent General Practices'. Again, while in many cases they will exist within locality boundaries by their nature they will have 'soft edges' to allow flexibility across where this makes sense.

Figure 2 shows how the different pieces come together. As noted previously, an evolutionary approach to the required structures is suggested to allow for local flexibility and to ensure we do 'what works'.

Figure 2: DRAFT Organisational Diagram



* Localities maybe aggregated for operational purposes

7. Next Steps

1. Embed a governance structure (LEGG) for the approach across Auckland & Waitemata DHBs which involves key stakeholders from primary care (PHOs), secondary care, DHB Planning and Funding, local boards, local iwi partners, whanau ora and other key stakeholders from primary care and the community.
 - This overall governing body will need to approve an action plan and communicate the vision, terminology and definitions regarding key aspects of the process.

- Introduce an alliance between health providers, which would include a Memorandum of Understanding and Data Sharing Agreement between PHOs, local iwi, secondary care and funders to agree a framework for progressing the primary/secondary care integration journey
 - The governing body will investigate the potential for funding models to work more practically across primary/secondary care, as well as the potential for intersectoral funding, and provision of a framework for community-held budgets to support self-directed care.
2. Continue to develop relationships at a locality, DHB and regional level to support service changes required including engaging with key provider stakeholders across the whole of system and working with our communities to ensure consistency where this makes sense.
 3. Agree common terminology across the approach.
 4. Continue development of local health partnerships in each local board area in association with the existing Healthlinks in Waitemata and the developing HealthLinks in Auckland.
 5. Complete the analysis and reporting of the Local Health Need Survey data
 6. Work with the Māori Health Team and other representatives to understand and align the developing Māori map of the population and the planned whanau ora centre developments.
 7. The further development of Local Clinical Networks/Clusters across Auckland & Waitemata creating enduring partnerships between service users, providers and funders to better integrate health and social services in the community. These Local Clinical Networks, through defined groups of stakeholders, will work in partnership with the community (via the local health partnerships) to:
 - undertake locality planning,
 - determine local health priorities and identify priority populations
 - determine how to implement national and regional priorities, including health targets, at a locality level
 - identify and assess opportunities for integration activities
 - enabling data sharing with electronic patient files visible to all key workers and the individual as appropriate
 - co-design new models of care based on defined (by communities, providers, MOH or DHB) priority populations
 - drive quality improvement initiatives
 - create intersectoral networks
 8. Develop a Business Plan to describe how we will operationalise our intent ensuring alignment with and specific reference to our 2013/14 Annual Plan commitments.

Appendix 1: Glossary of terms

Term	Definition
Cluster	Refer 'Local Clinical Network'
Community (as in the shared ADHB/WDHB Public consultation and engagement policy))	Community can be defined by place, identity and shared interest. In the locality context, the emphasis is on communities of place.
Community Representative (and community leader)	Community Representative means a person who has the mandate of a community (as defined above) network or organisation to represent the community's views. A community representative might also be a community leader in the sense that they have a mandate from their community to make decisions on behalf of their community (such as an elected official).
Consumer	For the purpose of consumer involvement in service planning or improvement activity, consumer means a person who uses or has used the type of health and/or disability service being planned or improved. Because health service managers and clinicians are employed to fulfil a professional role with regard to the delivery of health services, they can <i>not</i> be considered to offer the views of service consumers ⁹ .
Consumer Representative	Consumer Representative means a person who has the mandate of a consumer organisation or network to represent their views.
Engagement (as in the shared ADHB/WDHB Public consultation and engagement policy)	Engagement is not a legislated process. It can take many forms and serve many purposes that allow patients and other community stakeholders to inform and/or participate in decisions that affect their health and the development of services that they receive. <i>Informing</i> the community does not, in itself, constitute engagement. Engagement requires dialogue and building relationships. <i>Consultation</i> is one form of engagement. It is a legislated process for soliciting public feedback on a proposal and decision-makers being able to demonstrate that they have taken that feedback into account when finalising a proposal. Engagement can also be in the form of one-off or ongoing stakeholder involvement or collaboration in deliberation or in decision-making. It can also involve empowering stakeholders to make a decision.
Group	An operational grouping of localities. Currently these are being operationalised as Central (seven localities), West (three localities), and North (five localities) but this is subject to change.
HealthLink	Healthlinks are community driven organisations which promote community participation in healthcare decision making and encourage collaborative relationships between providers and the communities they serve. The core idea is that Healthlinks will provide the forum for patient and community representative input into the Localities. They would contribute informed comment and at times more actively participate in the development of more integrated models of healthcare service delivery. Waitemata DHB has two existing HealthLinks groups, Waitakere HealthLink and HealthLink North. The overall structure of the HealthLinks model for ADHB will be designed in partnership with the community. Once an ADHB model is agreed we will work across both districts and with the existing WDHB groups to discuss the possibility of a combined

⁹ When health professionals are patients they are likely to have a more positive experience than people who are not as familiar with how the system works. When a health professional is a patient, they are more likely to be able to understand the 'everyday' language and advice provided by their clinician. They are more likely to have the confidence to speak up if they feel they need to and they are more likely to know the right questions to ask. They are also more likely to know how to access the care they need and have the money to do so. What this means is that when we think about how to improve health care services, the views and experiences of health professionals cannot be taken to represent the views and experiences of people who are not health professionals. However, health professionals' experiences of being a patient and the knowledge they have about their patients are valuable to reflect on too.

Term	Definition
	<p>HealthLinks Forum to provide governance level input.</p> <p>For Auckland, the membership will be responsible for connecting with community representatives within their Local Board area (communities defined and networked by place, interest and identity). It is possible that an NGO Forum could be hosted by the HealthLink (as happens in West Auckland) and this could also extend to include relevant Government agencies such as the Ministry of Social Development through their Community Response Forums which share the same boundaries.</p> <p>The purpose of the ADHB HealthLinks is yet to be fully defined and scoped but is likely to include at a minimum:</p> <ul style="list-style-type: none"> • bringing local views (on proposals, service experience etc) to the attention of the Locality • distributing information from the DHB/locality through their community networks • participating in service planning and improvement activity through the locality • identifying activity that will promote local health outcomes
Integration	<p><i>Integrated care</i> includes both clinical and service integration to bring organisations and clinical professionals together, in order to improve outcomes for patients and service users through the delivery of integrated care. Integration is a key component of placing patients at the centre of the system, increasing the focus on prevention, avoidance of unplanned acute care and redesigning services closer to home (From the NHB's Annual Plan Guidelines 2012/13).</p>
Integrated Family Health Centres AND Whanau Ora Centres (As presented to CPHAC Oct 2011)	<p>Localities may contain one or more Integrated Family Health Centres (IFHCs) or Whanau Ora Centres (WOCs). They are both a central part of the Government's BSMC policy and function as service delivery hubs that allow access to the expanded suite of integrated services at a more local level. Such integrated services are expected to utilise re-designed pathways that span the traditional primary/secondary care divide. These larger centres may be networked with smaller practices using a hub and spoke model giving rise to an Integrated Family Health Network (IFHN). Critical to their development is greater clarity and explicit agreement regarding the flow of patients, resources, and revenue.</p>
Locality (As presented to CPHAC Oct 2011)	<p>A locality is geographically defined, and encompasses all people usually resident in an Auckland Council Local Board area. Localities are the basic building block of the locality approach and maybe aggregated for operational reasons (e.g. in Central, West & North groups).</p>
Local Health Needs Assessment	<p>A local health needs assessment is a process for and a product of quantitative and qualitative inquiry for determining the needs (and strengths/protective factors) of a locality's residents.</p>
Local Clinical Networks / (Clusters)	<p>Working description of groups of primary care practices coming together to deliver more integrated care. Established examples include those in West Auckland e.g. New Lynn, Henderson-Massey & Waitakere. They may include community based specialists (doctors, nurses, pharmacists, and allied health professionals) and will help facilitate improved patient navigation and service integration between hospital and community care by empowering the primary care workforce. They will facilitate better support and utilisation of our GPs, nurses, pharmacists, allied health professionals and community based specialists to empower patients and providers to develop practical solutions to the growing demographic demands, increased burden of chronic diseases, and resource limitations that can result in improved service delivery</p>
Local Health Partnerships	<p>Established and operated using co-design principles these groups are specific to each local board area with membership drawn from those who are either working and/or living in the locality. Depending on the locality, membership could include: NGOs, community development organisations, primary health care providers, Plunket, other Government organisations (e.g. Housing, Education, and Ministry of Social Development), Auckland Council's Local Board, local community members, representatives of specific populations (e.g. Pacific, Refugee, new Migrant) and Māori. The Partnership comes together to share learning and experience of the locality, engage in greater partnership thinking and</p>

Term	Definition
	<p>contribute, through the relevant HealthLinks, to the development of more integrated models of working via the local clinical networks and Clusters. The Partnerships will also be key informants in reviews of services and are central to the needs assessment and locality planning processes. Where possible existing networks and forums will be utilised, but if impractical then new networks will be facilitated by the DHBs, ideally utilising the resources of a locality based NGO. Over time servicing of these Partnerships could transfer to a locality based organisation.</p> <p>The Local Health Partnerships provide the forum for patient, family and community input into the Integrated Health Networks, and are the basis for extending the WDHB HealthLinks/HealthVoice model into ADHB</p>
Stakeholder	<p>A stakeholder is anyone who may be interested in and/or affected by a health-related activity, proposal or decision to be made. There are many different types of stakeholders. The range of types of stakeholders will vary according to the particulars of a proposal or a decision to be made. Stakeholder types should also be defined according to what is at stake. For example, a stakeholder cannot be considered to be a consumer if they are participating on behalf of an organisation. Some stakeholders will have more at stake than others. How 'key' a stakeholder is to a proposal and its engagement plan should be defined accordingly.</p>
Whanau Ora	<p>He Korowai Oranga (the Māori Health Strategy) defines Whānau Ora as “Māori families being supported to achieve their maximum health and wellbeing”.</p>
Whanau Ora Centres	<p>Whanau ora centres have many attributes in common with Integrated Family Health Centres the main difference being the emphasis that whanau ora centres place on integrating services across a number of sectors.</p> <p>See also 'Integrated Family Health Centres' (above)</p>

Appendix 2: Principles to support a locality approach¹⁰

The locality approach places communities at the centre of health service planning and delivery

Planning health services at a locality level offers an opportunity to understand community health priorities through meaningful engagement and allow those communities to shape the provision of services that can be delivered locally. There are a number of examples where good community engagement has led to increased community ownership of issues wider than health (e.g. the Ranui project in WDHB and HVAZ in Auckland DHB) and a locality approach allows us to build on learnings from those experiences.

Organisational configuration needs to adapt to support the locality approach described

An extension of the previous principle in that existing organisational boundaries and structures (e.g. DHBs and PHOs) need to adapt to best support community health outcomes.

The locality approach should enhance integration and coordination of care

The approach allows us to link hospital based and community providers with other health service providers working in the community. This might include having named specialists (or identified locality contact numbers) to support primary care practitioners in the area or creating opportunities for discussion across all nursing roles in communities.

The locality approach must maintain a focus on achieving Māori health gain and Whanau Ora

Whilst we may wish to see an increasing focus on locality populations all organisations involved have an obligation to focus on the needs of their Māori populations. Planning, funding, and delivery of services to Māori, either through mainstream services or Māori specific services, could occur at district, locality, PHO or other provider levels. Decisions will need to be made to what extent this responsibility will be undertaken at each level. Further to this, any approaches should be focused on achieving Whanau Ora and maintaining the DHBs commitment to the principles of Te Tiriti o Waitangi:

- **Partnership** – Manawhenua is a partner at the governance level.
- **Participation** – Māori engagement in planning, development and delivery of health and disability services.
- **Protection** – Equity of participation access and outcomes for all Māori. Māori are able to enjoy the same level of health as non-Māori and Māori cultural concepts, values and practices are safeguarded.

In addition the aspirations and needs of our iwi and our Māori MoU partners will be respected and aligned as part of this process. The Māori health plan of the Waitemata and Auckland DHBs includes the development of a spatial map of the Māori population of the two DHBs, the location of Māori providers and the ongoing development of Whanau Ora Centres across the DHBs as a matter of priority. The development of this process will occur in parallel with the development of this locality approach with linkages developed between the two plans.

The locality approach must improve the health of Pacific people.

This approach should strengthen and support the diverse Pacific communities to identify their strengths, needs, and to harness resources and respond in an effective and cohesive way to address them. Opportunities to ensure the Pacific patient/family journey is simple, clear and without barriers will be an aim of this approach. Stronger links between health services and also other agencies at a district, locality and PHO level should better support Pacific families to receive the assistance required.

The locality approach must improve the health of Asian people.

This approach should strengthen and support the diverse Asian communities to identify their strengths, needs, and to harness resources and respond in an effective and cohesive way to address them. Opportunities to ensure the Asian patient/family journey is simple, clear and without barriers will be an aim

¹⁰ A locality approach for Auckland: Paper to Auckland DHB CPHAC October 2010

of this approach. Stronger links between health services and also other agencies at a district, locality and PHO level should better support Asian families to receive the assistance required.

The locality approach must improve the health of other high needs populations and enhance our ability to reduce inequalities

Localities offer a great opportunity to focus on other high needs populations such as children, those with long term conditions or other high health needs, refugees and new migrants. Communities should be supported to identify their needs and priorities and harness resources to meet them. The opportunity provided by defining localities geographically will enhance the ability of agencies to work together to better support those people and families who require assistance from multiple organisations.

Understanding local health needs will be a key feature of the planning process

National and regional priorities will form the minimum available services at the local level but in addition needs assessments at the local level will increase our understanding of specific community needs within these areas and allow appropriate decisions to be made based on that in-depth knowledge. The Local Government Commission has spent considerable time to ensure local boards represent communities of interest based upon; “residents’ sense of identity with and belonging to a community, the ability to meet residents’ needs for services (both council and non-council services), and the ability to represent the interests and reconcile conflicts of the community.”

The locality approach should address issues of capability and capacity within primary care

The implementation of the locality approach will maximise the use of a scarce workforce. There may be ways in which practices can share human and physical resources, a specialist nurse for example, run joint chronic disease management clinics, and/or share equipment (such as spirometry or ECG machines). Better use of the community nursing teams and community support workforce (including social services) should also be an aim of this approach.

Funding flows will be directed to identified locality priorities

It is expected that increasingly a proportion of the flexible funding pool currently available to PHOs will be spent at the locality level. The PHOs have recently demonstrated a heightened capability to work cooperatively and it is probable that true “alliance contracting frameworks” will be able to build on the successful ‘special area initiatives’ that some PHOs have in place and be further used to align and incentivise a locality approach while preserving the natural affiliations of providers (not just general practice) to their PHOs.

The locality approach will be developed in a way that does not unnecessarily increase bureaucracy, costs or delay decision-making

It is not intended through the locality approach to introduce further structures but to enable better connections and communications. It can be more a way of thinking and implementation than about structure, more of way of linking people across a system and maximising resource currently in different sectors while pursuing the same outcome.