Te Whatu Ora Funded Services

▲ Acute Demand Service

A comprehensive range of targeted services, including Community Radiology, focused on reducing Emergency Department presentations and hospital admissions through enhanced service delivery within a primary care setting and ensuring people remain connected to and cared for by their primary care provider.

▲ After Hours Services

This suite of services, provides free access for children under 14 years of age and subsidised access for High Need and Community Service Card holders. Services include extended hours offered through General Practice on weekdays and after-hours on weekends, contracted after-hours services through Accident and Healthcare, and telephone-based access to health advice and triage.

▲ Clinical Pharmacist Medicine Optimisation

A targeted approach, supporting General Practice teams and referred patients with a comprehensive range of medicine management and adherence, and specialised prescribing support and advice. This is delivered through Medwise. Additionally, it supports effective discharge, medicine reconciliation, and care for residents within Aged Residential Care facilities and elders living independently within our communities.

▲ Community Radiology Service

As a component of the Acute Demand suite of services, this service offers a range of 'specialist' radiological services focussed on diagnostic Breast Imaging and DEXA Bone Mineral Density scanning. This service is an excellent example of an integrated partnership. Bay Radiology, Focus Ultrasound, Bethlehem Radiology, and Medex are contracted to provide this service.

▲ Coordinated Primary Mental Health Service

This service provides for a range of therapeutic services such as a social worker, youth-focused group therapy, GP or nurse extended consults, counselling or psychological support for depression, anxiety, Alcohol/drug issues and youth mental health. This support is delivered within a 'Stepped Care' model, by a range of contracted and internal specialist therapists. This service is one of the PHO's busiest.

▲ COPD Management

Funded as part of the Acute Demand initiatives focused on reducing unnecessary hospital presentations and avoidable admissions. Providing education and support to General Practice champions in the effective management of patients diagnosed with COPD as an initiative to reduce unnecessary ED presentations and admissions related to COPD.

▲ GP Shared Care

A service that provides intensive care to those managing opioid dependency. This service is delivered by an increasing number of GPs in partnership with the BOPDHB's specialist Bay of Plenty Addiction Services.

▲ Immunisation Outreach Services

Under sub-contract to EBPHA for this reporting period, an Outreach Immunisation Service has been provided to support General Practice maximise coverage of childhood immunisations across the Rohe. The service has worked collaboratively with Support to Screening Services to pool resources and efforts, building and developing internal capability which in turn has increased immunisation outreach services capacity. Changes to the service framework have been undertaken for the year ahead.

▲ Integrated Primary Mental Health and Addiction Services (IPMHA)

This service is for anyone who is enrolled in the general practice whose thoughts, feelings or actions are impacting on their health and wellbeing. This model of care is part of a suite of services being developed to expand access to, and choice of, Primary Mental Health and Addiction support. Health Improvement Practitioners (HIP) and Health Coaches (HC) work as a part of the practice team to provide brief intervention focused on strengthening self-management strategies. There are no barriers to accessing this support.

▲ Iron Infusion

A devolved service from secondary care, focused on providing timely access to iron infusion, for a dedicated patient cohort, within a community setting thus, reducing demand on hospital services and minimising travel and access barriers for patients.

▲ Long-Acting Reversible Contraception (LARC)

A targeted service delivered through General Practice to an eligible population with a focus on reducing unwanted and/or unplanned pregnancy.

▲ Long-Term Conditions Management Services

This is the PHO's most comprehensive integrated service, delivered through General Practice, community-based contracted providers and in-house Dietetic and Diabetes Specialist Nursing resources. It focusses on Cardio-vascular Risk Assessment, diabetes detection and management, high risk diabetic foot podiatry services, retinal health, nurse specialists and self-management education. Pulmonary Rehabilitation also falls within this suite of services and is a sub-contracted service arrangement with community provider – Asthma and Respiratory, BOP. COPD management also falls within the service umbrella, enabling the development of individual care plans to be completed with the patient, providing them and other carers a clear understanding of what actions should be taken during and post exacerbation.

▲ Routine Wound Management

This is a package of care approach, supporting General Practices to manage wound management for post-operative patients discharged back to their GP.

▲ Skin Lesion Service

The Bay of Plenty is included in statistics for the highest rates of skin cancer in the world. This service enables lesions to be surgically removed by approved specialist credentialed general practitioners. An independent specialist in skin cancer surgery is engaged to triage each referral, ensure clinical standards are maintained and the DHB-assigned resources used well. The PHO is also responsible for credentialing all approved clinicians.

▲ School-Based Health Services

A nurse led service delivering a comprehensive range of primary health services across secondary schools within the Western Bay of Plenty including two alternative educations sites and a teen parent unit. The team of experienced registered nurses are supported by regular onsite GP clinics and remote off-site GP support on a contracted basis. Services are underpinned by a collaborative partnership between schools and the PHO.

▲ Smoking Cessation Support

There are two areas of focus within this service. General Practice teams are enabled to offer support to patients who indicate they want to quit smoking. This is not dependent on a quit date being set and achieved. The other focus is the Hāpainga Smoking Cessation programme facilitated through EBPHA, which receives referrals from WBOP Practices for individualised support for those wishing to achieve a quit smoking status.

▲ Support to Screening Services and Cervical Screening for Priority Women

A nationally funded cervical and breast screening service focussed on improving screening coverage rates for priority women. A successful programme that creates opportunity for eligible priority population women: Māori, Pacific and Asian wahine to screen for breast and cervical screening. We give choices, we break down barriers, we kōrero with wahine, and we look after our communities. We create opportunities through a breast screen mobile clinic, community pop-up clinics, and support hauora events led by Iwi and Hāpu. National funding supports free access to these services through both General Practice and community-based service arrangements. The transition to HPV Self-Screening will impact the nature of these services for the coming year.

PHO Self-funded Services

▲ Community Outreach Nursing Service

Operating as a mobile and adaptable resource, this highly regarded registered and specialist nursing service is focussed on support to our most vulnerable populations on behalf of our General Practice network and Iwi partners through the provision of community-based outreach nursing care.

▲ Diabetes Service

Provides support to diabetes self-management groups as well as consultative support to clinicians across the PHO Network. In addition, the Accredited Diabetes Nurse Specialist works in collaboration with GP teams and diabetes specialist services to optimise care for people living with diabetes and the complexity in the community.

▲ Dietetics Service

The team provides a range of services including diabetes Self-Management Groups (SMGs) for people enrolled in the PHO who are over 18-years. Lifestyle Wellness groups are also available. All SMGs are supported by a range of allied health providers and facilitated by a Nutritionist and Dietitian. One on one consults are also available.

▲ Green Prescriptions/Active Families

These are a physical activity and healthy lifestyle-focussed suite of services, supporting individuals and their whānau who are seeking the benefits of improved levels of activity and improved lifestyle choices. Sport Bay of Plenty has been contracted to provide these services for more than 10 years.

▲ HBU (Ngāi Te Rangi)

A mobile primary healthcare and social work service delivered after hours across several high-need communities; this is a free walk-in service. The model of care incorporates health, social, welfare, housing, and cultural wellbeing and needs through a whānau and community approach across all ages.

▲ He Kokonga Ngākau Whānau Support Service (Ngāi Te Rangi Iwi)

This service works with Social Housing tenants and provides coordination and advocacy services that aim to stabilise the home environment of Accessible Properties Limited (APL). The service delivery approach is a whānau support model that works alongside whānau to identify and manage health and wellbeing issues, with the view that by developing a relationship based on support and trust these issues will be able to be addressed.

▲ Hepatitis C Treatment Initiative

Introduced in 2018 to support General Practice to engage with and support patients access and recovery from the Hepatitis C infection as part of a national eradication program. The uptake of this programme has more recently dwindled and it is likely the programme will be retired shortly.

▲ High-need Discretionary Funding

A dedicated funding line assigned to General Practice to use at their discretion, to assist high-need patients where financial barriers reduce access to health services. This continues to be a much-valued resource by our Practice network.

▲ Impaired Glucose Tolerance (IGT)

The IGT programme supports GP teams to target patients with pre-diabetes who are at risk of developing diabetes and cardiovascular disease.

▲ Insulin Starts

Funded appointment to support General Practice to undertake insulin starts independently.

▲ Koi Ora (Ngāi Te Rangi Iwi)

Koi Ora is a leadership development programme that focusses on enhancement of hauora Māori for rangatahi. The programme provides for the transfer of traditional and cultural knowledge as a basis for encouraging mental and spiritual health, good nutrition, regular physical exercise and enriched cultural connectedness. It is a forum that provides mentoring, sharing of knowledge, networking, and goal setting.

▲ Mataora Service (Ngāti Ranginui Iwi)

The Kaupapa Māori Mental Health Service offers three programmes within this service: Mental Health and Addiction Co-existing Problems Counselling, Trauma Counselling, and Peer Support Advocacy. The Programme is culturally responsive to address Māori wellness needs, either individually or with whānau through various therapeutic approaches.

▲ Mau Rākau (Te Puna Rangiriri Trust)

A kaupapa Māori health and wellbeing programme aimed at training rangatahi Māori in the art of Mau Rākau (traditional weaponry) through regular wānanga. The art form draws from a basis of training methods traditionally used by tupuna (ancestors). In a contemporary context, the programme endorses discipline, culture, and the importance of relationships and is underpinned by Mātauranga Māori (knowledge) and primarily delivered in Te Reo Māori.

▲ Mauri Ora (Ngāti Ranginui Iwi)

The service includes a range of programmes aimed at assisting and empowering whānau to improve and develop their health and wellbeing journeys. The concept of Mauri Ora extends beyond physical healthcare to include factors such as spiritual wellness, mental health, and connectedness to their whānau and community.

▲ Palliative Care Discretionary Funding

A limited resource intended to enable General Practice to provide more intense support during end-stage palliative care to the patient and their family through subsidisation of service costs.

▲ Performance Incentives (Incl. System Level Measures, Cvdra, and National Health Targets)

A range of financial incentives is available to our General Practice network to recognise optimal clinical performance in several key areas including CVDRA, 65+ Seasonal Flu coverage, Smoking Brief Advice, and Breast and Cervical Screening coverage for Māori women. Whilst the System Level Measures programme and associated funding via Te Whatu Ora has been inactive over the reporting period, however, the emphasis on achieving previous Health Targets has remained constant.

▲ Skin Surgery Discretionary Subsidy

A limited level of funding provided directly to General Practices to subsidise the costs of diagnostic services for patients that do not meet the eligibility criteria for access to the DHB-funded Minor Skin Surgery Service.

▲ St John Ambulance

WBOP PHO works closely with St John and ED to fund General Practice to manage eligible redirections from these services.

▲ Te Āhunga Whānau

This kaupapa Māori service provides support for people and whānau living with long-term conditions, via a mobile nurse and kaiawhina team. They work with a dedicated neighbourhood of General Practices and their enrolled populations, to provide mobile outreach services. Ngāi Tūhoe Iwi in collaboration with The Doctors Total Health provide this service in the Eastern Bay of Plenty area with Ngāti Ranginui Iwi providing services in the Western Bay of Plenty.

▲ Workforce Development

The PHO paused CME and CNE sessions over the reporting period to take time to reassess the needs and expectations of our Network around Professional Development. A focus on reintroducing a more user-friendly, online, self-managed service offering is being progressed to compliment face-to-face training programmes offered via external providers. WBOP PHO is also part of a collaboration between the Midland region's five DHBs and eight PHOs to offer the Midland Collaborative Recertification Programme for Registered Nurse Prescribers in Community Health.