DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Proactive Release

The following documents have been proactively released by the Department of the Prime Minister and Cabinet (DPMC), on behalf of Hon Andrew Little, Minister of Health:

Health and Disability System Reform Briefings October 2021 to January 2022

The following documents have been included in this release:

Title of paper: Health Reforms: Realising the Digital Shift for the Health System

Title of paper: Development of the Interim Government Policy Statement for the Reformed Health and Disability System

Title of paper: Further advice on the Interim Government Policy Statement - Priorities for Inclusion

Title of paper: Health Reform: Choices to Expand the Public Offer

Title of paper: Health Reforms: Public Health Transformation

Title of paper: Health Reforms: Addressing Workforce Supply and Demand

Title of paper: Localities: Setting a Narrative, and Updating on Rollout and Prototypes

Title of paper: Further Advice on the Interim Government Policy Statement – High Level Approach to Priorities

Title of paper: Monitoring Arrangements for the New Health System

Title of paper: Restructure of Vote Health Appropriations to Support Health Reforms

Title of paper: Health Reform – Progress Update and Assurance Framework

Title of paper: Update on the Pae Ora Bill: Select Committee Progress and Further Policy Decisions

Title of paper: Pae Ora Bill: Key Policy Decisions for Recommendation in the Departmental Report

Title of paper: Allocation of Commissioning Budgets Across Future Health Entities

Title of paper: Health Reform: Transfer of Functions from Ministry of Health to New Entities

Some parts of this information release would not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act). Where this is the case, the relevant section of the Act that would apply has been identified. Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

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Briefing

LOCALITIES: SETTING A NARRATIVE, AND UPDATING ON ROLLOUT AND PROTOTYPES

To: Hon Andrew Little, Minister of Health; Hon Peeni Henare, Associate Minister of Health			
Date	26/11/2021	**Priority**	Medium
Deadline	10/12/2021	**Briefing Number**	DPMC-2021/22-931

Purpose

This briefing seeks your agreement to a narrative on how we talk about and explain localities; and provides an outline of the roadmap for rolling out the locality model, and an update on progress on the locality prototypes.

Recommendations

a. **Agree** to the narrative at Annex 1, and the tenets at [8], as a blueprint for how the health reforms programme will talk about and communicate on localities and the locality approach.

b. **Note** that all New Zealanders will be part of a locality by July 2024, but that maturity will build over time, with an emphasis through reforms in early targeting of localities with large Māori and Pacific populations, and high levels of deprivation and unmet need.

c. **Note** that investments through Budget 22 and future Budgets, particularly in comprehensive primary care teams and priority cohorts will be needed to fully deliver the future model of primary and community care.

d. **Note** the Transition Unit's progress to date in delivering locality prototypes.

pp Stephen McKernan Director **Health Transition Unit**	Hon Andrew Little Minister of Health
26/11/2021	…../…../….

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LOCALITIES: SETTING A NARRATIVE, AND UPDATING ON ROLLOUT AND PROTOTYPES

Context

1. Localities are a central feature of the reformed health system. The core features of localities, and details of how they will operate, have already been agreed through advice to date:

    a. in the March Cabinet paper, which outlined the fundamental features of localities, and set out where in the future system decisions about the architecture of localities will be made [CAB-21-SUB-0092 refers];

    b. on the service delivery model for primary and community care, in which you took decisions about the shape and approach to be taken by the future system to deliver primary and community care [DPMC-2021/22-102 refers]; and

    c. on the 'public offer' of the health system, in which you took in-principle decisions about future settings for service coverage and enrolment [DPMC-2021/22-671 refers].

2. To supplement this advice over coming months with more detailed proposals for implementing localities, we will be providing you with further advice on:

    a. how funding flows from the centre out to the providers and services who deliver primary and community care within localities;

    b. how we will maintain accountability for locality performance, from commissioners through to network managers and providers, to achieve a meaningful shift in system performance;

    c. final enrolment settings for the future system, with work underway following your in-principle decisions in relation to the public offer; and

    d. how the transition to the future state will manage existing contracts, and the balance of maintaining service provision with ensuring transformation occurs.

3. The Pae Ora (Healthy Futures) Bill enables the above settings, by outlining a very simple legal framework to create localities and enable a localities approach to primary and community care. Much of the work to give effect to localities will be operational in nature, but will be tremendously complex – requiring a shift in how we plan, commission, deliver, and sustain accountabilities for primary and community care and those who provide it. The interim Government Policy Statement and the Budget 22 process, alongside development of the interim NZ Health Plan, create strong levers to start transforming primary and community care from 1 July 2022.

4. While the general concept of localities is increasingly well understood by the health sector, as are the principles and aspirations which underpin the locality model, there is a lack of widespread understanding of precisely how different features of the locality model (such as provider networks and network managers) are intended to come together.

5. To that end, this paper seeks your agreement to a narrative as to how localities fit into the reforms, and how they are intended to operate – blending both the legal structures outlined by the Pae Ora Bill, and operational expectations outlined through previous advice.

6. It also provides an explanation of the planned trajectory for the rollout of localities, and an update on how we are approaching locality pilots, both of which will form an important part of messaging around localities over coming months, both through Select Committee and in public communications.

How we discuss 'localities'

7. As noted above, the locality approach to primary and community care is relatively complex – reflecting the complexity inherent in tackling population health and wellbeing issues which bridge health, social, economic and wider hauora dimensions. Ensuring people understand the system we are moving to is made more difficult by the complexity of today's system, which means we must be clear how the future system relates to the one people know today (replete with DHBs and PHOs).

8. In how we outline and explain localities, both through Select Committee and wider public engagements, we recommend a handful of core tenets:

   a. **A focus on the experiences of people.** The locality approach is intended to shift from a fragmented experience of care, centred on GP practices, to one where a diversity of providers come together to provide wrap-around care to people – particularly those with the greatest unmet need. The future experience of primary and community care is intended to be more seamless, better targeted at social determinants and drivers of poor health and wellbeing, and much more equitable in how it reaches Māori, Pacific and disabled people.

   b. **A focus on localities and the locality approach, rather than networks.** While different audiences will have different needs, we recommend predominantly focusing on localities (an area with a community) and the locality approach (having providers work together more closely to take a population health approach to local health issues and challenges) when describing the shift intended.

   c. **Setting expectations for what localities will look like over time.** The Pae Ora Bill outlines an expectation that by July 2024, every New Zealander will be in a locality. This strict expectation will be met, but even by 1 July 2024 different localities will have different levels of maturity: some will be fully fledged with comprehensive primary care and priority cohorts embedded, while others will still be working to embed first-level integration across their provider networks. This is a feature of the implementation model – and provides for localities to grow and strengthen over time as their providers and communities are ready.

9. At Annex 1 we attach a fulsome narrative which sets out definitions and a narrative for localities and the locality approach, including key questions which should be answered consistently across reforms. We seek your agreement to this narrative.

10. Alongside the narrative, we address a small number of important or challenging questions about the localities model asked by the Select Committee to date, or by the wider sector.

Rolling out localities

11. The future model for localities is some way from how primary and community services are commissioned, organised and focused across most of New Zealand today. As part of laying out the path for reform, we have indicated that we would expect the locality model to be in place across New Zealand in time for the first full NZ Health Plan in 2024.

12. In rolling out localities, we will need to undertake structural design work – such as to identify the boundaries between localities – as well as building capability and capacity of providers to work differently together, alongside specific investments in comprehensive primary care teams (CPCTs) and priority cohorts through Budget 22 initiatives.

13. Come 2024, we expect that every New Zealander will be in a locality, meaning:

    a. New Zealanders will be able to identify which locality they live in (with locality boundaries confirmed following public engagement);

    b. communities will be invited to contribute to locality planning based on the 2024-2027 NZ Health Plan;

    c. every locality will have shifted to commissioning based on a locality model – i.e. with commissioning to coalitions of providers based on population health need and health system priorities (such as addressing secondary care needs in primary settings or responding to emerging public health issues) practiced by locality commissioners, including specific commissioning for network management services; and

    d. providers serving each locality will have been invited to join the locality network for that locality with clear expectations as to expected integration.

14. However, this does not represent the roll-out of the locality model to full maturity. A mature local network will have fully-resourced CPCTs and priority cohorts operating, and will have shifted significantly towards integrated practice in how they use technology, interdisciplinary working and care pathways – which will not be the case in all localities by 2024.

15. These aspects of localities will roll out over time, based on a blend of current locality maturity and readiness and community need, with maturity expected to continue building years into the future (subject to investments through Budget 22 and beyond). This means that communities with the greatest unmet need will have earliest access to the initial phase of CPCTs and priority cohorts (as this is where the impact will be greatest), with communities with lower levels of deprivation following.

16. s9(2)(f)(iv) [redacted]

c. s9(2)(f)(iv) [redacted]

17. Based on Budget 22 initiatives developed to date, we anticipate that this rollout would include a measure of locality integration, as well as funding for the first phase of CPCTs. We also expect localities to begin developing priority cohorts – though targeted funding to grow these networks is included for only some localities in current Budget 22 bids.

18. s9(2)(f)(iv) [redacted]

Locality prototypes

19. Locality prototypes will represent the first wave of the locality rollout, creating an opportunity to test new structures, mechanisms and delivery models which will drive equity and better outcomes through the locality approach. These will then inform the framework for future locality development. Prototypes will be stood up by March 2022.

20. We recently concluded a discovery phase to understand and catalogue existing practice and enablers, inviting the sector to share information about what they are already doing. We received more than 50 submissions, which signalled significant enthusiasm for the prototypes and the locality approach.

21. From these submissions, we propose to identify between five and ten localities to prototype from February – meaning that we will invest in developing them as fully functioning localities, using an agile and flexible approach to test different approaches across the prototypes. At the same time, we are exploring options to maintain momentum in other areas where communities and providers consider themselves well developed towards a locality model, such as leveraging existing investment by DHBs or PHOs to start other areas on the path to forming localities, or supporting locally funded 'vanguard' programmes to build readiness and early maturity in areas not funded centrally.

22. Of the localities we prototype:

    a. one will be from each region;

    b. at least one locality will have a large Māori population, or a network which is managed by an iwi- or Māori-provider;

    c. at least one locality will have a large Pacific population, or a network which is managed by a Pacific provider;

    d. at least one will be a rural locality; and

    e. at least one locality will be in an urban area with high levels of deprivation.

23. The emphasis of these prototypes will be to trial the design and mechanics of localities across three features: structures and organisation, funding, and provider delivery

models. This will ensure that the full rollout of localities from FY2022/23 will be informed by experience in how different models work in practice.

24. The prototypes will model both different kinds of CPCTs and priority cohorts focused on different groups (including mental health and addiction, mothers and babies, aged care and frailty, and chronic illness and complex care). Prototypes will be supported by a locality collaborative – an environment for prototypes, and later localities more widely – to collate and share expertise and best practice, drawing from a range of contexts and perspectives including those grounded in te ao Māori.

25. We have developed a long-list of 13 potential locality prototypes to select from. We will ask these potential prototypes to undertake an assisted submission process so that we can co-design fulsome options, allowing us to present the iMHA and iHNZ boards with recommendations for a final list of prototypes. Annex 2 lists the potential prototypes identified.

Next steps

26. Subject to your agreement, we will incorporate the locality narrative above into communications products supporting the wider reform, and into content supporting the Select Committee process. Subject to your ongoing feedback, Budget 22 initiatives have been, and will continue to be, shaped based on the assumptions and rollout plan above.

27. We will provide you with an update on locality prototypes once we have identified, and agreed with interim boards, a proposed list of prototypes.

Annex 1: The locality narrative

The shift to a **locality approach** to primary care is fundamental to these reforms. The locality approach describes a new way of delivering integrated health and care services to local communities across New Zealand. This approach brings together a breadth of expertise across providers to offer people more seamless, connected care closer to home, with a better balance of nationally consistent standards and local tailoring. It emphasises a population health approach, providing for greater engagement with communities (particularly Māori and Pacific peoples), integrated health and social care for those with complex needs, and a focus on the broader determinants of health.

By bringing together service providers into more responsive networks of care, and by better investing in and centring the expertise of kaupapa Māori providers, Pacific providers, and professions who sit outside the traditional models of general practice delivery (such as physiotherapists and pharmacists), the locality approach will improve continuity, quality and equity of care, particularly for Māori, Pacific peoples, disabled people and other communities traditionally underserved by our health system. Localities are also a tool to give effect to te Tiriti o Waitangi, empowering iwi, hapū and whānau Māori, alongside wider communities, to shape the care they receive close to home.

Localities are simply places defined by their communities: they are geographic areas which can be defined and bounded, and which make sense to the people who live there. From a practical perspective, they are a unit for planning and delivering health services; but they are also an important indicator of identity which will help to bind services around their communities. All of New Zealand will be covered by localities.

Each locality will have a **provider network**: the group of providers of health services who deliver care to people in a locality, ranging from general practice services through to health promotion and wellbeing support. All the providers who contribute to care pathways in a locality will be part of the network (over time), meaning that provider networks may run across multiple localities so that a breadth of providers can support several communities and localities (e.g. Wainuiomata, Lower Hutt and Upper Hutt might each be separate localities, with a single, shared provider network). Provider networks will be more integrated than most groups of providers are today.

The word *network* is also one commonly used in our health system, and there will continue to be lots of kinds of networks in future, including *clinical networks* (groups of clinicians and professionals working together on best practice) and *professional networks* of providers who serve similar communities or share disciplines. These networks will continue to be an important part of sharing capability and best practice in the future – but are not what we are talking about when we talk about provider networks.

Each locality will also have a **locality plan**, developed in partnership between communities (including iwi and wider Māori communities), commissioners and providers. The plan is designed to bring together the national expectations of the NZ Health Plan and its annexes (including those focused on Māori and Pacific peoples) with the priorities, needs and contexts of local communities. They will need to align to national pathways, best practice and minimum expectations set by the NZ Health Plan, but will otherwise have flexibility to tailor the design (and in some cases, scope) of care which is provided locally.

Within provider networks, there will be several ways in which providers group together to respond to people's health needs, building from the base of enhanced integration across the provider network:

a. **Comprehensive primary care teams (CPCTs)** will ensure people can access care from a range of providers seamlessly. Built around professionals who can provide care and referrals for a range of different health needs (such as general and nurse practitioners) CPCTs will bring together providers such as general practice and district nursing with other roles, like clinical pharmacists or physiotherapists, to offer wrap-around care. These other roles will be drawn from a 'menu' of roles which commissioners can fund to support comprehensive primary care across different groups of providers and different communities within a locality. Different CPCT models will reflect different communities, including Māori, Pacific peoples and rural communities. CPCTs will be distinct to each locality.

b. **Priority cohorts** are areas of particular focus for our health system, either revolving around a certain kind of care (e.g. mental health and addiction), specific cohorts of people with a common characteristic (e.g. older people with frailty), or public health issues. At any given time, a number of providers within a provider network will be contributing to addressing the population health challenges of different priority cohorts – which will have more commissioner focus, regional and local planning, and agreed clinical pathways and models of care. Priority cohorts will often run across multiple localities.

In today's system, PHOs act as both commissioners (for GP services) and as network managers, as well as taking clinical roles in areas like population health and prevention. In future, these functions will be broken out – with a **network management** function ensuring that networks of disparate providers are integrated and work together well, and Health NZ and the Māori Health Authority acting as the commissioner in all cases. There will be flexibility in how network management functions are delivered for each locality – we expect that contracting to a third-party provider, or to a lead provider (e.g. a kaupapa Māori provider with wide capability) will be most common, but Health NZ could do this themselves in some instances.

This function might be delivered in a range of ways. However, unlike PHOs, network managers will not be required to 'gatekeep' funding or contracts through to providers – though commissioners may choose to use network managers to direct and manage subcontracts or funding to other providers where that approach is most effective. The network manager will also work to connect the provider network to managed parts of our health system, including the national public health service, hospital and specialist services and district nursing.

GENERAL QUESTIONS

How will localities be determined?

To be most effective, localities should make sense to local people and reflect their understanding of their identity and community. This will involve considering a range of factors, including historic boundaries, iwi rohe, ethnic communities, geographical features, patterns of individual travel, and alignment with other public services. Localities should not be so big that they lack a clear identity or span too many people to feel 'local'. Nor should they be too small so that it is challenging to deliver viable services.

The first set of localities, which will be used to test and refine the approach, will be identified by early 2022. This is expected to be a small initial number in a number of areas which are representative of the different places and communities in New Zealand. From here, localities

will successively roll out alongside CPCTs and priority cohorts, subject to Budget 22 funding through to 2024.

Between July 2022 and July 2024 Health NZ and the Māori Health Authority will lead an open process to engage with people nationwide and determine the initial set of localities which will cover New Zealand. This will need to build from a blueprint of localities identified through the prototypes and early rollout, for validation with New Zealanders – with the prototypes and early rollout as best as possible on areas with clear, distinct localities to avoid modifying localities where CPCTs have already been formed.

The Bill requires that localities be confirmed to cover all New Zealanders from July 2024.

The number and boundaries of localities are expected to change over time, for instance in response to demographic changes. Health NZ will be able to vary these over time, but must always ensure that there are no gaps and that locality boundaries are publicly available.

How will providers be 'networked'?

Provider networks are ultimately made up of individual providers – so a mechanism to make these providers work together more closely is vital if we are to deliver on the promise of reforms, particularly ensuring that New Zealanders experience more integrated care.

There are several ways in which providers will be networked in future:

a. For all providers anywhere in the system, they will find themselves with common integration standards, nationally-agreed clinical pathways and shared national objectives and outcomes.

b. Across provider networks, there will be heightened expectations for information sharing and care coordination set through contracts, including shared local objectives and outcomes, and common contracting approaches. In addition, because provider networks will share network management, they will be brought closer together through those arrangements (as high performing PHOs do today).

c. Within provider networks, coalitions of providers working together as CPCTs or as part of priority cohorts will share resources (including staff through CPCTs, and likely funding in at least some cases) as they collaborate towards shared outcomes, which will strengthen their integration.

Over time, the share of primary and community care which is commissioned through provider networks in various arrangements – including through CPCTs and priority cohorts – will grow, as compared to that commissioned traditionally to individual services to deliver specific outputs. This will make our primary and community care more adaptive to local need and the real, underlying population health challenges which drive inequities, and will also encourage providers to work together ever more closely to be able to better respond to population and public health problems which no one provider can solve.

How exactly this manifests will differ from locality to locality, and will evolve as locality maturity progresses – which we discuss in more detail below in relation to the locality rollout and prototypes.

How will provider networks be managed?

In the future system, Health NZ regional – and below them locality – commissioners will have ultimate responsibility for ensuring that each locality has a locality plan which is given effect

to, including meeting national expectations and minimum standards set by the NZ Health Plan and its annexes (including those focused on the needs of Māori and Pacific peoples). However, day-to-day, they are unlikely to take sole responsibility for the management of provider networks, particularly when it comes to frontline initiatives and interdisciplinary working.

The network manager – however the network management role is commissioned – will take on this day-to-day responsibility for ensuring services are managed, coordinated and improve over time within the locality. Individual service providers will retain responsibility for their own internal day-to-day management as they are now, and will be accountable to their commissioner for the delivery of services and outcomes in line with their locality plan.

Network managers will undertake roles such as:

a. delivering tools and mechanisms to support practical service integration, e.g. systems for data sharing, facilities and resources that could be of use to multiple providers within the network;

b. supporting whole-population needs analysis to inform service design, including ongoing monitoring of service performance, access and utilisation;

c. supporting the integration and shared delivery of CPCTs and priority cohorts;

d. coordinating engagement between providers and with commissioners, consumers and communities as part of the locality plan or ongoing monitoring and reporting; and

e. supporting internal performance monitoring of the provider network against the locality plan, and continuous improvement and innovation.

In some instances, present day PHOs, kaupapa Māori providers or other provider coalitions may be well placed to provide these services. However, a deliberate approach to market building and strengthening, and to testing capability (particularly in delivering improved equity for Māori and Pacific peoples) will be needed to ensure that:

a. organisations with an incumbency advantage do not automatically become network managers in future; and

b. kaupapa Māori, Pacific and other community-oriented and equity-focused organisations have opportunities to build the capability and capacity to provide network management.

REACTIVE QUESTIONS

Can there be a locality for a population group or 'community of interest' (e.g. a Māori, Pacific, or LGBTQI+ locality)?

Specific population groups will not have their own localities in the future system. We considered carefully whether these kind of localities would be possible – but for two main reasons, they will not be a feature of our future health system:

a. Most importantly, people are more complex than just having a single identity or ethnicity. By cutting localities by population group, we risked forcing people to choose which locality they wanted to be a part of – which might cut someone who identifies as both Pacific and Māori off from kaupapa Māori care, or mean a young person couldn't access both an LGBTQI+ locality and a disabled locality. Instead, the localities approach takes people as we find them: with intersecting identities which are all

important to who they are. Within each locality, we will still have a focus on the needs of communities historically underserved by our health system – we just won't tackle that by separating those communities out from one another.

b. Localities are place-based – recognising that physical spaces determine where people live, work, go to school, and seek most of their care most of the time. That is important both to ensure that communities are kept together when we're thinking about their collective health needs, and to recognise the relationship between place and the care people need access to. This approach does not fit with separating out population groups into different localities, which would lead to many overlapping localities and many overlapping provider networks. Instead of making our system simpler, this would make it much more complex, with greater risk that resources and support don't end up with those who need it most.

How big can a locality be?

The Health and Disability System Review recommended localities cover between 20,000 and 100,000 people. That's a useful guideline to think about the size of a locality: not tiny, but also not covering the whole of a large city like Christchurch or Auckland.

However, the most important things in determining localities is that they make sense to the people who live there, and that they're a helpful size for tailoring care to the local community. This means that some localities might be a bit larger or a bit smaller than those parameters, if that's what makes most sense.

What about localities that cover large geographic areas?

One of the opportunities of these reforms is to ensure that rural communities get access to care that reflects the reality of their environment, and break down urban assumptions about how close you are to different kinds of care, and the best ways to get people the support and services they need.

Particularly in rural areas, we expect some localities to cover relatively large geographic areas. This is an advantage, meaning that we can plan for mobile services or those which are designed by and for rural communities, to meet the unique needs of each rural community.

How do people affect the services provided in localities without elected boards?

The process of developing a locality plan for each locality is all about engaging with the community. While the NZ Health Plan will set national expectations for what primary and community care you can access locally, your locality plan will provide opportunities to shape how care is provided in your locality. Instead of just being a vote for someone to help run a DHB, this involvement will be more meaningful in shaping the aspects of healthcare that people actually care about: like how services are delivered across providers, and how wrap-around support is provided across different services to those with complex needs.

Could there be multiple provider networks per locality?

We expect that each locality will have one provider network. That's because these reforms are trying to achieve greater cooperation and collaboration so that providers – who today work quite separately from one another – work together to improve the seamlessness and quality of care available in the community. That requires that high standards of integration and partnership are required across the board.

However, in some instances, multiple localities might be covered by a single provider network. That might be because localities cover relatively small geographic areas, and a range of providers which are physically situated in multiple localities could provide care to people across any of them (such as in dense urban areas). It might also be because we have to look outside the physical space of a locality to make sure people have access to all the services they will need close to home, such as in some rural areas.

Annex 2: Potential locality prototypes

The final list of locality prototypes is available on the Te Whatu Ora website: https //www tewhatuora.govt.nz/whats-happening/work-underway/localities/

Region	District	Localities of interest
Northern	s9(2)(f)(iv)	
	Counties Manukau*	*To be confirmed following further discussion*
Midlands	Waikato	South Waikato or Hauraki
	Lakes	Taupō & Turangi
	Bay of Plenty	Eastern Bay of Plenty (Kawerau, Ōpōtiki, Whakatāne)
	s9(2)(f)(iv)	
Central	Hawkes Bay	Wairoa
	Whanganui	Whanganui
	Mid Central	Horowhenua
	Capital & Coast	Porirua
Southern	West Coast	Westland or Buller
	s9(2)(f)(iv)	