



Midland Psychological and Social Support Services Plan 2015-2018

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Revision history

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30/4/15	Smith/Blundell	First draft based on DHB self-assessments	v 1.0
8/5/15	Smith/Blundell	Clarified TDH FTE, included Lakes self-assessment, minor edit changes, added preliminary Ministry of Health guidance regarding funding management of IDFs (MoH work in progress), referenced the Waikato psycho-onc model of service draft plan (2007).	v 2.0
19/5/15	Smith/Blundell	added glossary, high level implementation plan and high level model of service framework	v 3.0
5/6/15	Smith/Blundell	Ministry of Health feedback received 29/5/15. Midland Supportive Care Work Group reviewed feedback and endorsed changes – THD to have 0.2 psychologist instead of kaiawhina. Waikato clarification of involvement of tumour streams.	Final v 4.0
9/6/15	Smith/Blundell	Lakes P&F feedback - correction to stocktake table regarding allocation of Lakes psychologist visits.	Final v 5.0

Distribution

Name	Title	Issue Date	Version
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Midland DHB COOS		8/5/15	V 2.0
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Approvals

Approver	Signature	Issue Date	Version
BOP DHB – Pete Chandler Simon Everitt	  Pete Chandler BOP.pdf	11/6/15	Final
Lakes DHB – Dale Oliff Mary Smith	 	5/6/15	Final
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Waikato DHB – Brett Paradine Julie Wilson	  Brett Paradine 20150610164312259	11/6/15	Final

Executive summary

Introduction

Psychological and social support services are an essential component of a high quality integrated cancer service.

As part of the national faster cancer treatment programme, Budget 2014 announced (25/3/15) that sustainable funding for one full-time equivalent (FTE) regional cancer clinical psychologist in each of the six cancer centres will be available from 1 July 2015 and up to 20 additional FTE cancer psychological and social support positions across New Zealand focusing on adults with cancer.

The new roles are intended to build on and support existing services in DHBs to meet the psychological and social support needs of cancer patients and their family/whānau. These are new FTE; the funding is not for existing positions.

For Midland DHBs to access the Ministry of Health funding for the local cancer psychological and social support positions by 1 July 2015, DHBs were required to develop a regional plan and submit this to the Ministry of Health by 19 May 2015.

Approach

The Midland Supportive Care Work Group has undertaken a regional stocktake of current psychological and social support services and resources, a DHB self-assessment using the Ministry of Health template, and a service gap analysis. Midland has also developed an equity framework (appendix A), and within the available Ministry funding prioritised the professional discipline and FTE resource required to work towards addressing service gaps.

Prioritised additional investment

Budget Bid 2014 provides funding per annum, for new roles/regional service. The Ministry has indicated that funding is to be sustainable – this is an important consideration when recruiting to positions, as the proposed CFA variation is currently a three year term arrangement. The Ministry will fund the Midland DHBs via a CFA variation for the next three years using a population based funding formula (2012/13) for new cancer psychological and social workers roles. The following new roles have been prioritised as a means to address the identified gaps in the provision of services. The DHB recommended new FTE and funding is in the table below.

Role	BOP	Lakes	Tairāwhiti	Waikato	Midland total
Psychologist	0.8	0.8	0.2	2.2	4.0
Social Work	1.0		0.2	0.4	1.6
Available funding	\$188,773	\$84,190	\$42,967	\$302,775	\$618,705

Note: this table excludes the Lead Psychologist at the regional cancer centre for which there is a separate CFA variation and the amount is estimated to be \$133,333.

A total of **5.6 FTE** new positions will be added to the Midland DHB cancer psychological and social support service. In addition a **1.0 FTE** Midland Lead Psychologist (separate service specification) will be employed at Waikato DHB on behalf of the region. Total Midland investment is 6.6 FTE.

These new roles (FTE) will be integrated and linked into existing services. Midland appreciates that the additional investment in providing better cancer services to meet the needs of patients/whānau, and look forward to the implementation and development of an integrated and cohesive psycho-social and supportive care service for Midland.

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Introduction

Psychological and social support services are an essential component of a high quality integrated cancer service.

As part of the national faster cancer treatment programme, Budget 2014 announced (25/3/15) sustainable funding for one full-time equivalent (FTE) regional cancer clinical psychologist in each of the six cancer centres¹ will be available from 1 July 2015 and up to 20 additional FTE cancer psychological and social support positions across New Zealand focusing on adults with cancer.

The new roles are intended to build on and support existing services in DHBs and the community to meet the psychological and social support needs of cancer patients and their family/whānau. These are additional new FTE; the funding is not for existing positions.

For Midland DHBs to access the Ministry of Health (MoH) funding for local cancer psychological and social support positions by 1 July 2015, DHBs must work together to develop a regional plan and submit this to the Ministry of Health (MoH) by 12 June 2015.

Background

The *Cancer Control Action Plan 2005-10* (MoH, 2005) indicated that access to cancer support services and resources varied between and within regions.

The MoH developed *Guidance for Improving Supportive Care for Adults with Cancer in New Zealand* in 2010. An *Implementation Plan for the Guidance for Improving Supportive Care for Adults with Cancer in New Zealand* was published in 2011, prioritising care coordination, information support and psychological and social support domains.

The stocktake completed as part of *An Implementation Plan for the Guidance for Improving Supportive Care for Adults with Cancer in New Zealand* identified that there:

- is inconsistent assessment of adult patients' needs for psychological and social support
- are service gaps
- are few psychologists or social workers specialising in supportive care for adult cancer patients.

Emotional distress is common among people affected by cancer, and this distress can occur at any stage along the cancer continuum pathway.

Research indicates that 10% of people with cancer experience severe levels of psychological distress and are likely to benefit from specialised psychologist or psychiatric intervention (NICE, 2004; MoH, 2010). Generally psychological problems experienced by people with cancer are under-detected and under-treated.

The Voice of Experience (CCNZ, 2010) identified opportunities for improvement. Some examples relevant to this plan are related to:

- information and support regarding relationship changes, sexual activity changes, emotional changes
- putting people in touch with care providers to help with anxiety and fear
- offering people with cancer access to counselling, or support relating issues such as concerns about cancer or coping at home or at work.

This regional plan focuses on the psychological and social support component of supportive care.

1.1. Lead contact for plan

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¹ For Auckland, Canterbury, Capital & Coast, MidCentral, Southern and Waikato DHBs.

2. Midland region

The Midland psychological and social support service plan covers Bay of Plenty, Lakes, Tairāwhiti and Waikato DHBs with regional population of approximately 742,820 (Midland RSP 2014/15).

Bay of Plenty	Lakes	Tairāwhiti	Waikato
217,020	103,140	46,750	375,910

Midland population when compared to New Zealand as a whole has:

- the highest proportion of Māori 25%
- a low proportion of the population identifying as Asian or Pacific peoples (each at 3%) compared to national (Pacific 7%; Asian 9%)
- a higher number of people living in rural areas. The rural nature of the Midland population creates particular challenges in getting services to individuals
- a relatively higher proportion of people living in areas identified with high deprivation (deprivation quintiles 4 and 5). People living in lower economic circumstances may find accessing health services more difficult, and their circumstances may impact on their knowledge of available services and their confidence to seek those services.

New Zealand has approximately 21,000 cancer registrations per annum. *Cancer patient survival: 1994-2011* (MoH April 2015) report details the latest cancer survival statistics for selected cancers for the period 2010-2011 and time trends are included from 1998 to 2011. For the first time, the report also includes the addition of one-year survival rates and derives survival rates using ethnic-specific life tables. Findings included:

- one-year survival improved from 74.9 percent in 1998-1999 to 78.0 percent in 2010-2011
- females continue to have better one-year survival than males (79.2 percent and 76.9 percent respectively in 2010-2011)
- non-Māori continue to have better one-year survival than Māori (78.9 percent and 68.6 percent respectively in 2010-2011). This disparity is more evident in males
- one-year survival for Māori improved from 66.5 percent in 2008-2009 to 68.6 percent in 2010-2011. For the same time period, non-Māori one-year survival improved from 78.7 percent in 2008-2009 to 78.9 percent in 2010-2011
- in 2010-2011 one-year survival for 15 to 74 year olds was the highest since 1998-1999.
- five-year survival improved from 57.7 percent in 1998-1999 to 63.3 percent in 2010-2011
- females continue to have better five-year survival than males (64.3 percent and 62.4 percent respectively in 2010-2011)
- non-Māori continue to have better five-year survival than Māori (64.7 percent and 49.3 percent respectively in 2010-2011). This disparity is more evident in males (64.0 percent for non-Māori males compared with 42.5 percent for Māori males)
- five-year survival for Māori improved from 46.6 percent in 2008-2009 to 49.3 percent in 2010-2011. For the same time period, non-Māori five-year survival improved from 63.5 percent in 2008-2009 to 64.7 percent in 2010-2011
- between the periods 1998-1999 and 2010-2011 five-year survival improved the most for the 55 to 64 year age group (17.5 percent)
- the latest five-year survival rates for the five most commonly diagnosed cancers in New Zealand (2011) are as follows: breast 87.3 percent, colorectal 63.3 percent, lung 11.0 percent, melanoma 89.6 percent and prostate 91.1 percent.

Key drivers for cancer control action are:

- cancer is the country's leading cause of death (29.8 percent)
- cancer is a major cause of hospitalisation and a significant driver of cost
- while the overall 'risk' of developing cancer in New Zealand is decreasing, the number of people developing cancer is increasing mainly because of population growth and ageing. The number of cancer registrations is projected to increase annually by 2.6% from 2006-2016

- cancer continues to have inequalities with higher Māori incidence (20% greater), higher Māori mortality (80% higher) and Māori are more likely than non-Māori to have their cancer detected at a later stage of disease spread
- there are wide variations in survival rates between DHBs in New Zealand. Although both Māori and non-Māori showed an increase in survival over time (1994-2009), only the non-Māori change was statistically significant. For Māori the only tumour site to show a significant improvement in survival was cancer of the breast
- residents of more socioeconomically deprived areas are more likely to develop cancer, less likely to have their cancer detected early, and have poorer survival than residents of less deprived areas. Tairāwhiti and Lakes DHBs have significant areas of deprivation
- once people are diagnosed with cancer they are now less likely to die from it. This means that people are surviving longer, and being treated for longer periods of time, with different treatments.

Midland has approximately 4,000 new cancer registrations per annum. Table 1: Midland DHB cancer registrations volumes 1999-2011 (source: Ministry CancerMart, updated December 2013)

DHB	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
BOP	828	823	1,016	1,003	1,014	1,018	1,125	1,173	1,168	1,248	1,255	1,198	1,299
Lakes	385	383	440	436	470	416	452	468	503	510	475	506	563
Tairāwhiti	226	201	202	191	222	228	227	206	204	211	261	223	200
Waikato	1,371	1,376	1,428	1,378	1,579	1,602	1,577	1,660	1,711	1,647	1,676	1,774	1,821
Midland	2,810	2,783	3,086	3,008	3,285	3,264	3,381	3,507	3,586	3,616	3,667	3,701	3,883

Waikato, Lakes, Bay of Plenty and Tairāwhiti all have significantly higher age-standardised cancer death rates compared to the national rate (Ministry of Health, 2011). There is variation in registration and mortality rates between DHBs (MCN, 2014).

2.1. Equity

Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Significant health inequalities exist among different groups of New Zealanders. For example, Māori, Pacific peoples and people from lower socioeconomic groups have worse health and die younger than other New Zealanders.

Biopsychosocial models of cancer care are now being recognised as key components to improving inequalities, but also contribute to maintaining the wellbeing of those affected by cancer (Addressing cancer health disparities using a global bio psychological approach. Cancer. 2010; 264-269. PubMed). Despite the existence of a publicly funded health care system in New Zealand, not all aspects of the psychological and social effects of cancer are met. Psychosocial distress is now recognised as the 6th vital sign and appropriate distress management is an important part of ensuring the wellbeing of those affected by cancer. Research indicates that appropriate psychosocial support can lead to improving inequalities such as medical cost offset through reduced 'did not attend' (DNAs) appointments, improved treatment adherence, reductions in unnecessary medical appointments and procedures and reduced hospital visits.

In addition to addressing health inequalities, the development of the Equity of Health Care for Māori 2014 (The Framework) also guides the New Zealand health sector on key actions that can be taken by the health system (such as the Ministry of Health, PHARMAC and regulatory authorities); health organisations (such as DHBs, PHOs and other health providers) and health practitioners (such as doctors, nurses and community health workers) to achieve equitable health care for Māori.

The Framework is based upon current literature in the field of quality improvement and research on improving access to health services for Māori, indigenous peoples and minority ethnic groups. This equity framework can be applied to all existing, and the development of new service approaches that aim to improve cancer outcomes for Māori and other vulnerable populations.

Midland Supportive Care Work Group, in partnership with the Midland Hei Pa Harakeke Chair and Midland Cancer Network Equity Manager developed a Midland framework for psychological and support care: an equity approach (Appendix A) to inform and guide the development of the regional service to ensure equity is at the forefront of any service development for patient care.

2.2. Midland cancer supportive care initiatives

The following Midland supportive care initiatives provide background information to inform this Midland plan:

- Midland FCT service improvement initiatives 2014/15 – round 1
 - Midland DHB self-assessment of national tumour supportive care standards – in progress
 - Midland stocktake of DHB specific patient information resources – completed and the initiative demonstrated inconsistent and fragmented availability of information resources for patients and family/whānau generically and by tumour types
 - Midland cancer nurses education programme to support nurses undertaking psycho-social assessments – in progress
 - Review and update of the Midland supportive care services directory, including inclusion of Tairāwhiti – in progress.
- development and implementation of a Midland psycho-social assessment tool and guidelines for cancer nurses.
- participation in the Central Cancer Network Supportive Care Framework Project 2014-15 (FCT Service Improvement round 1 in progress).
- establishment of a Midland psycho-social education forum (BOP lead) in 2014.
- health professional one off education sessions on supporting patients with sexual activity needs and breaking bad news.
- MCN/Waikato psychological assessment pilot 2009.
- Waikato/MCN development of a Waikato Psychological Oncology Model of Care and Business Plan (draft) (Thomas, P., Fitzgerald, J. 2007). MCN undertook a stocktake of services, gap and HEAT analysis and identified psycho-oncology support requirements to meet the Waikato cancer patient needs. The model based resourcing on a distress prevalence rate of 35%.

2.3. Approach to developing the plan

The MoH sent communication to the DHBs chief executives, directors of allied health, DHB COOs, DHB planning and funding managers and regional cancer network managers 25 March 2015 (appendix B). The communication included background and expectation information, draft service specifications for the cancer centre psychologist, draft service specifications for the local DHB new roles and a questionnaire template.

MCN sent this information to Midland DHBs and the MoH request was discussed at the MCN Executive Group meeting on 26 March 2015.

The New Zealand Triple Aim for quality and safety outcomes is central and underpins the Midland plan. The Triple Aim means:

- Improved quality, safety and experience of care
- Improved health and equity for all populations
- Better value for public health system resources.

The Midland Supportive Care Work Group was refreshed with service manager, planning and funding portfolio manager and allied health director from all four DHBs, and Cancer Society (Appendix C). A regional chair was appointed (Di Peers).

MCN was to sponsor/facilitate the project (Jan Smith) and a project manager (Rawiri Blundell) was allocated to facilitate the development of the plan with stakeholders.

DHBs established a local expert group to complete a current FTE stocktake, work through the MoH questionnaire template and prioritise discipline and FTE for the new roles (appendix B). The regional work group then reviewed findings and assisted in the development of the regional plan. The following activities and timeframes were followed.

Activity	Due Date	By Whom
Regional planning approach communications sent to DHBs	Friday 10 April 2015	MCN
Local DHB response to template (see attached word and excel sheet)	Friday 24 April 2015	DHB
Consolidate regional feedback for discussion	Tuesday 28 April 2015	MCN
MSCWG teleconference to review DHB feedback and process to prepare draft plan	Thursday 30 April 2015	DHB/MCN
First draft regional plan sent to MSCWG for review	Friday 1 May 2015	MCN/DHB
MSCWG track changes to draft v1.0 plan back to MCN	Thursday 7 May 2015	DHB
Finalised draft plan submitted to Midland COOs, GMs P&F, MSCWG, MCN Executive Group via email	Friday 8 May 2015	MCN
Regional feedback to MCN received	Friday 15 May 2015	DHBs
Submission of draft regional plan to MoH	Tues 19 May 2015	MCN
MoH feedback received and circulated to MSCWG	Fri 29 May 2015	MCN
MCN circulate MoH feedback to MSCWG	Fri 29 May 2015	MCN
MSCWG teleconference to consider feedback and finalise	Wed 3 June 2015	DHB/MCN
Finalised plan submitted to Midland COOs, GMs P&F, MSCWG, and MCN Executive for endorsement	Fri 5 June 2015	MCN
Submit final plan to MoH	Fri 12 June 2015	MCN

Note: MSCWG = Midland Supportive Care Work Group

Excluded from the plan are private services and paediatrics.

2.4. Expectations

The following expectations are required to be reflected in the regional plan. As patients regularly travel across DHBs as part of their cancer treatment, regions are expected to develop a cohesive and equitable service. Different expertise should be available across the region on the basis of prioritisation to ensure people can access the services that meet their needs. As DHBs work together to develop and deliver their regional model for the psychological and social support service, the Ministry expects:

- regions to take a person-centred approach (focusing on the needs of cancer patients and their family/whānau) when building on existing services to develop and deliver a regional psychological and social support service
- that the psychological and social support service will be timely and equitably accessed by all cancer patients (recognising and meeting the needs of different populations)
- patients will have regular needs assessments to identify any areas where support could be offered
- the professional standard of care applying to staff working in these roles is acknowledged and managed, including making clinical supervision available.

The new DHB roles will:

- primarily have a clinical focus
- have a role in educating other health professionals to further develop or utilise their skills in providing supportive care, and in improving supportive care systems for cancer patients
- promote collaborative care
- sit at the front of the secondary care cancer patient pathway, with links to palliative care, community health, other allied health services and non-government service providers.

The new DHB roles are likely to be a mixed workforce made up of psychologists and experienced social workers. The workforce must be able to meet the moderate/severe and the severe psychological and social support needs of people with cancer by delivering interventions. Some of the areas that may be addressed to enhance patient experience and outcomes are:

- psychological: suicidal ideation, bereavement and loss, Māori cultural perspectives (e.g., tangihanga and wairua), phobias, fear of death, depression, chronic fatigue, sexual issues, body image concerns, relationship issues and changes, identity issues, anger, personality and behaviour change, as well as complex presentations and staff crisis
- social support: barriers to accessing services, multiple comorbidities (managing across other services), relationship issues and changes, child support and education, talking to children about cancer, grief, family support, financial support, crisis counselling.

Alongside new DHB clinical roles, a regional clinical psychologist based in the Waikato Regional Cancer Centre will provide leadership for the psychological and social support service, including working with the national lead to develop and implement regional referral pathways.

3. Midland current provision of services

This section considers the current psychological and support services and workforce FTE allocation in the Midland region for adult cancer patients and summarises the DHB self-assessments and findings. Please refer to appendix B for further DHB detail. A stocktake of current resourcing and proposed is summarised in the table 1.

Table 1: Stocktake of psychological and social support positions by DHB and proposed new roles

	Waikato current FTE	Waikato proposed FTE	Lakes current FTE	Lakes proposed FTE	BOP current FTE	BOP proposed FTE	Tairāwhiti current FTE	Tairāwhiti proposed FTE
Cancer – Specific Roles								
Lead Psychology	0	1.0	0	regional	0	regional	0	regional
Psychology	0	2.2	0	0.8	0	0.8	0	0.2
Social work	1 FTE in IP and OP and a community service that sees these patients as referrals arrive, difficult to determine FTE dedicated to this area.	0.4			1 FTE in Tauranga Hospital allocated to the Cancer Centre One service/ 2 sites Tga and Whakatane	1.0	0.5	0.2
Counsellor funded by your DHB	0				0		0	0
Psychotherapist funded by your DHB	0		0	0	0		0	0
Maori Patient Navigator	2.0 FTE Breast screening 0.2 Kaitiaki Oncology Ward M5		No cancer Specific		0		0	
Cancer Nurse Coordinator/CNS	4.5 FTE CNC tumour based from high suspicion to first treatment 8.0 FTE Clinical Nurse specialist and age specific adolescent Total 12.5 FTE		2.7 FTE CNS		1.6 FTE Nurse coordinator Respiratory/ Generic .9 FTE Oncology CNS .7 FTE Haematology CNS		1 plus other cancer CNSs	
DHB funded community roles	Not aware of any		Aroha Mai Maori Cancer service-no direct clinical qualifications		0		0	0
Other-NGO and Primary Service based roles, accessed by cancer patients, where identified								
Cancer Society nurse liaison	5.8 FTE across Midland (excl. Tairāwhiti) Tairāwhiti has no cancer liaison nurses							
Psychology	0	0	0	0	0	0	0	0
Social work	0	0	0	0	0	0	0	0
Counsellor	0	4-6 counselling sessions pp		4-6 counselling sessions pp	0	4-6 counselling sessions pp		3 counselling sessions pp
NGO provided	Hospices excluded from stocktake							
Total funding available	Unknown							

Note: TDH plan that balance of funding will be used for ad hoc psychology sessions

3.1. How are patients identified and referred to appropriate services

The following describes how Midland DHB patients who experience psychological or social impact as a result of their cancer diagnosis/treatment are currently identified and referred to appropriate services.

Generally patients are identified for referral to appropriate service through medical and nursing staff during an inpatient, outpatient or community contact. Midland cancer nurses screen using a regional psycho-social assessment tool and framework, and refer to social work services, Cancer Society and/or other NGOs, psychology (where available) as able. All Midland cancer nurses have been trained or are going through training to undertake psycho-social assessment. Social worker screens patients and provides care. Infrequently there are referrals to psychology consult liaison services. A degree of psycho-social support is provided by multidisciplinary teams.

3.2. What is the perceived level of need for cancer patients

There are many varying levels of need expressed by cancer patients, noting the spectrum of needs across cancer type, potential co-morbidity, age, ethnicity, gender, family circumstance and socio-economic situation. In general, the perception is that while staff attempts to meet the constellation of patient/whānau needs as best they can, there are still many instances where this is not possible. The DHBs screen patients for distress using staff available, but their ability to provide a satisfactory response can be limited as there may not be a pathway or resource to refer too.

The prioritisation of funding has been directed towards a mixture of psychologists and social workers to meet the multidisciplinary team gap and support providing holistic care for patients/family/whānau in need.

3.3. Access to DHB psychologist services

Midland DHBs do not have any dedicated cancer specific psychologist workforce, including haematology services. Access to psychologist input is significantly limited and it varies across the region via either the mental health service, Cancer Society, primary or private providers.

3.4. Access to DHB social work, counsellors or psychotherapists services

Midland DHBs access to dedicated cancer social work support is limited with most DHBs accessing services from the generic social work team. Given that the majority of cancer patients receive care in the ambulatory environment the stocktake identified generally the level of DHB ambulatory/community social work is significantly lower than services available to the hospital inpatient areas.

No DHB counsellors or psychotherapists were identified in the stocktake.

3.5. Access to other supportive care services

The stocktake attempted to identify other supportive care services that are available to adult cancer patients e.g. DHB funded community roles, Māori patient navigators, primary, mental health services and local NGO service provision. The Cancer Society and CanTeen are significant providers of supportive care in the community.

Midland has two Cancer Societies. The Waikato/BOP Cancer Society and CanTeen will fund 4-6 sessions of psychology counselling or family therapists. The Waikato/BOP Cancer Society Cancer Lodge provides supportive care for patients while undergoing treatment at the Regional Cancer Centre. Cancer Society Gisborne funds 3 counselling sessions per person.

BOP DHB have identified other local providers that support patient care i.e. Poutiri Trust, Te Kupenga Hauora o Tauranga Moana and Te Puna Ora o Mataatua (breast and cervical screening) and Kimi Hauora cancer service (for the McLeod family).

Lakes DHB contract Aroha Mai Māori cancer service for supportive care services within the community and links to Rotorua hospital and the Regional Cancer Centre in Hamilton.

3.6. Resource targeting Māori and Pacific populations

Lakes Aroha Mai Māori cancer service was the only targeted cancer supportive care service identified within the stocktake.

Tairāwhiti Hauora Māori department has a kaiatawhai and whānau ora pakeke but as yet they have not been involved in care of cancer patients. Tairāwhiti has noted challenges with a large Māori population geographically isolated supported by only generalist health professionals.

No community patient navigators were identified. However some DHBs have implemented cancer coordinators/CNS to support equity of access and/or for Māori, as per the Cancer Nurse Coordination Initiative (CNCI).

In partnership with the DHBs, Cancer Society and Midland Māori Health Providers Midland Cancer Network runs a Kia Ora e te Iwi programme which is a community based health literacy programme. This programme has a

cancer education and an awareness focus aiming to ensure earlier detection, improved access and empower people as they navigate through services.

4. Midland current service gaps

This section identifies the gaps in the current provision of where adult cancer patients are not receiving psychological and social support services (the gaps in the current provision of psychological and social support services).

4.1. Where cancer patients are not receiving services

This gap analysis links to the availability of current resources identified in table 1 for Midland. The key gaps where patients are not receiving services are:

- limited/no access to psychology services
- limited access to community/ambulatory social work services
- hard to reach high risk people, people living in rural and remote areas and the ability to access support
- impoverished families, financial burden on patient and family/whānau coping with cancer treatment and survivorship
- limited targeted supportive care resources, in particular for Māori
- access issues for patients with low level priority mental health needs
- information and support regarding relationship changes, sexual activity changes, emotional changes
- putting people in touch with care providers to help with anxiety and fear (Voices of Experience)
- offering people with cancer access to counselling or support relating issues such as concerns about cancer or coping at home or at work
- supporting patients to make informed decisions regarding complex and life changing treatment e.g. cancer diagnosis in pregnancy, considering reconstruction surgery
- complex patients and/or those with psycho-social comorbidities e.g. high adverse childhood experiences scores, mild coexisting mental health mood disorder, family violence and abuse, relationship issues, drug and alcohol abuse, criminality that result in difficulties coping with cancer
- supporting young people with acute serious conditions, unexpected outcomes, relapse, coping socially
- supporting people with late effects of surviving cancer treatment
- supporting whānau to care for the patient in the community
- no/limited psycho-social education for existing staff and limited informal debriefing for staff regarding dealing with psychological issues
- access to individual specific psychological interventions: sleep intervention, mindfulness, CBT, talking therapies, family therapy, sexual health interventions
- no/poor referral pathway to psychology and limited referral pathway to social work and specialist counselling services.

4.2. Resource targeted to improve Māori and Pacific People outcomes

The Midland stocktake and the development of the equity framework identified that there is limited dedicated resource targeted to improve Māori and Pacific Peoples outcomes. This regional plan and the Midland equity (Appendix A) aim to inform and guide the development of the regional service to ensure equity is at the forefront of any service development for patient care. There is also variable access to supportive care providers within the region.

We have made the best application of this new resource, in order to meet the most high priority patient/whānau needs as understood by stakeholders involved in developing this plan.

5. Prioritised plan to implement new funded roles

This section identifies how the Midland region has prioritised the allocation of the new funded roles to address the current service gaps.

5.1. What kind of professional discipline will be required

A mixture of professional disciplines comprising of psychologist, social worker and Māori patient navigator roles will be required.

5.2. How many FTE will be added to the regional service

The following new roles have been prioritised as a means to address the identified gaps in the provision of services. The DHB funding is in the table below.

A total of **5.6** FTE positions will be added to the Midland DHB cancer psychological and social support service. In addition a **1.0** FTE Midland Lead Psychologist (separate service specification) will be employed at Waikato DHB on behalf of the region.

These new roles (FTE) will be integrated and linked into existing services.

Role	BOP	Lakes	Tairāwhiti	Waikato	Midland total
Lead Psychologist*				1.0	1.0
Available funding					\$133,333
Psychologist	0.8	0.8	0.2	2.2	4.0
Social Work	1.0		0.2	0.4	1.6
Available funding	\$188,773	\$84,190	\$42,967	\$302,775	\$618,705

5.3. How does the allocation ensure equitable regional access to the service

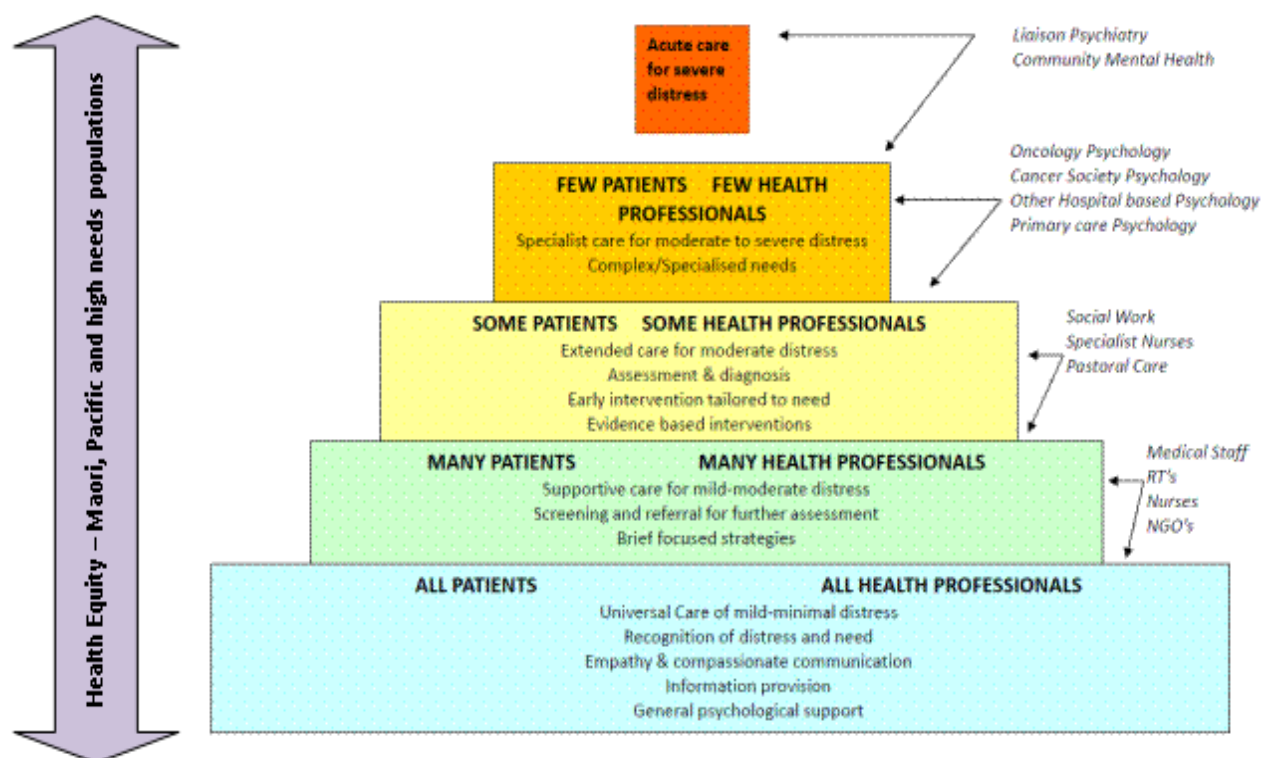
The allocation decision for equitable regional access has been made based on a combination of current service availability, resourcing and local DHB needs as well as expert opinion.

5.4. Regional model of service

Midland has a spoke and hub model for cancer services. The tertiary cancer centre hub is Waikato with a secondary cancer centre hub based at Tauranga Hospital, BOP DHB. Spokes are considered to be at Lakes DHB, Tairāwhiti DHB, Waikato rural hospitals (Tokoroa, Thames, Te Kuiti and Taumarunui) and BOP DHB Whakatane Hospital. All services will have linkages with primary and NGO services.

The following supportive care framework envisages that the psycho-oncology workforce would work directly with people with cancer and their families mainly at the two narrower levels and indirectly (supporting other health care team members). The model presents a tiered and triaged approach and identifies that all cancer patients have some level of need that require intervention.

The framework below has been adapted from Fitch 2008, the Ministry of Health guidance (2010).



6. Multidisciplinary integration

This section outlines how the new roles will be integrated into, and complement existing DHB services and the multidisciplinary cancer team.

6.1. Support for the new roles

The regional Lead Psychologist will have a leadership function to support implementation and development of the service and new roles.

Waikato new roles will sit within the existing allied health services structure which consists of an allied health manager of social work and allied health manager of psychology. This approach will provide operational management, orientation, collegial support and profession supervision. A partnership approach with all cancer services will be taken to orientate the new roles. The new roles will co-locate within the oncology/haematology, womens health and surgical services and be fully integrated with multidisciplinary teams and MDMs.

Waikato will have close linkages with other Midland DHBs to ensure equity of service delivery across the region and support clinical staff in geographical locations. The regional approach will support patients as they move across the region for treatment.

BOP DHB one service two sites (Tauranga and Whakatane hospitals) approach will have the new roles located within the existing allied health services structure. Reporting of the new roles will be to like professionals. BOP multidisciplinary team approach will continue ensuring patients have seamless access to services. The service will mobilise, travelling between hospital sites.

Tairāwhiti DHB is developing a cancer hub. The new roles will be physically located in the cancer hub but will be aligned to the existing allied health team or Māori health team for supervision and support as currently occurs. Tairāwhiti would continue to provide supervision in its existing structure. The regional lead psychologist would provide additional support.

Lakes Medical and Support Services includes secondary allied health service professionals, but have no psychologists. Lakes psychologists are predominately located in Mental Health Services. The proposed new

psychologist role will report to the Lakes Medical and Support Services Manager who has accountability for cancer. There would be professional linkages established locally and regionally.

The overall Midland governance and management arrangement for this regional service is summarised in section 6.3. Development of the regional service will have a continuous quality improvement approach with all roles participating.

6.2. How will the new roles be integrated into existing services

Midland focus is to link and integrate the new roles into existing services from the beginning. The Midland view is that this is an enhanced approach (when compared to CNCI model of service). DHBs will follow local recruitment policies. The national Clinical Lead and regional psychologist will be available to support DHBs with this process. Existing teams will be involved in orientation, support and service development.

The regional service will utilise the Map of Medicine and Bay Navigator pathway links within primary and secondary services.

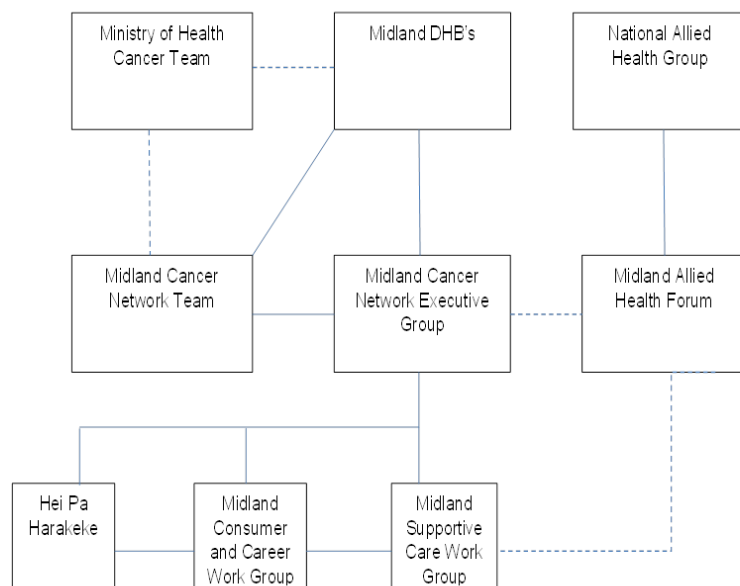
6.3. Regional governance

The Midland Cancer Network Executive Group is the sponsor of the Midland Supportive Care Work Group. The chair is a member of the Midland Cancer Network Executive Group. There is a Midland Cancer Consumer/Carer Work Group and Hei Pa Harakeke (Midland Māori Advisory Group) that will provide support for this new enhanced service. MCN provides secretariat and project support to the regional cancer network work groups as required. The Midland Supportive Care Work Group will have DHB representatives that include an allied health director, a service manager, planning and funding portfolio manager and Cancer Society representation. In addition there will be representative links for consumer/carers and Māori leadership work groups. The regional psychologist on appointment will join this regional group. The Midland Supportive Care Work Group will oversee the implementation of the Midland Psychological and Social Support Services Plan 2015-18 including participation in monitoring and evaluation.

There are links to Midland Allied Health Directors, COOs, GMs Planning and Funding, and other relevant regional forums.

The regional governance has links with the national cancer governance structure. Regional links will be developed with the new national Clinical Lead.

The simplified diagram below demonstrates the governance to support this regional service plan.



7. Monitoring and evaluation

Midland DHBs support an integrated and planned approach to evaluation at both national and regional level. The evaluation framework logic should outline the approach, methodology, process and metrics to measure that the

programme of service is making a difference should be developed as soon as possible, before the new roles are implemented. Midland DHBs are adamant that the evaluation should take a whole of service evaluation not just focusing on the new roles. The evaluation metrics should have standardised data points and definitions. The KPIs should have standardised framework, an example framework that could be used is the *Lung Cancer Clinical Quality Performance Indicators v2.0* (Scottish Government and Healthcare Improvement Scotland 2012; updated November 2013).

A lesson learnt from the CNCI evaluation is to consider the resourcing and support required and implications to undertake evaluation while at the same time developing a new service. Caution is required to ensure that the evaluation process doesn't become the service.

7.1. Indicators of success

Some ideas identified in the short timeframe of developing this regional service plan include:

- Process evaluation
- Implementation of the new roles
- Patient/whānau coverage and reach; increased uptake of service by rural/marginalised and Māori
- Leadership and governance
- Service development initiatives
- Demonstrate regional model of service, pathway and linkages
- Supervision
- Effectiveness of the roles
- Adherence to clinical referral pathways for patients presenting with psychological distress
- Satisfaction survey regarding the regional service – patients/family whānau, DHBs, health professionals
- Compliments / complaints
- DNA / CNA rates
- Intervention rates, types of services accessed and settings
- Post implementation review of the regional service plan (as a minimum).

7.2. National evaluation

The Midland Cancer Network notes there are opportunities to improve evaluation based on the learnings of the CNCI evaluation.

The Ministry of Health Cancer Team when planning the national evaluation framework could consider an enhanced approach as we have suggested with the partnering option of the Waikato Clinical School (Appendix D) and the Midland Cancer Network.

Midland recommends that the National Directors of Allied Health Group (mandated by the NZ DHB CEs) workshop evaluation logic and approach, methodology and metrics. This could include partnering with the National Clinical Lead and the National Cancer Programme Steering Group clinical representative for Directors of Allied Health, Science and Technical.

7.3. Regional evaluation

Midland DHBs will be responsible for reporting to the MoH as per the CFA variation clause 6.

The Waikato Clinical School has developed a Midland Regional Cancer Research Group that has developed expertise in research relevant to the care of people with cancer. Midland Cancer Network partners in the Waikato Clinical School initiatives. Professor Ross Lawrenson sits on the Midland Cancer Executive Group. The Waikato Clinical School has expressed interest and support for undertaking regional evaluation of this new service (refer to letter of support Appendix D). The Waikato Clinical School have submitted a partnership bid to HRC and are awaiting a response.

Regional evaluation logic, methodology and KPIs will be developed in partnership with the Midland Lead Psychologist, National Clinical Lead, Waikato Clinical School and Midland Supportive Care Work Group.

7.4. Risk management

The Midland Supportive Care Work Group will regularly monitor risks and issues related to implementation of the new regional service. The following risks have been identified:

Risk description	Probability (L/M/H)	Impact (L/M/H)	Owner of Risk	Risk management strategy
1. Recruitment – delays, availability of experienced staff able to support service development as well as clinical delivery, rural areas, part time roles, DHB FTE caps. TDH risk recruiting part time psychologist	H	H	Service and clinical managers	Planned approach to recruitment. Escalate issues to senior management as required. Midland SCWG support and advice to address issues as they arise. TDH/Waikato to work in partnership.
2. Regionalisation of the service – variation of current level of service & practice, professionals limited experience working across region and DHB boundaries	M	L	DHB Leads / Lead Psychologist	Midland awareness of services available in each DHB. Regional lead psychologist along with Midland SCWG support and advice Identify a lead sponsor(CE,GM or COO)
3. Unsure of population need – service unable to cope or spare capacity	L	M	DHB Leads	Monitor utilisation Regional monitoring and evaluation - KPIs
4. Poor development of service - inadequate time and resourcing to implement service development initiatives upfront – individuals develop the service ad hoc	L	M	MSCWG /Lead Psychologist /DHB Leads	Midland regional service plan. Regional approach to implementation.
5. Midland clinicians not aware or engaged with the implementation of regional psycho-social and supportive care model of service	L	M	DHB Leads Lead Psychologist	Midland regional service plan. Regional approach to implementation. Communication and engagement plan. Midland SCWG support and advice
6. Inconsistent allied health leadership model – regional variation in model	M	M	DHB Leads	Support region to implement a consistent model. Midland SCWG support and advice, good communication.

8. Finance

Budget Bid 2014 provides funding per annum for the new roles/services. The Ministry has indicated that funding is to be sustainable – this is an important consideration when recruiting to the positions, as the proposed CFA variation is currently a three year arrangement.

The Ministry will fund the Midland DHBs via a CFA variation for the next three years, using a population based funding formula (2012/13) for the cancer psychological and social support workers new roles. The funding per DHB is:

DHB	2015/16 PBFF	Funding available
Bay of Plenty	5.55%	\$188,773
Lakes	2.48%	\$84,190
Tairāwhiti	1.26%	\$42,967
Waikato	8.91%	\$302,775
Midland total		\$618,705

Nationally there is a total of \$800,000 p.a. for the six psychologists in the cancer centres. This amount is based on the MECA and includes overheads. The Waikato DHB funding for the regional cancer centre psychologist is effective 1 July 2015 in the July crown funding agreement round. The revenue for this service is estimated to be \$133,333 p.a. This funding is not included in the above financial table.

The network asked the Ministry of Health Cancer Team 4/5/15 for guidance of managing the funding and volumes between DHBs for a regional service. Ministry verbal feedback is in principal this is a regional service and that there will not be charge back between DHBs. The Ministry of Health is seeking planning and funding expert advice to ensure that there is national consistency.

9. Implementation plan and approach

On approval of the regional plan and Ministry of Health agreeing the CFA Variation Agreements with Midland DHBs a phased implementation plan will be developed by the Midland Supportive Care Work Group in partnership with Midland DHBs and Midland Allied Health. The Midland DHBs will need to develop internally a business plan for approval prior to implementing the new roles. The aim of the regional implementation plan is to inform DHBs internal business planning process. The high level implementation plan includes the following components:

Service evaluation:

- develop regional evaluation framework
- develop regional key performance indicators, definition and data parameters and implement systems to capture data points at point of contact, develop reports, regional based repository set up

Recruitment:

- develop position descriptions
- DHB submit recruitment business cases as required
- develop recruitment process and implement
- set up work environment
- develop orientation programme
- develop and agree annual performance objectives

Supervision:

- Agree and document supervision process for existing and new roles

Stakeholder communications and engagement plan

- develop
- implement
- evaluate
- contract reporting as per Ministry of Health agreement

Patient pathways

- develop and agree referral criteria and process for current and new positions
 - social work
 - psychologist
 - other
- implement referral criteria and evaluate
- upload onto Map of Medicine and/or Bay Navigator
- develop framework for integrating with primary and NGOs, implement and evaluate
- develop regional lead psychologist framework, implement and evaluate

Education and training






- needs analysis for current and new roles
- needs analysis for health professional i.e. breaking bad news, addressing sexual issues
- develop and implement programme and evaluate.

10. Appendix A – Midland framework: an equity approach





	Leadership <i>Health system leadership is about setting an expectation that good supportive care provision will contribute to better health equity for all New Zealanders</i>	Knowledge <i>The health system requires knowledge in adapting to behavioural and systemic change</i>	Commitment <i>The health system is committed to reconfiguring services to deliver high-quality Psychological health care that meets supportive health need of all New Zealanders</i>
Health System	<ul style="list-style-type: none"> Health system leadership by Midland DHB is expressed through raising awareness and strategic direction for Supportive care provision. Raise awareness and set direction for supportive care health literacy at Governance and senior leadership levels. Excellent supportive care provision is embedded in all levels of the health system, including planning work programmes and reporting. Apply National framework for health literacy: A health systems approach. Midland Cancer Network Executive Group linked to Midland GM Māori Governance group. (Ngā Toka Hauora) Midland Allied Network establishes linkages to regional and national psychological and supportive care workgroups/leads Ensure that equity is a central focus for all supportive care planning and reviews Ensure sufficient representation of Māori, Pacific and other high risk groups are presented on Midland Governance workgroups. 	<ul style="list-style-type: none"> To develop ways to effectively deliver and monitor high-quality psychological care for Māori. Collaboration and sharing of information between services, programmes and initiatives. Develop methods to ensure that services, programmes and initiatives share knowledge and contribute to developing excellent and equitable Supportive Care services. Ensure that high quality ethnicity data are available for planning and monitoring services. Ensure that evidenced based methods are used to achieve equity access, and quality of care. 	<ul style="list-style-type: none"> The availability of high quality data/information to measure and ensure high quality equitable access to Psychological services. A system approach that includes action to improve psychosocial support services for Māori, Pacific and other high risk groups. The Health system is organised and improved in a way that makes it easier for individuals and whānau to navigate, understand, and make decisions regarding psychological support. Ensure that equity quality targets are developed Ensuring explicit organisational commitment to delivering high-quality psychological care that ensures equity for Māori, Pacific and other disadvantaged groups. Build and maintain a health workforce responsive to the psychosocial care needs and aspirations of Māori, Pacific and other high risk groups.
Health organisations	<ul style="list-style-type: none"> Improving supportive care provision and procedure's is considered business as usual, with effective communication becoming an integral part of the process. Linkages with primary and secondary health services are developed, fostered and established to enable whānau to have their psychological support needs met. Supportive Care improvement is embedded across all levels of health organisations including policy, planning, procedures', patient safety and service quality improvement. Service providers address the needs of their populations that have varying degrees of supportive care requirements. 	<ul style="list-style-type: none"> Health organisations review supportive care practises in their services and health care environment. Positive working relationships are achieved to collaborate across the health and social services to build knowledge on supportive care needs. Matauranga Māori is acknowledged and supported to improve psychological referral pathways for Māori whānau and individual's. Patient focus groups and consumers are utilised in the development and testing of strategies to improve supportive care services. 	<ul style="list-style-type: none"> Health organisations are committed to reviewing the status of supportive care practises to improve standards, pathways and action plans. Health organisations are committed to workforce development in the areas of psychosocial and supportive care need. Health organisations provide adequate investment and resourcing to sustain supportive care services. Consumers are included in service models (where appropriate).

	Leadership <i>Health system leadership is about setting an expectation that good supportive care provision will contribute to better health equity for all New Zealanders</i>	Knowledge <i>The health system requires knowledge in adapting to behavioural and systemic change</i>	Commitment <i>The health system is committed to reconfiguring services to deliver high-quality Psychological health care that meets supportive health need of all New Zealanders</i>
	<ul style="list-style-type: none"> Midland Māori cancer advisory workgroup (Hei Pa Harakeke) actively supports and provides leadership and advice for implementing new services Regional psychologist lead builds linkages to ensure services meet the needs of patient and whānau. 		<ul style="list-style-type: none"> Health organisations grow champions to support sustained effort to improving psychological support. Midland Supportive Care workgroup actively supports and provides advice in the development of new initiatives and supportive care programmes.
Health Practitioners	<ul style="list-style-type: none"> Health practitioners develop meaningful relationships with Māori and Pacific individuals, whānau, and communities Provide high quality health care that delivers equitable health outcomes for Māori Health practitioners recognise the link between psychological support and cultural competencies with both being expressed as good practise standards. 	<ul style="list-style-type: none"> Health practitioner's build their knowledge base on how they can effectively communicate, and provide supportive care information to support whānau and individuals. Health practitioners realise individuals and whānau may have reduced ability to process supportive care information when they are sick and vulnerable during a diagnosis. 	<ul style="list-style-type: none"> Health professionals and other staff can readily describe the pathway in relation to psychological and supportive care requirements.

11. Appendix A – Ministry Budget Bid 2014 information

Ministry document title	Document
Background as provided by the Ministry of Health	 2015-4_MoH Psychosocial Backgroi
Ministry of Health letter amending PBFF funding allocations by DHB	 2015-4-2_MOH Letter amended PBFF
Template for development of Regional Plan	 2015-4_MOH Psychosocial Templat
Lead Psychologist Service Specification	 2015-4_MoH Draft service schedule 6 FT
Cancer Psychologist and Social Support Worker Service Specification	 2015-4_MoH Draft service schedule up to

12. Appendix B – Midland DHB self-assessment

DHB	Self-Assessment document as at 30/4/15
Bay of Plenty DHB	 Cancer Response DRAFT 042015 BOP.c
Lakes DHB	 Psychological and support assessment L
Tairāwhiti DHB	 Template Midland Region1 TDH (3).doc
Waikato DHB	 Midland Supportive care services stocktal

13. Appendix C - Midland Supportive Care Working Group

Name	Role	DHB
Di Peers – Chair	Group Manager, Child Womens & Allied Health	Waikato DHB
Lindsay Pooley	Assistant Group Manager, Allied Health	Waikato DHB
Liz Court	Manager Psychology Allied Health	Waikato DHB
Amanda Wright	Service Manager	Waikato DHB
Margaret Krauss	Director of Allied Health	BOP DHB
Neil McKelvie	Service Manager	BOP DHB
Jane Chittenden	Service Manager	Lakes DHB
Vanessa Russell	Planning and Funding Portfolio Manager	Lakes DHB
Arish Naresh	Director of Allied Health	Tairāwhiti DHB
Debbie Barrow	Clinical Care Manager, Medical & Mental Health (A)	Tairāwhiti DHB
Virginia Brind	GM Planning and Funding	Tairāwhiti DHB
Anton Turner	Planning and Funding Portfolio Manager	Waikato DHB
Mike Agnew	Planning and Funding Portfolio Manager	BOP DHB
Hayley Goodall	Supportive Care Manager, and Chair Midland Cancer Consumer/Carer Work Group	Waikato/BOP Cancer Society
Ditre Tamatea	GM Māori Services and Chair Midland Hei Pa Harakeke	Waikato DHB
Rawiri Blundell	Project Manager - Equity	Midland Cancer Network
Jan Smith	Manager	Midland Cancer Network
Keryn Roderick	Portfolio Manager-Cancer Services	Taranaki P&F

14. Appendix D – Waikato Clinical School letter of support

WAIKATO CLINICAL CAMPUS

Faculty of Medical and Health Sciences



THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

Peter Rothwell Academic Centre

Waikato Hospital

Pembroke Street

Private Bag 3200

Hamilton

New Zealand

21 April 2015

Rawiri Blundell

Re: New position - Psychology support for patients with cancer

The Waikato Clinical Campus has developed a Midland Regional Cancer Research Group that has developed expertise in research relevant to the care of people with cancer. The group has been built on the basis of the Ministry of Health funded partnership grant around prostate cancer and subsequent grant with the HRC around breast cancer outcomes. Additional funding has also been obtained from the Ministry of Health for a Health Economist and funding from other sources such as Waikato Medical Research Foundation, Prostate Cancer Foundation and the Breast Cancer Foundation.

Part of our research has included qualitative investigations of patients with both localised and advanced cancer. This research has identified an unmet need for psychosocial support for these patients and has identified a number of causal factors including aspects around health literacy, financial pressures, and relationship pressures that cause an added burden to patients facing a diagnosis of cancer.

Our research team is a multidisciplinary team that includes expertise in cancer diagnosis and treatment, epidemiology, health services research, health economics, and Māori and Pacific health. We believe with the multidisciplinary team that we would be well placed to provide an evaluation of a new service in this much needed field of psychosocial support. Part of the expertise of our team is that we have good links and are well integrated both with the specialist secondary services including medical oncology, surgery and radiation oncology as well as palliative care. We also have strong links with the primary care sector. Part of a Midland programme for psychosocial support, we believe, should include an ongoing partnership regarding evaluation of the programme from the perspectives of effectiveness and patient acceptability.

We also are developing international links with the University of Southampton, University of Surrey and the University of Oxford in the UK and the University of Melbourne in Australia and the University of British Columbia in Canada. We believe that our team, working in conjunction with the Midland Cancer Network are well placed to undertake a high quality evaluation of the proposed new services.

Yours sincerely,

Ross Lawrenson

Assistant Dean, Waikato Clinical Campus and Professor of Primary Care

15. Glossary of abbreviations/acronyms

Abbreviation	Full Name
BOP	Bay of Plenty
CCN	Central Cancer Network
CD	Clinical Director
CFA	Crown Funding Agreement
CNCI	Cancer Nurse Coordinator Initiative
CND	Clinical Nurse Director
CNM	Clinical Nurse Manager
CNS	Clinical Nurse Specialist
COO	Chief Operating Officer
CSD	Clinical Services Director
DNA	Did Not Attend
DHB(s)	District Health Board
FTE	Full Time Equivalent
HPH	Hei Pa Harakeke (Midland Māori Cancer Advisory Group)
GM	Group or General Manager
KPI	Key Performance Indicator
MCN	Midland Cancer Network
MoH	Ministry of Health
MSCWG	Midland Supportive Care Working Group
NGO	Non-Government Organisation
P & F	Planning and Funding
PHO	Primary Health Organisation
PM	Project Manager
Q & R	Quality and Risk
RSP	Regional Services Plan
SW	Social Worker
TDH	Tairāwhiti
TPO	Te Puna Oranga, Māori Health Unit, Waikato DHB
WCS	Waikato Clinical School