



Midland District Health Boards Regional Services Plan 2012/13

1st July 2012

Regional Services Plan (2012/13)
Midland District Health Boards

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Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

Received
C.E.O. Division

02 JUL 2012

04 JUL 2012

Mr Craig Climo
Lead CEO, Midland Region
Chief Executive Officer
Waikato District Health Board
PO Box 934
HAMILTON 3240

Waikato DHB

B. Michael CES
Tom Watson
Michael Chavis
Cathy Taylor

Dear Mr Climo

2012/13 Midland Regional Services Plan

This letter is to advise you that I have approved the 2012/13 Midland Regional Services Plan.

I want to thank the District Health Boards (DHBs) in the Midland Region for making good progress during 2011/12 with the implementation of your Regional Services Plan (RSP). You have now laid a solid foundation from which substantial regional integration is expected in the 2012/13 financial year.

As I indicated in my 2012/13 *Minister's Letter of Expectations*, regional integration is a key priority to me as we strive for improved health services for all New Zealanders. DHBs working collaboratively within regions is about ensuring services are delivered in a clinically sustainable and financially viable way to meet the needs of the region's populations. It is also about reducing variation in clinical practice, and consolidating some functions to improve the productivity of the health system.

I expect DHBs to make significant progress in implementing their 2012/13 Regional Service Plans. This includes

- implementing actions for identified Government priorities ie. cancer services, cardiac services, elective services, stroke services;
- providing regional workforce initiatives, Regional Training Hubs, the implementation of regional IT systems and capital objectives;
- implementing actions for agreed DHB regional and sub-regional priorities; and
- supporting and advancing the work of Health Benefits Limited, Health Workforce New Zealand, the National Health Committee and the Health Quality and Safety Commission.

I look forward to seeing tangible benefits provided to patients as a result of these important regional initiatives being implemented. The National Health Board will continue to work with the Midland region DHBs and will closely monitor progress against your identified actions, offer support and act as a resource to assist you to deliver on your RSP.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

Finally, please ensure that a copy of this letter is attached to the copy of your signed RSP held by the Board and to all copies of the RSP made available to the public.

Yours sincerely



Hon Tony Ryall
Minister of Health

cc: Midland Region DHB Chairs
Midland Region DHB Chief Executive Officers

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Note:

This plan should be read in conjunction with the Midland District Health Boards Annual Plans (AP) and Māori Health Plans

Message – from the Board Chairs and Chief Executives

Introduction

As Boards at a district level, we assume governance of our DHBs and are responsible to the Minister of Health for our overall performance and management. Our core responsibilities are to set strategic direction and develop policy that is consistent with Government objectives and improve health outcomes for our population. At a regional level we are required to ensure our local or district activities are aligned in a consistent manner to allow for the best possible outcomes for our regional population.

The Midland DHBs Chairs and Chief Executives Group comprises members from their respective DHBs.



Front Row: (L-r) Deryck Shaw (Lakes), Sally Webb (Bay of Plenty), Graeme Milne (Waikato), Mary Bourke (Taranaki), David Scott (Tairāwhiti)

Back Row: (L-r) Phil Cammish (Bay of Plenty), Cathy Cooney (Lakes), Craig Climo (Waikato), Jim Green (Tairāwhiti)

Absent: Tony Foulkes (Taranaki)

Our Vision

All residents of Midland District Health Boards lead longer,
healthier and more independent lives

Our Priorities

We are determined that our region will continue to strive for ongoing achievement of the Government's priorities, the Minister's expectations, the national Health Targets and key strategic priorities.

 Sally Webb, Chair Bay of Plenty DHB	 Phil Cammish, Chief Executive Bay of Plenty DHB	 BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI
 Deryck Shaw, Chair Lakes DHB	 Cathy Cooney, Chief Executive Lakes DHB	 LAKES DISTRICT HEALTH BOARD
 David Scott, Chair Tairāwhiti District Health	 Jim Green, Chief Executive Tairāwhiti District Health	 Tairāwhiti District Health <small>Te Hōkai Kaitiaki o Te Tairāwhiti</small>
 Mary Bourke, Chair Taranaki DHB	 Tony Foulkes, Chief Executive Taranaki DHB	 TARANAKI DISTRICT HEALTH BOARD
 Graeme Milne, Chair Waikato DHB	 Craig Climo, Chief Executive Waikato DHB	 Waikato District Health Board

Date: 20 June 2012

The Honourable Tony Ryall
Minister of Health

Date: 30 June 2012

Executive Summary

Introduction

The Regional Services Plan (RSP) describes a vision for the future of health services in the Midland Region and provides a framework for the five Midland DHBs to continue to plan and work cooperatively. This approach builds on activities commenced in earlier years while focusing on tangible activities with increasing specificity. Although the region strives to advance this programme the plan does not prescribe radical changes in current patient flows or existing configuration of hospital services. Rather, it focuses on how the region can work together to support vulnerable services, to develop a consistent standard with regard to quality, to improve equity of access and outcomes to regional services and national service priorities and to improve health outcomes across the region as a whole.

DHBs across New Zealand and health systems internationally, face a myriad of significant challenges from dealing with workforce shortages within a competitive global market, to keeping up with rapid technological and therapeutic advances within constrained resources whilst achieving changes in models of service delivery to better meet healthcare demands of this century.

In the Midland region these challenges impact in ways that reflect the unique characteristics of the five DHBs. The DHBs face a range of common problems, for which we are seeking common solutions where possible and practicable.

By actively participating in planning across the Midland Region, we will:

- reduce the duplication of effort;
- enable the five Midland DHBs to collectively develop more sustainable solutions;
- identify efficiencies; and
- ensure that specialist skills, services and input remain available at a local level.

Collectively, working as a strong group of DHBs, we are in a better position to respond to the challenges facing our region's healthcare system.

Regional Cooperation

There is already significant cooperation in the Midland region from service development (maternity, mental health, cancer, cardiac, trauma and renal services) through to infrastructure (information, workforce, and Maori health).

The Midland Region Clinical Services Plan (2010) mapped a 10-20 year pathway for service development while concentrating on those services that were the most vulnerable in the short term. This strategic document was produced by engaging with clinicians across the continuum of care and this approach continues. The 2012/13 implementation plan prioritises the work streams either currently in train (established under the previous year's RSP) or those proposed to be established (such as Radiology and Health of Older People); and does not cover the exhaustive range of regional clinical activity. Owing to a significant increase in mandatory reporting requirements, this plan is significantly expanded in terms of service priority areas from 2011/12.

This RSP is a plan of action around specific areas clinicians have identified as priorities for action as well as those specified from the centre as national priorities. However, this activity is scalable and the networks established for these priority areas are able to be replicated in other service areas subject to appropriate resources being available. Notable achievements in the year have been:

- Establishing several clinical networks for our identified vulnerable services being Rural Health, Maternity and Renal Services as well as national priority services being cardiac, cancer and elective services.
- Building regional workforce development capacity and focus with the appointment of the regional workforce development manager, and the establishment of a regional approach to workforce planning and development activities aligned to national requirements.
- Building a regional view for IT projects and processes to ensure IT investment is prioritised on a regional basis.

We are fortunate as historically the region has been able to deliver a significant level of service within our funding, ie that we have been able to *live within our means*. The 2012/13 year represents a significant collective challenge, as we face a number of resource pressures across our DHBs.

We look forward to meeting the challenges presented by the upcoming year, and to work as a region to develop systems and processes that enable efficient and effective use of resources which facilitate equitable access to services of a high quality across the Midland region.

Key Highlights in the 2012/13 Regional Services Plan:

- Detailed Action Plans have been developed for 12 service priority areas (up from six in 2011/12) being maternity, renal, rural health, health of older people, radiology, cardiac, cancer control, elective services, mental health, smokefree, stroke services and trauma
- All action groups and networks continue to be clinically led with a strong overarching governance framework
- A continued focus building depth into key enablers such as workforce, Maori health and information systems
- The expansion of HealthShare Limited to support back office functions, strategic planning and implementation
- The development and implementation of agreed prioritisation frameworks for clinical service implementation activity and information systems
- Development of electronic tools to allow action groups and networks to communicate and share information quickly and efficiently
- Further development of clinical governance arrangements building on earlier work
- System Integration opportunities with primary care partners at a local level and across the Midland region

Section 1 – Strategic Overview

This Regional Services Plan

Regional Services Plans (RSPs) are central to DHBs' delivery of health and disability services and drive increased cooperation to plan services. RSPs describe the strategy and vision for the region and what cooperative actions can be taken to achieve this vision. This includes current and future population characteristics and plans of the models of care and configuration of services across the region that will best ensure service viability and financial affordability. The RSP guides resource allocation and service provision decisions at the regional and district level.

The Midland RSP outlines how the five DHBs intend to cooperate for regional service planning, funding and service provision in order to improve the quality of care as well as reduce service vulnerability and cost. 2011/12 was a transition year for all DHBs in terms of accountability and the first year for RSPs. In 2012/13 we will embed this transition by building on the intent of recent changes with specific, measurable actions to deliver on national, regional and local goals. Led by our clinical staff and partners from primary care, our RSP seeks to provide a focus on specific service priority areas and infrastructural enablers across the continuum of care.

Under section 38 of the New Zealand Public Health and Disability Amendment Act 2010 District Health Boards (DHBs) as a region are required to produce a Regional Service Plan for approval by the Minister of Health. The plan provides that accountability to the Minister.

The Midland region comprises Waikato, Bay of Plenty, Lakes, Tairāwhiti, and Taranaki DHBs. The region serves as the organising and decision-making structure for regional planning. However, it is important to preserve the flexibility for DHBs to plan services noting that 'one size fits all' solutions are not always the most appropriate way to configure services.

For this reason the RSP in some cases specifies activities that occur on a sub-regional basis.

Structure of this Plan

In 2010 Cabinet determined that RSPs must contain the following elements below:

- a) A strategic element; and
- b) An implementation element.

In doing so RSPs must identify each DHB involved in each aspect of each element of the plan.

This Plan has been approved by the individual Boards of the five Midland DHBs outlining the intentions and objectives of the region for the period 1 July 2012 to 30 June 2013.

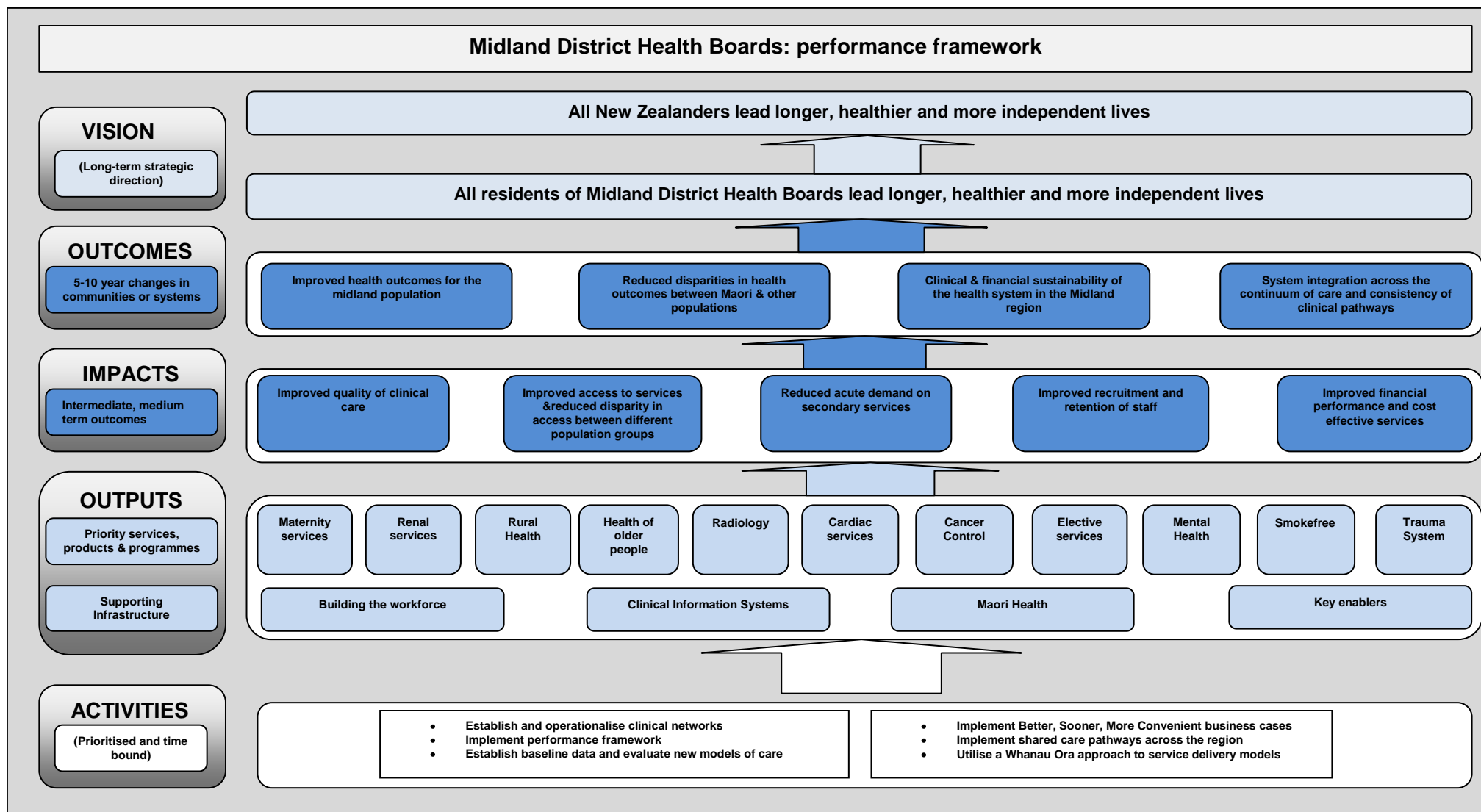
This Plan is split into four sections consistent with the NHB planning guidelines 2012/13:

A: Strategic Element	Section 1: Strategic Overview
B: Implementation Element	Section 2: Regional Governance, Leadership and Decision Making Section 3: Sustainability and Clinical Integration Section 4: Key Enablers and Priorities

For the purposes of this document, these sections shall be referred to collectively as “this Plan”.

RSP Performance Framework

The framework below was developed specifically for RSP activity, as a component of the overall Regional performance framework (see appendix 1). Focussed specifically on the activities contained within the RSP it outlines the specific areas of focus within the RSP.



Our Regional Objectives

In alignment with our Annual Plans across our region we have identified the following five regional strategic objectives. These have been developed as follows:

1 To build the workforce

We need to strengthen innovation, new ways of working and the development of sustainable workforces into the future. We will do this by ensuring workforce development enables sustainable service delivery. The regional focus includes health workforces across the continuum of service delivery.

2 Systems integration across the continuum of care

We will work within a whole of system approach; ensuring regional services are integrated and delivered in a better, sooner, more convenient primary care environment.

3 To improve quality across agreed regional services

We will improve the quality of the services as a region. Midland DHBs have adopted the Health Quality and Safety Commission's 'Triple Aim' of:

- Improved quality, safety and experience of care
- Improved health and equity for all populations
- Best value from public health systems and resources

4 To improve clinical information systems

We operate in a challenging environment. Robust information is vital to enabling system integration, good decisions and ultimately improving the health outcomes of the Midland population. To enable this, we will implement a region-wide approach to prioritising information system investment in a planned and structured way.

5 To improve Maori health outcomes

We will work with iwi Māori to:

- reduce health disparities by improving health outcomes for Māori and other population groups
- establish and maintain processes to enable Māori to participate in and contribute to strategies for Māori health improvement
- continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori
- provide relevant information to Māori for the purposes above

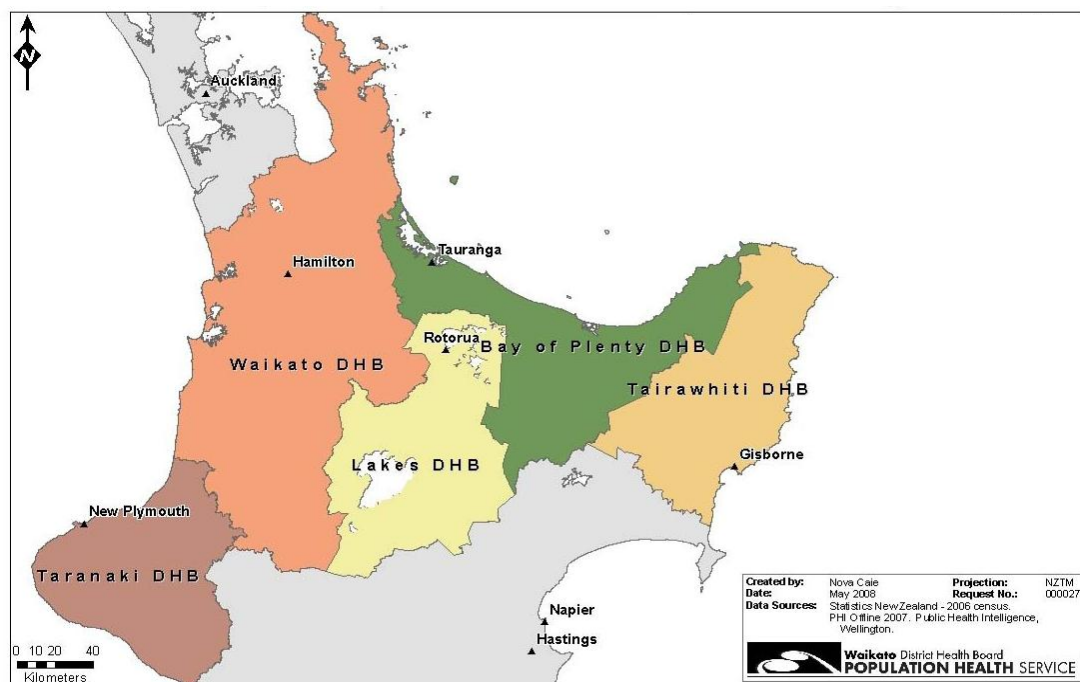
Our Aim: Clinically sustainable and financially viable services

Our Population

Geography

The Midland region stretches from Cape Egmont in the West to East Cape and is located in the middle of the North Island. The region comprises five District Health Boards: Tairāwhiti, Taranaki, Lakes, Bay of Plenty and Waikato. These boundaries take in the major population centres of New Plymouth, Hamilton, Rotorua, Tauranga, and Gisborne. The region covers an area of 56,728 km², or 21% of New Zealand's land mass.

Figure 1: Map of the Midland region DHBs



The Midland region has been defined as the five DHBs that have cooperated to develop this plan. However, the five DHBs are geographically dispersed, and arguably have less of a natural network than the other regions. This has led to greater variety in service flows, with for instance, Taranaki and Tairāwhiti receiving some tertiary services from outside the region. In producing this plan Midland DHBs recognise and accept that in practice the span of the region will vary by service.

A snapshot

Each day in the Midland region:

- 26 babies are born;
- 541 people are admitted to a Midland Hospital;
- 25 people are admitted to an out of region hospital;
- 837 people have a first specialist or follow up appointment;
- 5,033 people have a general practice consultation; and
- 17 people die.

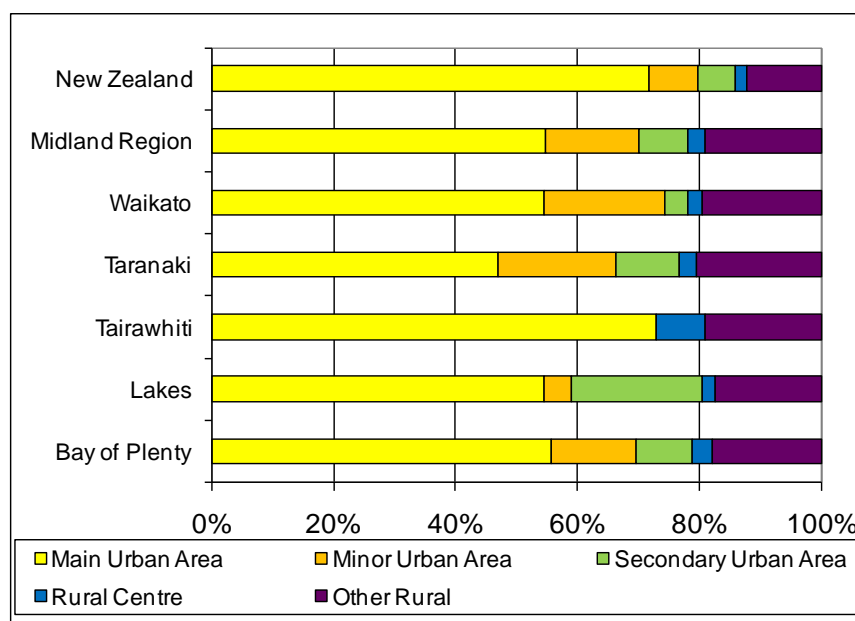
Some distinguishing features of our region compared to New Zealand as a whole:

- Highest proportion of Māori;
- Low proportion of the population identifying as Asian or Pacific peoples;
- Higher number of people living in rural areas;
- a relatively higher proportion of people living in areas identified as high deprivation (deprivation quintiles 4 and 5)
- Lower life expectancy than the New Zealand average; and
- Higher smoking rates than the New Zealand average.

Rurality

The population of the Midland region is somewhat less urbanised than average for New Zealand, although this does vary by DHB as shown below. The more rural nature of the Midland population creates particular challenges in getting services to individuals, and individuals to services. For example, home haemodialysis usually requires an urban water supply. The lower population density areas may also result in people having fewer informal carers (family, friends) able to care for them in time of illness or recovery.

Figure 2: Proportion of residents in NZ and in each Midland DHB, living in main, minor and secondary urban areas, and in rural centres or other rural areas



(Data sourced from: <http://www.uow.otago.ac.nz/academic/dph/research/socialindicators.html>)

Who do we serve?

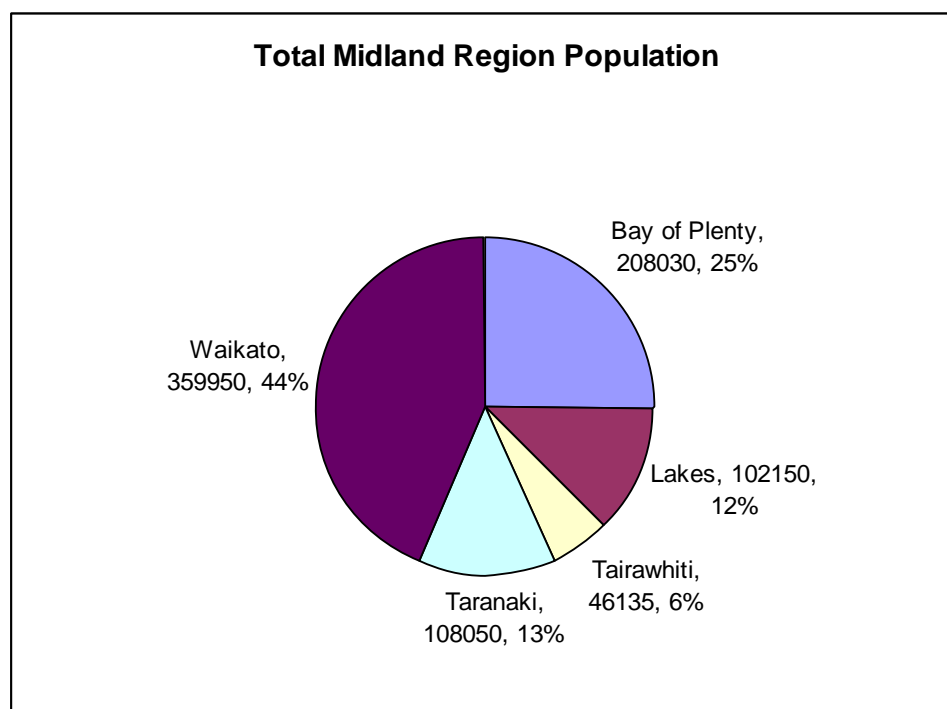
Demographic overview

According to the 2006 census, there were approximately 750,000 people living in the Midland region, constituting approximately 20% of New Zealand's total population. Waikato, the largest DHB in the group, has a population seven times larger than Tairāwhiti, the smallest.

Ethnicity

In the Midland region, the Pacific and Asian populations (each at 3% of total population) are proportionately smaller than the national average (at 7% for Pacific peoples and 9% for Asian). While these communities are comparatively small, the Pacific and South Asian populations have high health needs that need to be addressed.

Figure 3: Population breakdown by DHB, 2009 population forecasts from 2006 census data

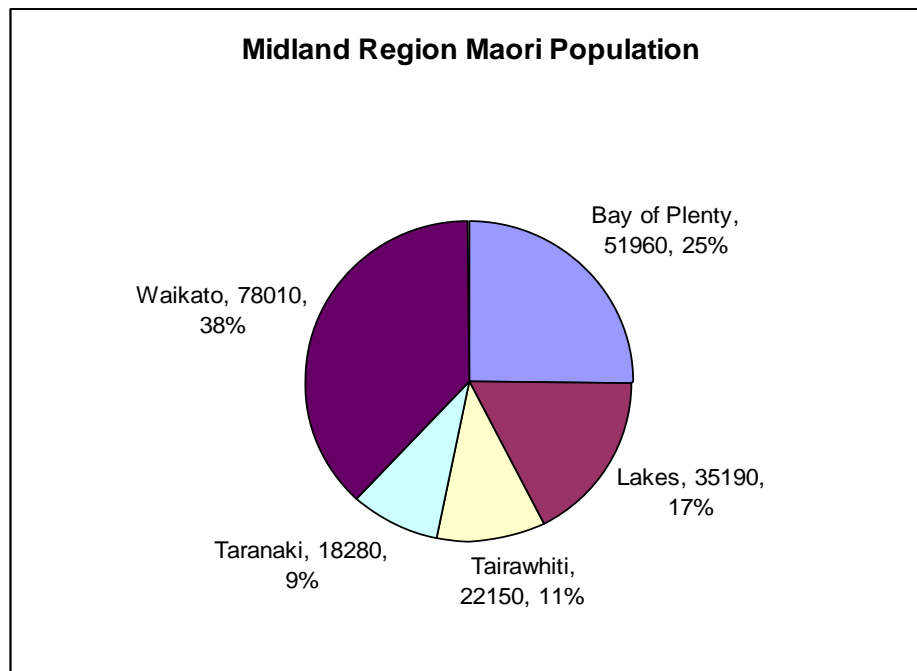


Total population: 824,315

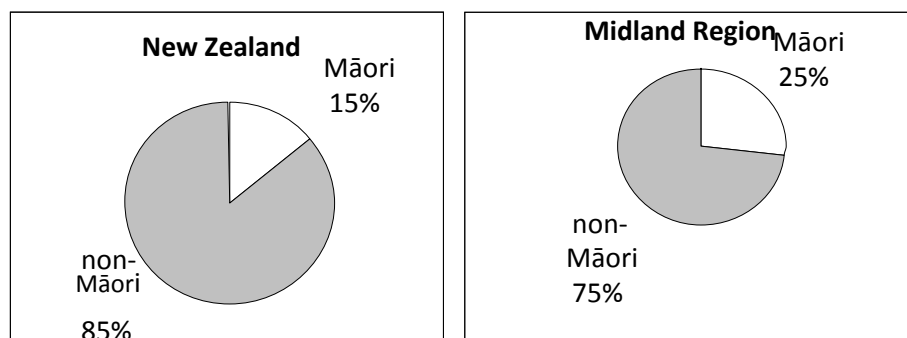
The proportion of Māori in the Midland population is much higher than the proportion in the national population, with the percentage of Māori in each DHB exceeding the national average. 48% of the population of Tairāwhiti identify as Māori, and while Taranaki has the smallest proportion of Māori, they still make up 17% of the population, compared to 15% for NZ as a whole.

This leads to the region facing a significant additional burden of disease in comparison with the New Zealand average, as poor social and health outcomes for Māori health are common. Further, Māori tend to develop some conditions related to ageing younger than other groups. Also, services must be provided in ways that are culturally appropriate and effective to meet the needs of Māori.

Figure 4: Proportion of Māori in comparison with NZ population, 2009 population forecasts from 2006 census data

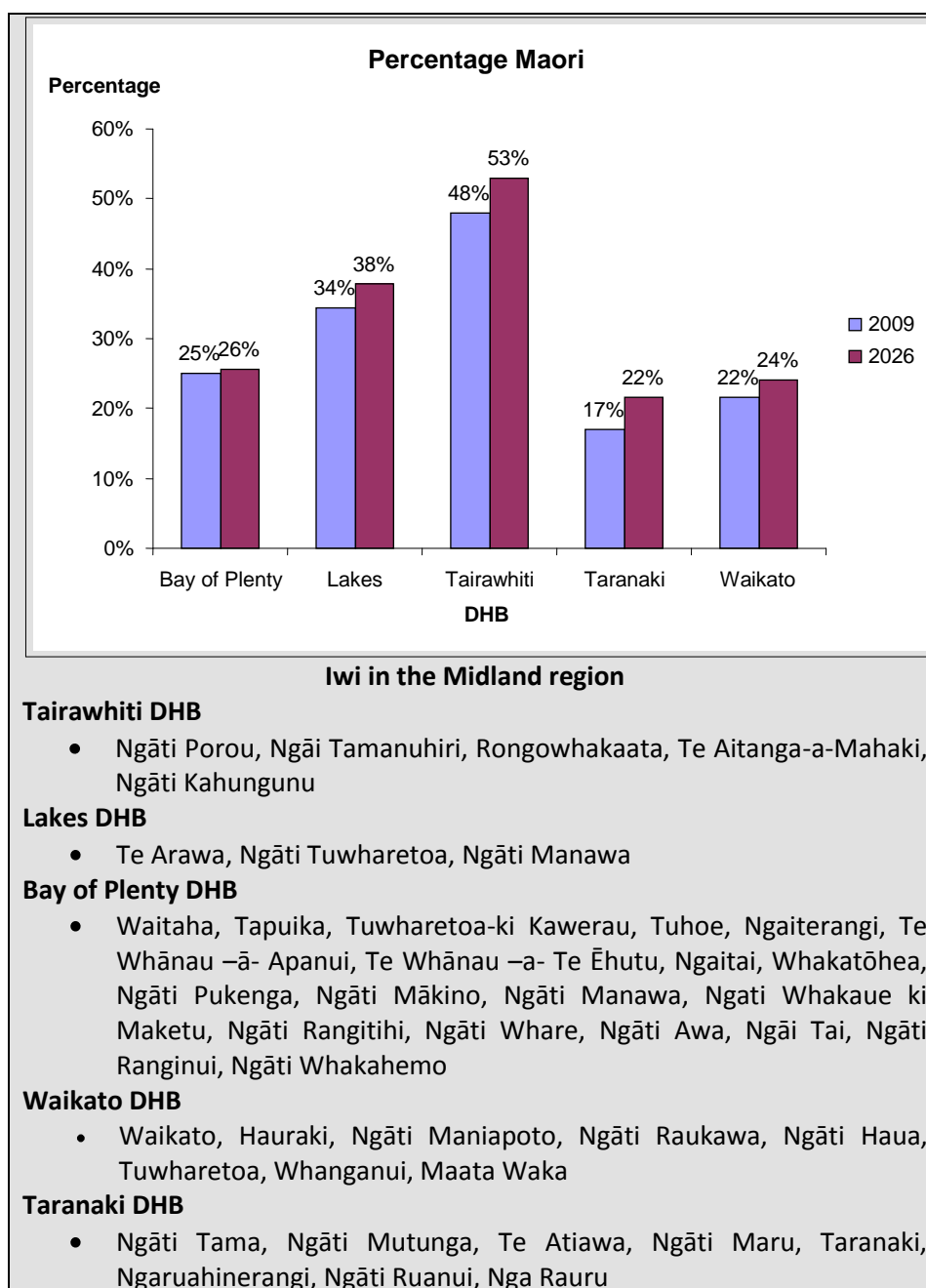


Total Population: 205,590



The proportion of Māori is expected to grow over the next 2 decades, with the largest forecast increases seen in Tairāwhiti and Taranaki DHBs. This effect is a consequence of higher birth rates for Māori, and of improved life expectancy and ageing among Māori. The overall pattern of Māori population across DHBs remains unchanged from 2009 to 2026, although the level is in all cases somewhat higher.

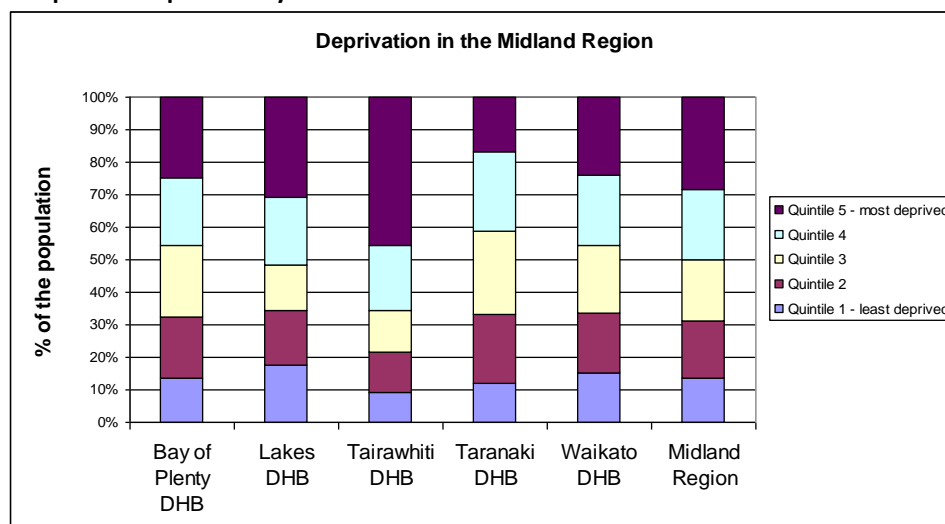
Figure 5: Proportion of Māori 2009 and 2026



Deprivation

Deprivation correlates with higher morbidity and mortality, and with lower life expectancy. People living in lower economic circumstances may find accessing health services more difficult, and their circumstance may impact on their knowledge of available services and their confidence to seek those services. The Midland region has a higher proportion of the population with lower quintile deprivation scores. Tairāwhiti in particular has 65% of its population in quintiles 4 or 5 (versus 40% for NZ as a whole). The exception to this pattern is Taranaki, which has a greater proportion of people in the middle rather than highest or lowest quintiles. DHBs such as Waikato and Bay of Plenty have smaller pockets of very high deprivation that may be masked by lower averages.

Figure 6: Deprivation quintiles by DHBi



In particular, the three Territorial Local Authorities with the largest proportion of people in deprivation 5 quintiles are Kawerau and Otago in the Bay of Plenty DHB, and the South Waikato District in Waikato DHB. The largest populations of people in deprivation quintile 5 are found in Hamilton, Rotorua and Gisborne.

Population growth and ageing

As is the case for the rest of New Zealand, the Midland region will experience population growth and ageing over the next two decades, although specific patterns vary considerably between DHBs.

Our Health Needs: What is the health status of our populations?

Life expectancy

Babies born in the Midland region (with the exception of females in the Bay of Plenty) have a lower life expectancy than average for New Zealand. Tairāwhiti in particular stands out as having a life expectancy 4.2 years lower than the national average for both females and males.

Average life expectancy at birth in the Midland region 2005-07 ⁱⁱ							
	Bay of Plenty	Lakes	Tairāwhiti	Taranaki	Waikato	Midland	NZ
Females	82.4	80.5	78.0	81.5	81.8	80.84	82.2
Males	77.5	76.4	73.8	77.2	76.9	76.36	78.0

Mortality

The table above shows the age standardised death rates from all causes in 2006 for the Midland DHBs and New Zealand as a whole.ⁱⁱⁱ Tairāwhiti stands out as having significantly higher mortality rates.

A major driver of variances between DHBs is likely to be ethnicity, since Māori have higher mortality rates at all ages with greater variability across DHBs. In New Zealand, Tairāwhiti has the highest national age standardised Māori death rate, while Lakes DHB has the third highest.

Figure 7: Age standardised all cause mortality in 2006 by DHB

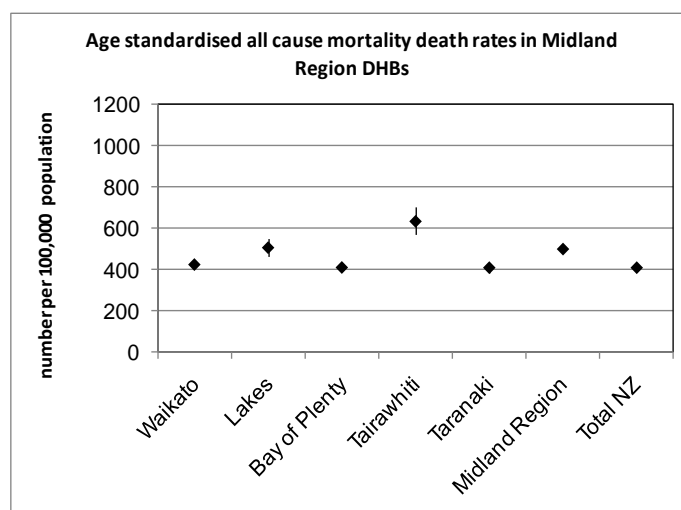
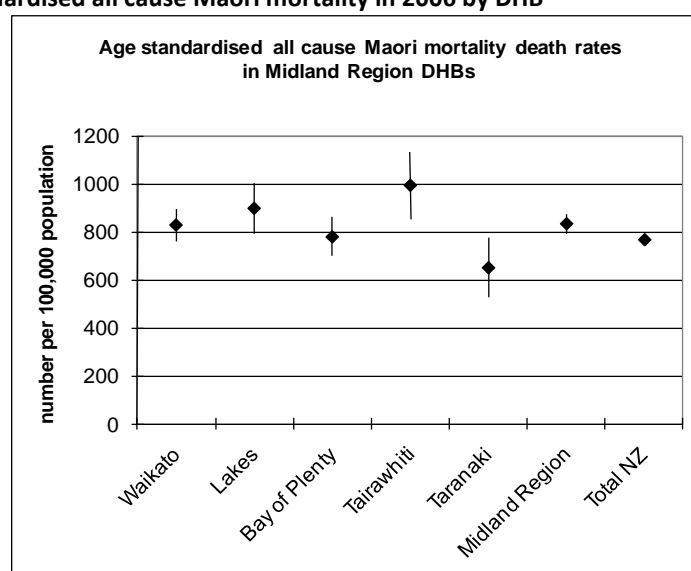


Figure 8: Age standardised all cause Māori mortality in 2006 by DHB



Unique characteristics of each DHB

Tairāwhiti

Tairāwhiti is one of the North Island's most sparsely populated districts, with some 29% of the total population of 46,000 living in rural areas (compared to 15% nationally). The geography causes significant transportation issues for both patients and travelling clinicians, both within the district (with travel times accentuated by the relatively high proportion of unsealed roads) and for travel to other centres for specialist care not available within the district (with limited availability of direct flights).

Tairāwhiti has a high proportion of the population (48%) identifying as Māori – three times the national average. Overall the population is proportionally young (in comparison with the NZ profile) but the large Māori population is relatively older. This adds further to the significant burden of disease faced, particularly given that Māori tend to develop some conditions related to ageing younger than other groups.

The DHB has the highest rate of deprivation in New Zealand, with 65% of the population living in either quintile 4 or 5 deprivation categories. The low paid workforce and a high proportion of irregular, seasonal work contributes to this.

Both males and females have the lowest life expectancies seen in the Midland region and the highest age standardised all-cause mortality rate of all DHBs in New Zealand. Tairāwhiti also has the highest smoking rate of the Midland DHBs and the rate of ambulatory sensitive hospitalisations is substantially above the national average.

The district's secondary hospital, located in Gisborne, has the smallest capacity of all of the main Midland DHB hospitals. (There is also a small GP run unit at Te Puia, Te Whare Hauora o Ngāti Porou.)

The district has a high volume of FSAs and follow-ups in relation to its population size, at more than 25% above the regional level, related to the burden of disease in the population. Tairāwhiti has some of the best local elective services access nationally, as well as excellent elective access to surgical services to Waikato DHB.

Waikato

Waikato DHB has the largest population in the Midland region of around 360,000. While Hamilton is a major metropolitan city, the district remains highly rural, with nearly 22% of the population living in rural areas, compared to the 15% national average.^{iv}

Approximately 22% of the Waikato DHB population identify as Māori, compared to the national average of 15%.

Waikato Hospital, the largest hospital in the region is the provider of tertiary healthcare services to the Midland population; nearly half the health staff employed by the Midland DHBs work for Waikato. It also has four rural hospitals and two continuing care facilities and provides regional forensic mental health services from the Waiora Waikato campus.

Babies born in Waikato DHB have a slightly lower life expectancy than the average for New Zealand. The DHB has the highest volume of potentially avoidable hospitalisations of the Midland region DHBs (though the rate remains below the national average).

Lakes

Approximately 102,000 people live in Lakes DHB region according to 2009 population forecasts from 2006 census data. Māori make up approximately 34% of the population, with forecast increases of 11% in the Rotorua Territorial Authority area and 10% in the Taupo Territorial Authority area from 2006 to 2016.^v

Approximately 19% of the population live in rural areas and 31% of the population fall into deprivation quintile 5, showing the highest levels of deprivation. The 2002/2003 New Zealand Health Survey estimates that 50.1% of the Māori population smoke, compared to 25.2% of the non-Māori population.^{vi}

Babies born in Lakes DHB have the second lowest life expectancy of the Midland region. The DHB has the third highest age standardised mortality rate in New Zealand, and the second highest smoking rate of the Midland region DHBs. Other outcomes of concern (where the DHB compares poorly against the national average) include: high obesity rates; cancer mortality; low birth weight babies; oral health; and high rates of ambulatory hospitalisations for older people.

Lakes DHB has ambulatory sensitive hospitalisation rates that are substantially higher than the national average, for both Māori and non-Māori.

Bay of Plenty

The Bay of Plenty has a population of approximately 208,000 people according to 2009 population forecasts from 2006 census data. The east and west parts of the district have a very different demographic makeup - some 75% of the population living in Western Bay of Plenty. An estimated 21% of the DHB population live in rural areas, compared to the national figure of 15%.^{vii}

In the Western Bay of Plenty, 17% of the population identify as Māori compared with 50% of the Eastern Bay of Plenty population.

The population is ageing, and the proportion aged over 65 is 29% higher than the national average. Total population growth by 2026 is forecast to be higher for the DHB than for the rest of New Zealand.

There are two main hospitals in Bay of Plenty, Tauranga Hospital and Whakatane Hospital.

Life expectancy for the district is close to national average. Key points relevant to the health status of the population include: rates of COPD and cardiovascular disease 10% higher than the national average; higher than national rates of avoidable hospitalisation; and cervical cancer hospitalisations 7.7 times higher for Māori woman compared to the national average.

Taranaki

The population of Taranaki DHB (at around 108,000 people according to according to 2009 population forecasts from 2006 census data, has smaller populations of Pacific and Asian people and a larger population of European people when compared to the national average. Some 15.8% of the population is Māori. More than half of Taranaki's Māori population is aged less than 25 years, and there are a relatively lower proportion of people aged in the 15-34 age group, compared to the rest of New Zealand. At the same time, the proportion of the population aged over 65 is considerably higher than the national average.

The distribution of the population between the different deprivation quintiles follows a bell shape, with a larger proportion of the population ranged between quintiles 2 and 4, and smaller proportions in quintiles 4 and 5.

Taranaki Base Hospital provides a high level of service complexity given its population (indicating more large specialised services, with some subspecialties). The South Taranaki population is more rural; more deprived and has greater travel distance to a base hospital. The rural hospital at Hawera is seen as an important base for this area, which also has fewer GPs per 1000 population.

Babies born in Taranaki have a lower life expectancy than the average baby in New Zealand. Taranaki DHB's age standardised all-cause mortality rate is similar to the national average. However, Taranaki's all-cause Māori mortality death rate is below the national average. Taranaki has a lower than average level of ambulatory sensitive hospitalisations.

Section 2 – Regional Governance, Leadership and Decisionmaking

The Midland Region– who are we?

The Midland Region contains five DHBs geographically covering the central North Island and is one of four regional groupings in New Zealand. The region stretches from Taranaki in the west to Tairāwhiti in the east, and also encompasses Waikato, Lakes and Bay of Plenty DHBs.

Governance and the Management of the Region

Each DHB has a chief executive with governance provided by a Board comprising appointment and elected members. The Board chairpersons are appointed by the Minister of Health.

Regional activities are led by the five DHB Board chairs and five chief executives and who meet monthly as a group. While this group provides direction to regional planning, ultimately the RSP requires endorsement from each of the DHB boards on the recommendation of the Chief Executive and Chair. The Board of each DHB is responsible to the Minister of Health for the DHB's overall performance and management including its commitment to the RSP. Each DHB board's core responsibilities are to develop plans and policy that is consistent with Government objectives and improve health outcomes for the local population, while operating in an increasingly regionalised context.

Regional Principles

A series of principles designed to facilitate regional decision-making were developed in 2009 for the strategic MRCSP document refreshing earlier work that framed the basis for initial cooperation. These principles are central to effective decision making in the development and implementation of the Midland Regional Services Plan in 2012/13 and further regional actions.

1. Regional Services will be delivered according to the following criteria:
 - a. Tertiary
 - b. Vulnerable
 - c. More cost effective and sustainable to do regionally
2. Secondary services are provided from domicile DHBs unless an alternative delivery option is demonstrated to be the most clinically appropriate, sustainable and cost effective solution including financial and non-financial transition costs. Sustainability considerations include financial, clinical and workforce considerations.
3. Waikato DHB will be the main provider of tertiary clinical services in the Midland region but individual DHB's may have other historical arrangements.¹
4. Tertiary clinical services should not be duplicated across the region unless development of satellite services is demonstrated to be the most appropriate sustainable and cost effective solution.
5. Corporate services should not be duplicated unless local services have demonstrated to be the most sustainable and cost effective solution.
6. Clinical Alliances will provide evidence based clinical leadership in determining the most appropriate service configuration for the Midland region.

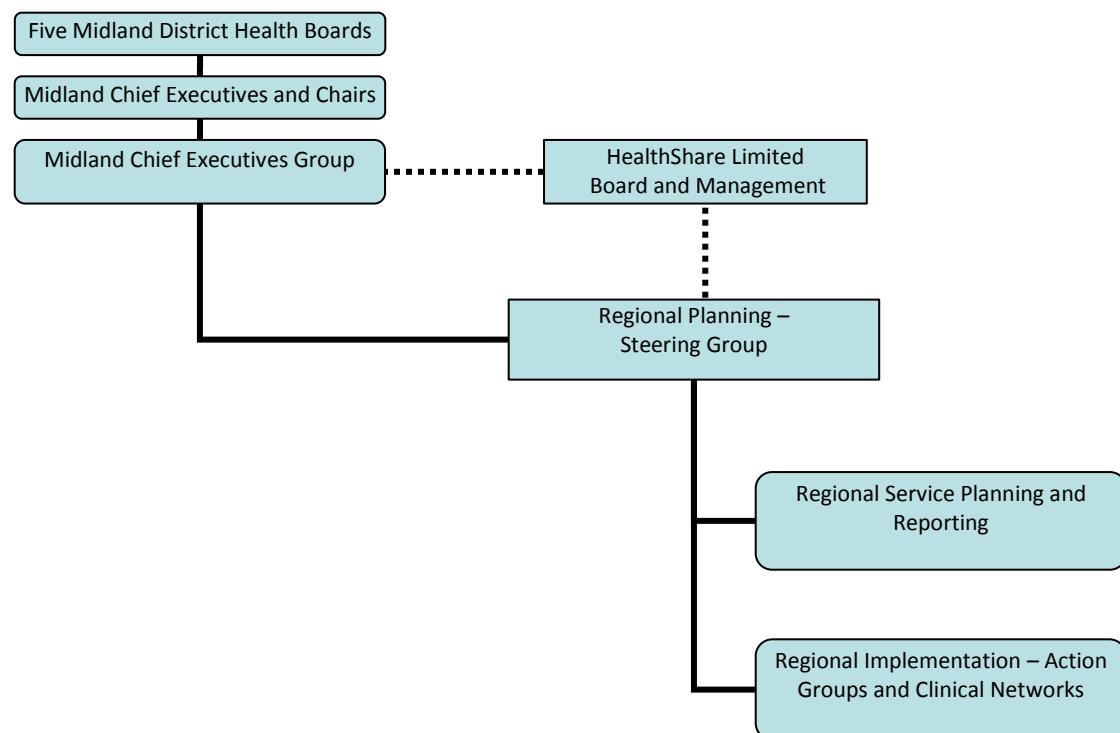
¹ Over time some services currently delivered in a tertiary setting will be able to transition to a secondary setting due to advances in technology. These principles do not preclude Midland DHBs for offering these types of services in the future as the setting changes.

7. Equity of access to regional services.
8. Secondary and tertiary care is acknowledged as episodic in response to short term higher health needs. Primary and community care provides ongoing care in response to change in health needs over the course of an individual's lifetime.
9. All DHBs will have input into the development of Regional Service Plans.
10. Funding prioritisation for local services remains a local DHB responsibility².
11. Funding prioritisation of Regional Services will be regionally determined.

Regional Structure

While responsibility for the overall performance of regional activity collectively rests with the five Boards, operational and management matters concerning the RSP and its implementation have been delegated to the Midland Chief Executives Group. This group is supported by a programme steering group structure managed by HealthShare Limited, the Midland region's shared service agency. HealthShare is tasked with coordinating the delivery of regional planning and implementation on behalf of the Midland Region DHBs and monthly progress reporting is provided to the Chief Executives group.

Midland Region – Our Organisational Structure



Steering Group

The steering group co-ordinates and drives regional activity whilst reporting to Chief Executives and DHB Boards. The steering group meets monthly and is comprised of the following representatives for 2012/13:

² Further discussion needs to be had on what remains a local service and what becomes a regional service

RSP Steering Group Membership

Group	Clinical	Management	Enabling
DHBs	<ul style="list-style-type: none"> • Dr Tom Watson, Chief Medical Advisor Waikato DHB, Chair • Dr Ross Lawrenson, Waikato Clinical School • Dr Johan Morreau, Chief Medical Advisor, Lakes DHB • Kerry-Ann Adlam, Director of Nursing, Taranaki DHB 	<ul style="list-style-type: none"> • Helene Carbonatto, GM P&F, Tairāwhiti District Health • Phillip Balmer, Chief Operating Officer, Bay of Plenty DHB 	<ul style="list-style-type: none"> • Ditre Tamatea, GM Maori Health, Waikato DHB
Primary Care	<ul style="list-style-type: none"> • Dr Jo Scott-Jones, General Practitioner , Eastern BOP PHA (BSMC partner) • Dr Allan Moffitt, Clinical Director, Midlands Health Network (BSMC partner) 		
Health Share Limited			<ul style="list-style-type: none"> • Chief Executive, HSL • Angela Norman, Regional Workforce Development Manager • Darrin Hackett, Regional CIO • Cathy Taylor, Regional Planning and implementation
National Health Board (in attendance)			<ul style="list-style-type: none"> • Andrew Campbell-Stokes, Principal Planner, National Health Board

The purpose of the steering group is to:

- Provide overall programme ownership of clinical networks and action groups across the Midland region including coordinating of enabling activity with individual service area action plans
- Monitor, review and approve quarterly reporting to NHB and governance groups prior to Chief Executive endorsement
- Provide overarching leadership for regional workforce planning and development. Specific regional work programmes and work streams such as the Midland Training Network will require tailored membership to appropriately represent the key stakeholders
- Provide direction for RSP development and content, and
- Provide recommendations via the HealthShare CEO to Chief Executives for approval.

Action Groups / Clinical Networks

Each action group for the service priority areas identified in the RSP are tasked with developing a regional work plan including milestones, deadlines and service specific performance measures. The process was established in 2011/12 and is led by the clinicians in each service area, informed by and aligned with any national initiatives. This ensures that no duplication

occurs and the activities and measures developed are fit for purpose. There are representatives from each Midland DHB, Maori health and primary care on each action group to ensure appropriate representation, but the clinicians as a group, not individual DHBs are leading the process. Each group is chaired by a senior clinician from one of the Midland DHBs as follows:

- Maternity Services – Corli Roodt, Clinical Midwife Director
- Renal Services – Jo-Anne Deane, Clinical Director
- Cardiac Services – Dr Gerry Devlin
- Rural Health – Professor Ross Lawrenson
- Cancer Control – Dr Charles de Groot
- Mental Health and Addiction – Professor Graham Mellsop
- Elective Services – Dr Martin Thomas
- Radiology – Jill Wright, Service Manager
- Health of Older People – to be appointed
- Stroke – to be appointed

Individual plans for these Service Priority Areas are outlined in Section 3.

DHB Performance / Participation

As outlined above, the process is clinically driven across our region rather than DHB led. The quarterly reporting template provided to the National Health Board is the primary tool for ensuring individual DHBs participate as outlined in approved planning documents. As this document is approved by the steering group and then discussed collectively with Chief Executives and the National Health Board on a quarterly basis, any nonperformance by individual DHBs (or the regional as a whole) is able to be identified and corrected. If a DHB having endorsed activities within an RSP then wishes to 'opt out' of participating in the implementation the matter will be highlighted in the report and form part of the dispute resolution process.

It should be noted however that there are several opportunities in the process to reach consensus prior to Dispute Resolution being initiated. The final quarterly report for the planning year will highlight any divergence from the approved plan and outline whether incomplete actions are owing to timing (and are subsumed within the following years plan) or have been superseded by new activities not specified in the initial plan.

Dispute Resolution Process

In the Midland Region, the dispute resolution adopted is as follows:

- The region operates a consensus model
- In the first instance, issues should be resolved by the appropriate group and level, and in the absence of that, that the matter goes up a level
- Existing structures will be used wherever appropriate - there is no special disputes group
- If a dispute is escalated to the level of the Chief Executives Group and no resolution can be reached then it goes to the five Midland DHB Chairs Group
- If the DHB Chairs can't reach consensus then the dispute goes to the National Health Board for resolution

Clinical Governance

Strengthening regional clinical governance over regional /vulnerable services is an important element in ensuring Midland region services are sustainable.

Views of clinical governance vary from being narrowly centred on dimensions of quality, safety and risk management; to being more broadly focused on how resource allocation decisions are made to improve overall system efficiency and effectiveness.

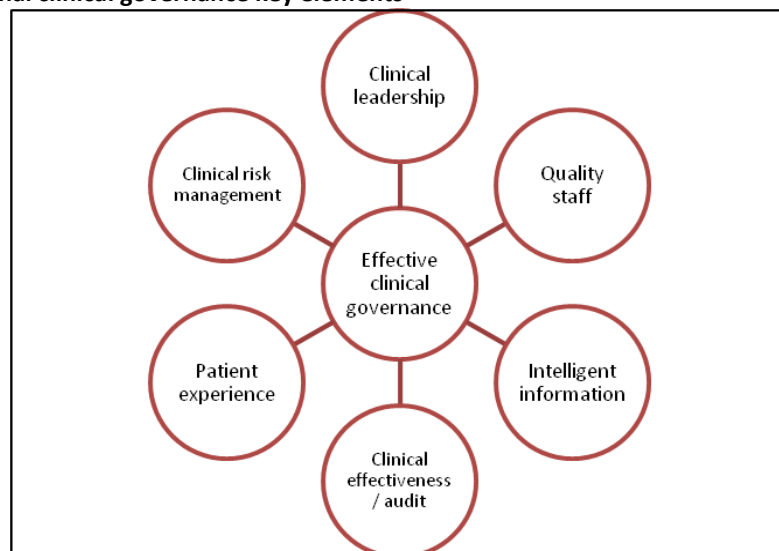
Statement of aspirations for the regional clinical governance framework

The regional clinical governance framework actively manages service quality and access in order to:

- Measure and reduce variation in care;
- Improve clinical effectiveness;
- Improve the patient experience;
- Improve the sustainability and continuity of vulnerable services;
- Maintain local service access where this is consistent with safety;
- Manage clinical risks and improve safety; and
- Reduce inequalities.

The Midland regional clinical governance framework includes the domains set out in the schematic below.

Figure 9: Regional clinical governance key elements



Regional clinical governance framework – Action groups and Networks

For each service priority area identified in this plan, we have a regional clinical governance framework that ensures the major components of effective clinical governance are in place. As described in the proceeding section, every action group is chaired by a senior clinician who links to their professional group across the Midland Region.

Each action group and/or network aims to

- Support, not duplicate local clinical governance arrangements;
- Cover areas where a regional approach aligns with the needs of individual DHBs;

- Aim to achieve 'equitable access to quality sustainable services' in the Midland region;
- Provide an overarching view of the key elements of clinical quality in the region;
- Advise DHB boards on regional priorities, clinical quality improvement and strategies to manage vulnerable services;
- Maintain an overview of the activities and effectiveness of discrete clinical networks; and
- Have a minimalist infrastructure to support their pre-agreed work programme.

The regional clinical governance element of individual service priority areas work by advising and informing about best practice, reviewing outcomes and influencing rather than directing the work of individual clinicians, networks or DHBs. However the Midland DHBs collectively agree to give appropriate consideration to the advice from the action groups and networks via the Regional Service Plan Steering Group.

Regional clinical governance framework – Clinical Leadership groups

Standing alongside the framework for RSP activities are the regional clinical groups that regularly meet across Midland. Each of these groups are kept informed as to RSP progress and are invited to contribute either directly or via their representation on the groups outlined in the section above

Regional Group	Linkage to RSP
Midland Chief Medical Advisors Group	<ul style="list-style-type: none"> • RSP is a standing agenda item • 2 CMAs on RSP steering group
Midland Directors of Nursing	<ul style="list-style-type: none"> • RSP presentation made regularly • DON representative on steering group and action groups
Clinical Director Groups	<ul style="list-style-type: none"> • Representation / Chair of action groups and networks
Primary Care	<ul style="list-style-type: none"> • 2 clinical representatives on steering group • Representation on action groups / networks

Section 3 – Sustainability and Clinical Integration

RSP Focus Areas

The following action plans focus on outlining the specific tangible and measurable actions we will undertake in 2012/13 to deliver on identified service priorities and targets in relation to:

- **Regional cooperation:** means DHBs working together more effectively, whether regionally or sub-regionally.
- **Integrated care:** includes both clinical and service integration to bring our organisations and clinical professionals together, in order to improve outcomes for patients and service users through the delivery of integrated care. Integration is a key component of placing patients at the centre of the system, increasing the focus on prevention, avoidance of unplanned acute care and redesigning services closer to home.
- **Value for Money:** is the assessment of benefits (better health outcomes) relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

Service and Infrastructure Priorities

Service priorities	Infrastructure priorities
1. Vulnerable Services <ul style="list-style-type: none">• Maternity Services• Renal Services• Rural Health• Health of older people• Radiology	<ul style="list-style-type: none">• Information Systems• Building the Workforce• Maori Health
2. National Priority Services <ul style="list-style-type: none">• Cardiac Services• Cancer Control• Elective Services• Stroke Services	<ul style="list-style-type: none">• Key Enablers• Health Quality and Safety Commission• National Health Committee• Asset Planning• Midland Region Training Network
3. Regional Activities <ul style="list-style-type: none">• Mental Health• Smokefree• Trauma	

Clinical Leadership

Each of the action groups for the services priority areas identified in our RSP are tasked with developing service specific performance measures building on the work undertaken in the 2011/12 year. Planned completion dates for this work are outlined in the RSP for each service priority area. This process will continue to be led by the clinicians in each service area and will be informed by and aligned with any national initiatives. This will ensure that no duplication occurs and the measures developed are fit for purpose. There are representatives from each

Midland DHB on each action group to ensure appropriate representation, but it is the clinicians as a group, not individual DHBs that are leading the process.

Improving service sustainability

The RSP provides a framework for DHB planning and acting cooperatively on a regional basis. The RSP focuses on how the region can work together to support vulnerable services, to improve equity of access to regional services and to improve health outcomes across the region as a whole. As 2012/13 is seen as an 'activity focused year' by the National Health Board, plans and activities implemented are expected to pave the way for further regional activity in 2013/14.

Clinical networks and models of care

Clinical networks are the primary vehicle through which change will be driven and delivered. This was one of the key areas the region identified in developing our regional activities. Clinicians noted the need for clinical networks to lead service improvement through the use of integrated patient pathways, common clinical policies, and shared clinical audit programmes. Networks help small services to develop sustainable services plans to ensure quality and safety, with vulnerable local services transferred in a planned way to regional locations or supported regionally. Clinical networks aim to:

- Share knowledge and information to enable informed decision making.
- Facilitate regional service quality improvement leading to better, sooner, more convenient services.
- Support innovation and infrastructure development to reduce inequalities and build capacity and capability.

Regional service priorities

Several Service Priorities were identified as requiring regional action to improve quality and strengthen clinical services that have been identified as being vulnerable. The Service Priority Areas for 2012/13 that are being led through a strong clinical governance framework are:

Vulnerable Services

- **Maternity Services:** Maternity services were identified as a vulnerable service early in the development of regional planning. There are significant workforce issues across maternity services, and opportunities exist to strengthen quality improvement activities, share resources and standardise approaches to service delivery across the region.
- **Rural Health:** The Midland region has a large rural population; this coupled with the current transformational change in driving better, sooner, more convenient care supported the need to focus on rural health as an early priority area for regional action. The focus of the Rural Health Action Group will be on ensuring that rural communities have access to services that are of an appropriate standard, and the effective use of available resources.
- **Renal Services:** The focus of the Regional Renal Action Group will be on implementing new models of care to strengthen renal services across the midland region. There are significant workforce issues across renal services, and opportunities exist to strengthen quality improvement activities, share resources and standardise approaches to service delivery across the region.

- **Health of Older People:** This action group will consider opportunities for the Midland region to work together in terms of sharing initiatives and information that will support maintenance of a good quality of life and independence for as long as possible for our aging population. This work will be aligned to the National HOP Steering Group; the Midland Region has indicated its support for a “lead region” approach where areas of national interest are identified.
- **Radiology:** A multi-regional radiology group has been established and will facilitate a number of national activities. The Midland Health Network Service Alliance Leadership Team (SALT) has completed significant work around the development of primary referred radiology guidelines. The Midland Region Radiology Network will build on the work of the SALT, implement appropriate national initiatives, and consider broader regional radiology issues.

National Priority Services

- **Cardiology/cardiac services:** The Midland Region Cardiac Network will focus on activities that will work towards ensuring equitable access to cardiac care across the Midland Region. The focus will be on making a difference to population health outcomes and inequalities through a cardiology pathway strongly rooted across the continuum of care from prevention through to specialist care, inclusive of cardiac rehabilitation. Further development of the acute coronary syndrome (ACS) pilot is a major focus area for this network.
- **Cancer Services:** The Midland Cancer Network involves cancer continuum stakeholders working across organisational and service boundaries to reduce the incidence and impact of cancer; address inequalities with respect to cancer and improve the experience and outcomes for people with cancer. The Midland Cancer Network Strategic Plan 2009-2014 guides implementation of the strategic direction.
- **Elective Services:** Regional activity will focus on best use of regional expertise and capacity to support delivery of elective services across the Midland region. Service improvement will be supported by regional referral pathways, clinical networks and consistently applied access criteria.
- **Stroke Services:** The focus of the Midland Region Stroke Network will be on working in alignment with the National Stroke Network to support implementation of the 2010 Stroke Guidelines.

Regional Activities

- **Mental Health Services:** The network exist to lead regional planning and delivery and to reduce inequalities in mental health and addiction outcomes. A three-tiered structure has the Chief Executives, GMs Planning and Funding and GMs Māori Health providing the corporate and strategic leadership to the Midland Regional Network.
- **Smokefree:** The Midland Smokefree Network has developed a vision and action plan for the coming year and beyond.
- **Trauma:** The Midland Regional Trauma System is a clinical programme that links multiple services across the region with a common goal: to provide the best care leading to the best outcomes for trauma patients and their families. Dedicated trauma teams

are being established in all Midland DHBs - Tairāwhiti, Bay of Plenty, Lakes and Taranaki, following a Waikato initiative.

The regional service priority focus outlined in the plan does not preclude other work streams being identified and progressed during 2012/13. These groups will generally have a lead or joint lead COO and will, at an appropriate time, link into or transit to the RSP programme.

Infrastructure priorities

To improve financial and clinical sustainability, the Midland region has chosen three infrastructure areas to focus on. Each of these areas has its own work programmes that both interface with the service priorities and set a broader plan of action for improving regional infrastructure.

- **Clinical Information Systems** – This workstream will implement the Midland Region Information Services Plan and advance NHITB priorities, specifically the implementation of the NHIT Plan priority areas. This includes implementing regional connectivity as a first phase of the Midland Connected Health programme, allowing health service providers to securely exchange information and data. Development of a clinical workstation programme across the region will allow clinicians to have access to common tools. The Medications Management Programme will include agreed region configuration /architecture for ePharmacy. A Clinical Data Repository with secure access to core clinical information will also be developed.
- **Workforce** – The regional workforce programme will address the workforce change required to meet current and future service need, and address the most commonly raised issues across the region, relating to the future sustainability of the workforce. This includes the need to better anticipate future states and investigate regional cooperative activity that supports this approach. Workforce development activity underpins the collective response required to ensure access to quality, sustainable services across the whole region. Midland DHBs share responsibility for planning and undertaking forward-looking action on workforce development that minimises duplication. This includes regional cooperation to investigate the impact of reducing the rate of growth in health spending on design, capacity and workforce utilisation in general.
- **Māori Health** – A reduction in health inequalities must remain a core focus of regional work, ensuring that DHBs pool their resources and understanding of how to reduce health inequalities, and implement a monitoring plan to ensure health inequalities are addressed at all organisational levels. Our Maori Health Plans prioritise improving Māori health and reducing Māori health outcome disparities by focusing on the key indicators where the health inequalities experienced are the greatest between Māori and non-Māori.

Linkages

There is significant effort underway with our three Better, Sooner, More Convenient Primary Care partners that are beyond the focus of the Regional Services Plan. However, the RSP seeks to 'join up' activity across the continuum of care in our region and nationally, where appropriate:

Service Level Alliance Teams – Midlands Health Network

Clinically-led, dedicated Service Level Alliance Teams (SLATs) were established to identify gaps in provision of care in key areas of priority. Over 100 health care professionals have been involved in this work. The areas under review are cardiovascular disease, child and youth health, diabetes, mental health, primary care nursing, regional access criteria for primary referred radiology, smoking cessation and older people. Each team is developing new ways to redesign current services so patients have access to proactive screening, timely assessment and treatment based on best practice guidelines, which also will help to achieve national Health Targets.

Service Alliance Leadership Teams– Eastern Bay of Plenty Primary Health Alliance

SALTS are the working groups of the Alliance Leadership Team (ALT). Areas of focus common to RSP priorities are chronic conditions and Whānau Ora.

National Hauora Coalition:

Whānau Ora” is the driving force and ideology. This means:

- Māori led, Māori owned and Māori protected;
- A whānau-centred approach that anticipates how the health sector activities interact with whānau activities;
- An integrated approach for improved outcomes across sectors;
- Offering Māori experience whānau-centred services.

District Level Pathway initiatives:

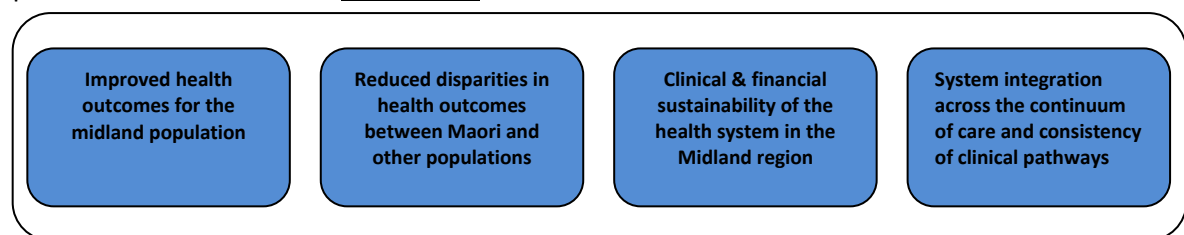
Joint approaches to pathway development are *Lakes Links* in Lakes District and *Bay Navigator* in Bay of Plenty District.

Public Health and Allied Health:

These Clinicians are represented on action groups where there are areas of alignment between their work programmes and RSP service priority areas.

Performance Framework: Regional Outcomes

The 2012/13 activities listed in this section link back to the Regional outcomes listed in the performance framework in [section one](#)



2012/13 Activities

Each Action group has considered a programme of activity for 2012/13 that aligns with these outcomes. For the purposes of clear presentation activities are grouped according to the following categories:

Governance: Each service priority area will have a clear governance process to enable evidence based clinical decision making.

Quality and Safety: Linking through to the Health Quality and Safety Commission’s ‘Triple Aim’.

- Improved quality, safety and experience of care
- Improved health and equity for all populations
- Best value from public health systems and resources

Service Delivery: Ensuring that model of care and organisation structures developed are of benefit to the patient and the wider health system.

Research and Evaluation: Robust data is produced in a timely and consistent manner supporting clinical decision making.

Enablers: Supporting activities that allow the plans for each area to be successfully implemented.

The Regional Outcomes Framework contained within the appendices to this document, illustrates how regional activities align to and support national outcomes and objectives.

Section 4 - Action Plans

Vulnerable Services



Activities highlighted in *italics* are locally led and funded. The remaining activities are to be led, funded and completed regionally

Maternity Action Group 2012/2013 Work Programme

Chair:

Project Manager: Cathy Taylor

Vision: To lead regional activity, including implementation of maternity actions on behalf of the Midland DHBs, and to provide expert technical advice to the DHB CEOs through the development of:

- A regional work programme to support the Implementation of the National Quality standards within current financial constraints
- A regional maternity workforce action plan within current financial constraints
- A Performance Framework to measure clinical network improvements

To facilitate improved coordination and responsiveness of services across the Midland region provided to those requiring maternity services and their families.

Key Objectives: To address issues associated with low critical mass in smaller DHBs, lack of measurement of clinical outcomes, and inequality of access to specialist care.

Measures: The Midland Region will focus on ensuring consistent measurement of the maternity clinical indicators and establishing baseline data during 2012/13, targets will be identified for 2013/14

National Maternity Standards Measures

- 1 xx primiparae who have a spontaneous vaginal birth
- 2 xx primiparae who undergo induction of labour
- 3 xx primiparae who undergo an instrumental vaginal birth

- 4 xx primiparae undergoing caesarean section
- 5 xx primiparae with an intact lower genital tract (no 1st–4th degree tear or episiotomy)
- 6 xx primiparae undergoing episiotomy and no 3rd–4th degree perineal tear
- 7 xx primiparae sustaining a 3rd–4th degree perineal tear and no episiotomy
- 8 xx primiparae undergoing episiotomy and sustaining a 3rd–4th degree perineal tear
- 9 xx General anaesthesia for all Caesarean sections
- 10 xx Postpartum haemorrhage and blood transfusion after vaginal birth
- 11 xx Postpartum haemorrhage and blood transfusion after Caesarean section
- 12 xx Premature births (delivery from 32–36 weeks)

Regional: Total number of (#) caesarean deliveries in the DHB region

Regional: Percentage (%) of caesarean deliveries in the DHB region, compared with the national rate per 1000 of live births

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Governance					
Maternity quality committee in place in each DHB	Maternity Quality Committees established	<ul style="list-style-type: none"> • <i>Quality committee in place in each DHB</i> • Standardised TOR agreed • Communication structure between national, regional and local governance groups in place 	<ul style="list-style-type: none"> • Reporting requirements met • Communication processes effective • <i>Committee oversees and ensures coherence of all maternity quality and safety activities</i> 	Dec 2012	MMAG
Maternity Strategic Plan	Maternity Strategic Plan developed	<ul style="list-style-type: none"> • Plan approved 	<ul style="list-style-type: none"> • Plan guides future decision making regarding regional maternity services • Consider and, where appropriate, support implementation of recommendations from national bodies such as the Perinatal and Maternal Mortality Review Committee (PMMRC) and the National Maternity Monitoring Group 	May 2012	MMAG
Maternity Annual Report	Maternity Annual Report complete	<ul style="list-style-type: none"> • Template developed • Final report accepted/approved 	Report guides future developments/RSPs/APs	June 2013	MMAG

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Quality and Safety					
Implement the National Maternity Quality and Safety Programme	Maternity Quality and Safety Programme implementation plan developed and agreed	Standardised templates developed to ensure: <ul style="list-style-type: none"> • <i>Standardised formal review processes for serious and sentinel events are in place</i> • <i>Standardised evidence-based clinical case review processes are in place</i> • <i>Representation of community-based clinicians and consumers in the formal and informal review processes to ensure their perspective is considered.</i> • <i>Defined processes in place to:</i> • <i>implement changes in clinical practices</i> • <i>reduce unnecessary variation in clinical practice</i> • <i>define and strengthen clinical pathways</i> • <i>influence local service delivery planning and policy</i> 	<ul style="list-style-type: none"> • <i>Maternity Quality and Safety Programme in place in all 5 DHBs</i> • <i>Mechanisms in place to evaluate systems and processes</i> 	June 2013	MMAG
Implement the National Maternity Standards	Standards implementation plan developed and agreed	Standardised templates developed to ensure: <ul style="list-style-type: none"> • <i>MDT meetings in place</i> • <i>Annual report complete</i> • <i>LMCs, consumers and other community/hospital -based maternity practitioners/stakeholders are involved in appropriate forums</i> 	<ul style="list-style-type: none"> • <i>All Standards are met</i> • <i>Mechanisms in place to evaluate achievement against the standards</i> 	June 2013	MMAG
RSP Māori Accountability Framework	Deliver upon the standards of the RSP Māori Accountability Framework	Evidence of performance against standards and associated measures as indicated in the RSP Māori Accountability Framework <ul style="list-style-type: none"> • <i>Regional resource in place</i> • <i>Meaningful Māori participation on all workgroups associated with this plan</i> • <i>Mechanisms in place to evaluate achievement against standards</i> 	<ul style="list-style-type: none"> • All standards are met • Cultural responsiveness KPIs established 	June 2013	MMAG and associated workgroups

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Explore opportunities for shared educational activities/ initiatives	Education sub-group formally established and action plan developed and implemented	Facilitation of the education sub-group to support <i>increased number of educational initiatives available across the region</i> including: <ul style="list-style-type: none"> • <i>Face to face foetal surveillance training</i> • <i>Epidural recertification</i> • <i>Return to practice pathway</i> • <i>Regional training supervisor network</i> • Review of regional educational resources and development of resource library • Identified E-learning modules 	<ul style="list-style-type: none"> • <i>Access to maternity education increases on 11/12</i> • Regional template developed to meet Midwifery Council requirements 	June 2013	MMAG Education sub-group Regional Training Network
<i>Identify the “top ten” policies/guidelines and standardise regionally</i>	Lippincott Manual reviewed – guidelines for review agreed and action plan developed by Guideline subgroup	Facilitation of the guideline sub-group to ensure: <ul style="list-style-type: none"> • <i>Guidelines/policies are evidence based</i> • <i>Guidelines/policies are communicated and implemented</i> 	<ul style="list-style-type: none"> • <i>10 policies/guidelines complete and implemented across the region</i> 	June 2013	MMAG Guideline sub-group
Service Delivery					
Develop a regional neonatal and maternity emergency response plan	Regional neonatal and maternity emergency response plan developed and implemented	<ul style="list-style-type: none"> • All stakeholders involved in plan development • Escalation plan for resource shortages included • Plan links to regional transport project • Plan communicated to all maternity providers 	<ul style="list-style-type: none"> • Emergency response plan in place • Mechanism in place to audit/evaluate communication between providers in cases of clinical emergency 	June 2013	MMAG

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Integrated pathway developed for 2 maternity/obstetric conditions	<i>Guideline sub-group identify and develop pathways</i>	Facilitation of the guideline sub-group to support: <ul style="list-style-type: none"> • <i>Current best practice used to drive development</i> • <i>LMCs, consumers and other community/hospital -based maternity practitioners/stakeholders involved in pathway development</i> 	<ul style="list-style-type: none"> • <i>2 Pathways developed and implemented</i> • <i>Mechanism in place to evaluate compliance/success</i> 	June 2013	MMAG Guideline sub-group
<i>Stakeholders are involved/engaged in all service development activities</i>	<i>Process in place to ensure stakeholder involvement/engagement</i>	<ul style="list-style-type: none"> • <i>LMCs, consumers and other community/hospital -based maternity practitioners/stakeholders are involved in service development activities and improvement</i> • <i>Feedback is obtained on local consumer experiences of maternity services</i> 	<ul style="list-style-type: none"> • <i>Process implemented</i> • <i>Consumer survey developed/implemented as per national agreement</i> 	June 2013	MMAG Guideline sub-group
Research and Evaluation					
Develop consistent and aligned data collection systems and standards to enable regional benchmarking and reporting against the national maternity clinical indicators	<ul style="list-style-type: none"> • Review clinical indicators and establish what is already collected/where • Ensure regionally consistent approach to data collection and reporting • Data presented locally and regionally to allow for local and regional approach to service improvement where appropriate 	<ul style="list-style-type: none"> • An overview of local maternity demographics and outcomes is available • Information in the New Zealand Maternity Clinical Indicators report is disseminated to maternity clinicians and other relevant stakeholders • Collection of consistent and comprehensive primary maternity data occurs, regardless of the provider of primary maternity care • Data/information used to prioritise quality improvement activities • Processes to audit and improve the quality of maternity data collection, storage and reporting are in place 	<ul style="list-style-type: none"> • Maternity Quality and Safety Programme in place in all 5 DHBs • Mechanisms in place to evaluate information/reporting 	June 2013	MMAG
Consistent approaches to audit and evaluation are developed	Current audit/evaluation activity reviewed and regional schedule agreed	Audit/evaluation templates developed for agreed areas	Template and schedule agreed and implemented	June 2013	MMAG with DHB Audit teams

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Enablers/support					
Integrated service and workforce planning to meet future need	Workforce Action Plan developed	MMAG contribution to Maternity Workforce Action Plan	Workforce Action Plan developed	Dec 2012	Regional WFD
Maintain links to regional workforce developments	Workforce alignment to maternity developments	Maternity developments include consideration of workforce elements/requirements	Maternity workforce needs identified/met where possible	Full year	MMAG Project Manager
Explore opportunities for a shared regional patient activity repository	Regional patient activity repository in place	Ability to consolidate and compare patient activity/information across the 5 DHBs	<ul style="list-style-type: none"> Regional understanding of current patient activity and associated costs Regional approach to developing future demand scenarios based on regional growth/demographics etc. Impact analysis of different models of care from a regional perspective 	June 2013	MMAG
Explore opportunities for a web-based shared communication/information sharing tool	Shared electronic workspace/tool in place	Mechanisms are in place for discussion and dissemination of data, guidance or guidelines, innovative practice, new research, and local initiatives to LMCs, consumers and other community-based maternity practitioners/stakeholders	Maternity Quality and Safety Programme in place in all 5 DHBs	June 2013	MMAG with Regional IT Manager
Maintain links to regional IT developments	IT alignment to maternity developments	Maternity developments include consideration of IT elements/requirements	Maternity IT needs identified/met where possible	Full year	MMAG Project Manager

Renal Action Group 2012/2013 Work Programme

Chair: Jo-Anne Deane

Project Manager: Cathy Taylor

Vision: To lead regional activity, including implementation of renal health actions on behalf of the Midland DHBs, and to provide expert technical advice to the Regional Steering Group and the HealthShare CEO through the development of initiatives leading to:

- Improved clinical outcomes through optimal treatment of early stage renal disease and management of fully developed disease – resulting in increased life expectancy for renal patients
- Reduced disparity in clinical outcomes for renal services between population groups and DHB areas

Key Objectives: The principle purpose of the action group is to be a regional group providing:

- renal expertise
- steering regional renal services in cooperation with other agencies
- offering assistance to providers
- benchmarking performance

Outcome Measures:

Measures
<ol style="list-style-type: none"> 1. For Transplanted patients per 6 months – the time from referral to transplant workup to date accepted on transplant list per DHB within Midlands 2. Number of patients on home-based CAPD per DHB 3. Number of patients on haemodialysis per DHB 4. CKD: Reduce late presentation patients – the number per head of population of IP discharges with primary diagnosis Renal Failure per DHB 5. Hospital days per patient per year 6. For newly started haemodialysis patients the time from the identified need for dialysis to establishment on a dialysis programme

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Governance					
Develop a Regional Renal Plan	Regional Renal Plan developed	Plan approved and adopted	Plan guides future decision making regarding regional renal services and focuses on achieving equitable access and outcomes for renal patients	June 2013	RRAG
Quality and Safety					
Develop a regionally consistent model of care for chronic kidney disease (CKD) across primary/secondary/tertiary	GP referrals <ul style="list-style-type: none"> Working cooperatively with GPs develop agreed criteria for referrals including usage of virtual FSA Publish guidelines on website + key contact details Existing Kidney Health CKD guidelines - Review and approve for regional use, pilot in Taranaki during development phase Link into existing Waikato CKD program Produce shared care guidelines, including: <ul style="list-style-type: none"> FSA Screening in primary care Information flow between providers Education programme for GPs Ongoing patient management 	<ul style="list-style-type: none"> Reduction in late referrals Reduction in number of referrals sent back / turned away due to non-compliance with guidelines/access criteria 	<ul style="list-style-type: none"> Increase in self-care /self-care modalities Improved quality of life/ wellness of patients on dialysis Consistent application of care pathways/models of care in place across the Midland Region supporting equitable access and outcomes for renal patients Appropriate use of resources 	December 2012	Alistair Williams, Taranaki DHB, David Bennett Jones & Gerald Waters, Waikato DHB and Rawiri Keenan, GP

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Service Delivery					
Develop specialist outreach/partnership model of service delivery	<ul style="list-style-type: none"> • Develop MOC with expertise and support at the centre with local ownership and autonomy • Consider access to part FTE to provide support where there are gaps • Use of Telemedicine • Education for clinicians • Robust communication processes in place 	<ul style="list-style-type: none"> • Common + consistent standards of care, policies, pathways, audit, education, visits etc. in place • Consistent approach(es) to patient training in place in each DHB 	<ul style="list-style-type: none"> • Consistent application of care pathways/models of care in place across the Midland Region supporting equitable access and outcomes for renal patients • Appropriate use of resources 	June 2013	RRAG
Research and Evaluation					
Develop consistent and aligned data collection systems and standards to enable regional benchmarking and reporting	<ul style="list-style-type: none"> • Review clinical indicators and establish what is already collected/where • Ensure regionally consistent approach to data collection and reporting • Data presented locally and regionally to allow for local and regional approach to service improvement where appropriate 	<ul style="list-style-type: none"> • An overview of local renal demographics and outcomes is available • Collection of consistent and comprehensive renal data occurs • Data/information used to prioritise quality improvement activities • Processes to audit and improve the quality of data collection, storage and reporting are in place 	Mechanisms in place to measure standard of care across the Midland Region enabling a targeted approach to achieving equitable access and outcomes for renal patients	June 2013	RRAG

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Enablers/support					
Explore opportunities for a web-based shared communication/information sharing tool	Shared electronic workspace/tool in place	Mechanisms are in place for discussion and dissemination of data, guidance or guidelines, innovative practice, new research, and local initiatives to consumers, hospital and community-based practitioners/stakeholders	Consistent standard of care in place across the Midland Region supporting equitable access and outcomes for renal patients	June 2013	RRAG with Regional IT Manager
Ensuring the best use of available workforce capacity and skills	<ul style="list-style-type: none"> • Stock take and review current workforce roles across renal services • Analyse role, skills and task allocation aligned with key patient pathways • Identify options for greater workforce flexibility and skills utilisation • Confirm the workforce development requirements for future sustainability including new workforce 	<ul style="list-style-type: none"> • Workforce intelligence informs future service planning • New ways of working programme implemented • Future workforce strategy developed for renal services including Maori workforce development 	Workforce innovation enables sustainable service delivery	June 2013	RRAG Clinicians, RRAG Maori Health Representative, Regional WFD

Rural Health Action Group 2012/2013 Work Programme

Chair: Ross Lawrenson

Project Manager: Cathy Taylor

Vision: The principal purpose of the Rural Health Action Group is to develop a vision for rural health across the Midland Region which:

- addresses issues of access to health services for rural communities
- supports seamless care across community, primary, secondary and tertiary services for rural communities
- provides choice for patients in how they access their health care
- improves health outcomes

By:

- strong clinical engagement and leadership
- evidence based decision making in the planning, development and delivery of services
- ensuring equity of access
- reducing disparities

And by the most effective and efficient use of human, financial and other resource.

Key Objectives: To establish a regional rural health network to share innovation across primary care providers and DHBs and to develop a prioritised action plan to address specific rural health issues.

The Action Group will consider a number of clinical services for rural populations with a focus on:

- Acute care, including after-hours care
- Range of services rural hospitals should provide to support primary care
- A consumer perspective of the service

Over time actions will lead to:

- Improved **clinical outcomes** through the development and implementation of evidence based shared clinical pathways
- **Reduced disparity** in clinical outcomes for chronic conditions between population groups resulting from consistent regional clinical pathways and audit.
- Improved **financial and clinical sustainability** of services resulting from a stable workforce and a primary care focused health sector.

Linkages: The Rural Health Action Group will maintain linkages to the following networks and action groups and contribute to developments for rural communities as appropriate:

- Maternity
- Cardiac
- Renal
- Health of Older People
- Radiology
- Mental Health
- Cancer
- Primary Care Leadership Forum
- BSMC Service Level Alliance Teams
- ECCT

Outcome Measures: For 2012/13 the focus will be on establishing baseline measures around services delivered, access and workforce availability to identify gaps which will drive service development.

Outcome Measures
The aim is to have a consistent standard in relation to access to primary care service providers for rural communities - baseline data around current access will need to be analysed during 2012/13 and targets set for future years.
Note: it is anticipated that the following measures will be collected and reported on by age, ethnicity and by rural/urban split – the ability to do this will be confirmed prior to the start of the 12/13 year.
Maternity : 1. Clinical indicators for pregnant women living in rural communities 2. Access to maternity services for rural communities
Cardiac: 1. Outcomes for ACS in rural communities 2. Treatment options for patients with ACS in rural communities

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Governance					
Midland Region Rural Health Action Group development	Develop Action Group and work to agreed terms of reference, meeting schedule and work plan	Work Plan deliverables achieved	Clinical leadership across the continuum of care contributing to service delivery, sustainability and redesign	June 2013	Rural Action Group
Quality and Safety					
Service development stocktake	Complete a stocktake of current activities/initiatives occurring across the Midland Region impacting on/supporting rural communities	Stocktake complete	The Midland Region has a full understanding of current initiatives/developments	December 2012	Rural Action Group
Level of service	Identify range of services that should be available for emergency and trauma care, and maternity and cardiac specialist care	<ul style="list-style-type: none"> • Baseline data collected for emergency services in rural communities • Mapping of emergency services for rural communities complete • Baseline data collected for maternity clinical indicators for women living in rural communities • Mapping of maternity services for rural communities complete • Baseline data collected for ACS outcomes for people in rural communities • Mapping of ACS treatment options for rural communities complete 	<ul style="list-style-type: none"> • Consistent application of care pathways/models of care in place across the Midland Region supporting equitable access and outcomes for rural patients • There is evidence of effective use of available resources 	October 2012 December 2012 February 2013 April 2013	Rural Action Group

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Service Delivery					
Emergency and Trauma Services	Set up working group in conjunction with regional trauma group to consider emergency and trauma care in rural communities, include: Need/demand <ul style="list-style-type: none"> • What services should be provided and • Where services should be provided • Integrated care • Partnership building • Funding • Workforce • Training • IT requirements • Communications • Clinical Governance • Evaluation/customer feedback 	<ul style="list-style-type: none"> • Establish a baseline of access to after-hours care • Engagement with rural communities provides expectations about access and delivery of services • Model of care developed • Proposal for change/business case as appropriate put to DHBs for approval • Implementation plan developed • One action has begun to be implemented 	<ul style="list-style-type: none"> • Consistent application of care pathways/models of care in place across the Midland Region supporting equitable access and outcomes for rural patients • There is evidence of effective use of available resources 	September 2012 December 2012 April 2013 June 2013 June 2013 June 2013	Rural Action Group
Access to Specialist services	Set up working group to consider services for maternity and ACS for rural communities, include: <ul style="list-style-type: none"> • Need/demand • What services should be provided • Where services should be provided • Integrated care • Partnership building • Funding • Workforce • Training • IT requirements • Communications • Clinical Governance • Evaluation/customer feedback 	<ul style="list-style-type: none"> • Engagement with rural communities provides expectations about access and delivery of services • Model of care developed • Proposal for change/business case as appropriate put to DHBs for approval • Implementation plan developed • One action has begun to be implemented 	<ul style="list-style-type: none"> • Rural communities have appropriate access to services that are of an appropriate standard. • Outcomes for rural communities are consistent with those expected for the whole population 	December 2012 April 2013 June 2013 June 2013 June 2013	Rural Action Group

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Monitoring framework					
Rural Communities Analysis	Baseline data of services currently used by rural populations, capacity, and workforce availability of rural services to guide service development activity	Mapping of communities, services, and workforce complete	Service and workforce development/sustainability guided by robust data/information Informs 'service delivery' initiatives (see above)	December 2012	Rural Health Action Group with Regional WFD
Enablers/support					
Skills training for rural workforce	A multidisciplinary emergency management skills program will be developed for rural health practitioners	Program will be developed and delivered to at least two multidisciplinary primary care teams	Improved confidence in emergency management for generalist practitioners working in rural communities		RHAG, Clinical Skills and Simulation team from Waikato DHB
Explore opportunities for a web-based shared communication/information sharing tool	Shared electronic workspace/tool in place to enable rural communities and stakeholders to participate in regional project	Mechanisms are in place for discussion and dissemination of data, guidance or guidelines, innovative practice, new research, and local initiatives to consumers, hospital and community-based practitioners/stakeholders	Consistent information regarding standards of care/care pathways is available across the Midland Region supporting equitable access and outcomes for rural communities	November 2012	Rural Health Action Group with Regional IT Manager

Health of Older People 2012/2013 Work Programme

Chair: TBC

Project Manager: Cathy Taylor

Vision: To facilitate appropriate support and care allowing 'ageing in place', and maintenance of a good quality of life and independence for as long as possible.

Key Objectives: There are consistent systems and processes in place across the Midland Region to support:

1. Keeping older people well and self-managing, reducing the need for avoidable hospital admissions and long term residential care
2. Older people having access to timely and quality coordinated care from a range of providers enabling them to remain independent and in their own homes and communities
3. Reduce duplication
4. Manage the demand on related high cost service expenditure to a level that can be sustained within current financial resources.
5. Supporting smarter investment in home care for older people, including a stronger focus on home support after hospital discharge

Measures:

Outcome Measures

Given the variation in data collected across the 5 DHBs suitable regional outcome measures for older people will be investigated during 2012/13

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Governance					
Midland Region HOP Action Group establishment	Establish Clinical Network with agreed Terms of reference and work plan	Network in place with agreed meeting schedule and work plan for 2012/13	Clinical leadership across the continuum of care contributing to service delivery, sustainability and redesign	September 2012	HOP Portfolio Managers, HealthShare Project Manager
Service Delivery					
Dementia pathway development	Identification and implementation of dementia pathway which identifies best practice in dementia care across the care continuum	A dementia pathway will be developed by June 2013	<ul style="list-style-type: none"> • People with dementia and their primary informal caregivers have early access to assessment, diagnosis, treatment, information and support services • Clinicians, health professionals and providers are confident in how to meet the needs of people with dementia and support their primary, informal carers • HOP & MHSOP and primary care (BSMC) services link and integrate at Levels 1-4 of the 7-tiered model 	June 2013	HOP Action group
Research and Evaluation					
Develop consistent and aligned data collection systems and standards to enable regional benchmarking and reporting	<ul style="list-style-type: none"> • Identify HOP clinical indicators and establish what is already collected/where • Ensure regionally consistent approach to data collection and reporting • Data collated and analysed both locally and regionally to allow for local and regional approach to service improvement where appropriate 	<ul style="list-style-type: none"> • An overview of local older people demographics and outcomes is available • Collection of consistent and comprehensive HOP data occurs • Analysed Data and information used to prioritise quality improvement activities • Processes to audit and improve the quality of data collection, storage and reporting are in place 	Mechanisms in place to measure and match client need, service gaps and standard of service delivery across the Midland Region enabling a targeted approach to achieving equitable access and outcomes for older people	June 2013	HOP Action Group

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
HBSS	Identify future service needs for HBSS: <ul style="list-style-type: none"> • Build on outcomes of case mix development • Build on C&CDHB and CDHB findings • Review service investments and service coverage • Align with MoH service development work 	Standard approach to service delivery and capacity management for HBSS in place	<ul style="list-style-type: none"> • Consistent application of care pathways/model of care in place across the Midland Region supporting equitable access and outcomes for HOP patients • Appropriate use of resources 	June 2013	HOP Action Group
Enablers/support					
Explore opportunities for a web-based shared communication/information sharing tool	Shared electronic workspace/tool in place	Mechanisms are in place for discussion and dissemination of data, guidance or guidelines, innovative practice, new research, and local initiatives to consumers, hospital and community-based practitioners/stakeholders	Consistent standard of care in place across the Midland Region supporting equitable access and outcomes for HOP patients	June 2013	HOP action Group with Regional IT Manager

Radiology Network 2012/2013 Work Programme

Chair: Jill Wright

Project Manager: Cathy Taylor

Vision: to provide robust leadership through evidence based best practice to achieve the specific outcomes which are identified and prioritised by the Network.

Key Objectives:

- Identify specific and achievable initiatives to address the above activities and outcomes, and to prioritise these initiatives
- Make recommendations on the priorities and workplan, including financial implications and other implications
- Support the implementation of approved priorities across the region
- Oversee the analysis of benefits and impacts and other relevant work
- Establish close linkages and take an active role in key initiatives, including Clinical Pathways
- Liaise with other regional and national bodies such as Regional Service Planning, Multi-Regional Radiology Group and MTRAC
- Identify ways to provide a workforce that is flexible and able to support changing demand

Measures:

Measure (*still subject to agreement with MoH)	BOP DHB	Lakes DHB	Tairāwhiti DHB	Taranaki DHB	Waikato DHB
	Target				
	2012/13	2012/13	2012/13	2012/13	2012/13
Improving Waiting Times for Diagnostic Services for Community and Outpatient Referrals: CT and MRI Imaging	xx%* of accepted referrals for scans receive their scan within 6 weeks (42 days).	xx%* of accepted referrals for scans receive their scan within 6 weeks (42 days).	xx%* of accepted referrals for scans receive their scan within 6 weeks (42 days).	xx%* of accepted referrals for scans receive their scan within 6 weeks (42 days).	xx%* of accepted referrals for scans receive their scan within 6 weeks (42 days).

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Governance					
Midland Region Radiology Network establishment	Establish Clinical Network with agreed Terms of reference and work plan	Network in place with agreed meeting schedule and work plan for 2012/13	Clinical leadership across the continuum of care contributing to service delivery, sustainability and redesign	July 2012	Regional Network
Quality and Safety					
Improving radiology outcomes	<ul style="list-style-type: none"> Monitoring against known MOH access criteria (or develop regional criteria if the MoH doesn't provide this) Agree regional monitoring measures Share information to identify processes and efficiencies that can be adopted. Implement improvements locally and when resource and funding become available. 	<ul style="list-style-type: none"> Utilisation of NHB Templates Regular comparison of data between Midland DHB's 	Ongoing focus on improving wait times within radiology	September 2012	Regional Network
Service Delivery					
Regional Radiology SLAT recommendations implemented across the region	<ul style="list-style-type: none"> Participation in the regional project as required As agreed from project implementation plan (reference SLAT project Plan) 	<ul style="list-style-type: none"> Successful completion of the project where relevant to radiology service provision Monitoring template 	<ul style="list-style-type: none"> Midland Region IS Integrated Shared Care Solution across Primary and Secondary Services Implement agreed equity of access for diagnostic for Primary Referred Radiology criteria as approved by the Alliance Leadership Team (Midland Health Network) 	December 2012 July 2012	Regional Network
Supporting clinical pathway development	Involvement in clinical pathways discussions with clinical teams at a local level for regional or national pathways	Monitoring tool for each pathway	Agree Regional pathways and metrics for Diagnostics as required	June 2013	Regional Network
Research and Evaluation					
Systems & processes to measure support equity of access and consistent standards of care	Regional access benchmarking to comprise of activity data and analysis of affordability and demographics	Regional benchmarking Template	<ul style="list-style-type: none"> Assess equity of access across regional DHBS Understanding of referral practice and current public access 	September 2012	HealthShare to co-ordinate on behalf of Region

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Consistent use of measures/KPIs	Benchmark RVU	Comparison of RVU for each DHB	Agree consistent use of MoH KPI's and RVU's across region	September 2012	HealthShare to co-ordinate on behalf of Region
Enablers/support					
Best use of available workforce capacity and skills	<ul style="list-style-type: none"> Review current workforce roles across radiology services Analyse role and task allocation aligned to agreed pathways Identify options for greater workforce flexibility and skills utilisation Confirm the workforce development requirements for future sustainability 	<ul style="list-style-type: none"> Workforce intelligence informs future service planning New ways of working programme implemented 	Workforce innovation enables sustainable service delivery	June 2013	Regional Network with Regional WFD
Improve training outcomes	Monitor the success of local registrar and sonographer training programmes	Design and implement monitoring tool	Retention of vocational trainees and sonographer trainees within the region.	June 2013	Regional Network with Midland Training Network
Employee Relations	<ul style="list-style-type: none"> Identify regional/local issues and priorities in consultation with MRTAC Agree regional/local programme of work Setup user groups to work through issues Implement agreed changes 	Priority issues resolved through consultation and management of change process.	To progress a programme of work as identified through the national bargaining process for MRT Collective agreement.	December 2012	Regional Network with IR
Develop a regional approach to asset management	<ul style="list-style-type: none"> Agree format for Capital Plan Discuss requirements Assess Requirement for business case Discuss with Regional IS Managers 	<ul style="list-style-type: none"> Published Capital replacement Plans – lifecycle Completed assessment 	<ul style="list-style-type: none"> Publish and share Radiology CAPEX plans and have a commitment to work cooperatively as per the Regional Procurement Strategy Assess the need for Regional Radiology PACS/RIS Manager 	July 2012 December 2012	Regional Network with IT Manager

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Explore opportunities for a web-based shared communication/information sharing tool	Shared electronic workspace/tool in place	Mechanisms are in place for discussion and dissemination of data, guidance or guidelines, innovative practice, new research, and local initiatives to consumers, hospital and community-based practitioners/stakeholders	Consistent standard of care in place across the Midland Region supporting equitable access and outcomes for patients accessing radiology services	June 2013	Regional Network with IT Manager

National Priority Services



Cardiac Network 2012/2013 Work Programme

Chair: Gerald Devlin

Project Manager: Cathy Taylor, Diane Penny (ACS)

Vision: The Midland Cardiac Network supports the goal from the national Cardiac Network:
"To stop New Zealanders dying prematurely from heart disease"

Key Objectives: A health system that functions well for Cardiac Services is one that is:

- increasing cardiac surgery discharges
- improving access to cardiac diagnostics and specialist assessment
- reducing waiting times for people requiring cardiac services
- improving prioritisation and selection of patients selected for cardiac surgery

Outcome Measures:

Outcome Measures
Measures reported to include ethnicity age and domicile code (rural/urban)
<ul style="list-style-type: none">• 90 % of ACS patients receiving a risk assessment and classification within 24 hours of presenting
<ul style="list-style-type: none">• 70 % of high risk ACS patients receiving angiograms within 3 days of presenting

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Governance					
Cardiac Network development	Work with the Midland Cardiac clinical network and the National Cardiac Network to implement actions to improve outcomes for people with suspected Acute Coronary Syndrome (ACS) and other regionally prioritised cardiac conditions/activities.	Cardiac Network is functioning as per agreed Terms of reference	Initiatives in place to support improved patient outcomes	On-going	Midland Cardiac Network
Quality and Safety					
Outcomes for patients with ACS are improved	<p>Acute Coronary Syndrome (ACS)</p> <ul style="list-style-type: none"> Develop and establish regionally agreed guidelines, protocols, processes and systems to ensure prompt local risk stratification of suspected ACS patients, and the transfer of high risk patients to the tertiary centre for angiography required. <p>Examples of the activity we will undertake to achieve this objective include:</p> <ul style="list-style-type: none"> Agreed clinical guidelines for the clinical and nursing management and transfer of the ACS patient will be developed and clinically endorsed at each Midland DHB by 30 September 2012 Agreeing regionally the clinical pathway from primary to tertiary care for management of patients with suspected ACS by 30 June 2013 Ensure local staff are trained in risk assessment of patients with suspected ACS, according to national guidelines Develop and maintain systems to monitor the access and management of patients with suspected ACS to ensure clinically appropriate waiting times are achieved by 30 April 2013 ensure systems and processes for patients with suspected 	<p>Measures of ACS risk stratification and time to appropriate intervention have been established from the Midland ACS pilot programme as follows:</p> <ul style="list-style-type: none"> 90 % of ACS patients receiving a risk assessment and classification within 24 hours of presenting 70 % of high risk ACS patients receiving angiograms within 3 days of presenting <p>Midland DHBs will continue to report this through the pilot programme.</p> <p>Population access to the following conditions will not be significantly below the agreed rate:</p> <ul style="list-style-type: none"> Cardiac Surgery: 6.5 per 10,000 of population Percutaneous revascularization: 12 per 10,000 of population Coronary Angiography: 32.3 per 	<ul style="list-style-type: none"> Patients with suspected ACS receive seamless co-ordinated care across the clinical pathway. More patients survive acute coronary events, cardiac damage from these events is minimised, and the likelihood of subsequent cardiac events is reduced. More people receive access to cardiac services which supports New Zealanders to live longer, healthier and more independent lives. 	<p>September 2012</p> <p>June 2013</p> <p>April 2013</p>	ACS Project Manager/ Midland Cardiac Network

	<p>ACS are effective by being tailored to the needs of high risk population groups such as Māori, Pacific and South Asian people 30 June 2013</p> <ul style="list-style-type: none"> • A review of patient flow processes of the ACS patient from acute admission to discharge will be completed by 30 December 2012 with recommendations for further quality improvement strategies to the clinical governance groups (incl the network) for implementation by 30th June 2013 • Establishment of ANZACS-QI database into the Midland DHBs by 30th September 2012 to monitor the management of patients with suspected ACS to ensure clinically appropriate waiting times are achieved • The transfer of high risk ACS patients from referring hospitals to the tertiary centre will be managed using the guidelines of the agreed document of the Midland Interhospital Transfer Project by 30 September 2012 • A Regional Service Plan for cardiac services will be developed by 30 June 2013 and implemented to support appropriate access to cardiac services including surgery, percutaneous revascularisation and coronary angioplasty. 	<p>10,000 of population.</p> <p>The Midland ACS project will introduce on-going solutions into the region for access problems within the cardiology and cardiac services until its completion in March 2014.</p> <p>The regional plan will include measures in the following areas:</p> <ul style="list-style-type: none"> • Production planning • Meeting the following waiting time expectations: <ul style="list-style-type: none"> ○ No one waits longer than the national target for first specialist assessment or treatment 		<p>June 2013</p> <p>December 2012</p> <p>June 2013</p> <p>September 2012</p>	
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Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Service Delivery					
Cardiac Surgery	<ul style="list-style-type: none"> The National Cardiac Network will identify and agree cardiac surgery targets which will improve equity of access. The Midland Region will monitor cardiac surgery intervention rates to ensure that they are aligned with national targets/timeframes Remedial plans will be implemented should any slippage against production plans occurs 	<ul style="list-style-type: none"> The waiting list for cardiac surgery remains between 5 and 7.5 percent of annual cardiac throughput, and does not exceed 10 percent of annual throughput. Improving consistency of clinical prioritisation, measured by: <ul style="list-style-type: none"> use of national cardiac CPAC tool, treatment in accordance with assigned priority 	Cardiac surgery patients operated on within nationally agreed timeframes.	June 2013	Midland Cardiac Network
Patients undergoing revascularisation are treated consistently	Revascularisation: <ul style="list-style-type: none"> Acute access: Develop consistent approaches to decision making, management, coordination, and prioritisation (TIMI – risk assessment + stratification) of time from referral to table for revascularisation Elective Access: consideration needs to be given to assessment, geography, transport, social needs IT access – links needed between sectors DHBs and PHOs 	<ul style="list-style-type: none"> Benchmark volumes and waiting times across the region to identify where variations in access occur Identify options for managing variation and develop an implementation plan to address as appropriate/required Consistent tools are in place to support prioritisation/decision making Linkages with Regional IT Governance group to ensure cardiac priorities are incorporated into regional prioritisation process. 	<ul style="list-style-type: none"> The Midland Population receives equity access to both acute and elective services Prioritisation occurs on a consistent basis across the region using agreed criteria applied in a consistent manner Information is collected and reported on in a consistent manner 	June 2013	Midland Cardiac Network

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Cardiac care is integrated across the continuum	Primary care: <ul style="list-style-type: none"> Showcase innovative and successful programmes Targets/outcomes/KPIs need to be developed around risk management to show are interventions working –including the need to collect robust data and audit outcomes Develop Pathways/guidelines – primary/secondary/tertiary engagement Health literacy, public awareness, education all need to be co-ordinated. Define good health outcomes from a consumer perspective 	<ul style="list-style-type: none"> Incorporate Cardiac Network presentation and update into Regional Primary care leadership Forum quarterly meetings in 2012/13 Prioritise pathways development as part of wider Primary care engagement on integrated pathway development across the region Agree and prioritise education and consumer engagement activities in association with Primary Care across the region 	Patients across the region are offered consistent pathways to care and rehabilitation	June 2013	Midland Cardiac Network
Research and Evaluation					
Develop consistent and aligned data collection systems and standards to enable regional benchmarking and reporting	<ul style="list-style-type: none"> Review clinical indicators and establish what is already collected/where Ensure regionally consistent approach to data collection and reporting Data presented locally and regionally to allow for local and regional approach to service improvement where appropriate 	<ul style="list-style-type: none"> An overview of local cardiac demographics and outcomes is available Collection of consistent and comprehensive cardiac data occurs Data/information used to prioritise quality improvement activities Processes to audit and improve the quality of data collection, storage and reporting are in place 	Mechanisms in place to measure standard of care across the Midland Region enabling a targeted approach to achieving equitable access and outcomes for cardiac patients	June 2013	Cardiac Network

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Enablers/support					
Workforce profiling	Complete a workforce profile to understand the current distribution of roles and future need	Profile of roles across the region complete	Service and workforce development guided by workforce intelligence	June 2013	Cardiac Network with Midland Region Training Network + Regional WFD
Explore opportunities for a web-based shared communication/information sharing tool	Shared electronic workspace/tool in place	Mechanisms are in place for discussion and dissemination of data, guidance or guidelines, innovative practice, new research, and local initiatives to consumers, hospital and community-based practitioners/stakeholders	Consistent standard of care in place across the Midland Region supporting equitable access and outcomes for cardiac patients	June 2013	Cardiac Network with Regional IT Manager

Elective Services Action Group Work Programme 2012/2013

Chair: Martin Thomas

Project Manager: Cathy Taylor

Vision: To lead regional elective services activity on behalf of the Midland DHBs and to provide expert technical advice through the development of initiatives leading to the delivery of safe and quality sustainable elective services that achieve equity of access for the Midland Regions population.

Key Objectives: The principle purpose of the action group is to focus on regional equity of access for patients requiring elective services by:

- Utilising elective services expertise
- Identifying and steering those elective services where a regional approach is required
- Benchmarking performance
- Improving and integrating provision of elective services

Outcome Measures: In the 2012/13 year the focus will be on the collection and analysis of baseline information/data to inform and guide regional elective services activity with a goal of providing equity of access across the Midland Region.

Outcome Measures – Specific to Orthopaedics	Midland Region
	2012/13 Target
ESPI 2: Patients waiting longer than 5 months for their first specialist assessment	100% compliance
ESPI 5: Patients given a commitment to treatment but not treated within the last 5 months	100% compliance

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Governance					
Midland Region ES Action Group development	Action group works to agreed meeting schedule, terms of reference and work plan	Achievement of action plan deliverables	Clinical leadership across the continuum of care contributing to service delivery, sustainability and redesign	June 2013	ES Action group
Orthopaedic Services	Work with the College of Orthopaedic Surgeons in the development of tools/initiatives to support delivery of high quality orthopaedic services	Midland Region contribution to national initiatives	<ul style="list-style-type: none"> Consistent application of care pathways/models of care in place across the Midland Region supporting equitable access and outcomes for orthopaedic patients Appropriate use of resources 	November 2012	Chair of Orthopaedic Working Group
Service Delivery					
Orthopaedic Services	Develop a Working Group chaired by an SMO to consider: <ul style="list-style-type: none"> Capacity Workforce SIRs SDRs Access criteria/thresholds Prioritisation tool(s) use Exit criteria IDFs 	Regional suite of information/guidelines/tools developed to support delivery of orthopaedic services Initial area of focus to include spinal surgery	<ul style="list-style-type: none"> Consistent application of care pathways/model of care in place across the Midland Region supporting equitable access, improved outcomes and quality care for orthopaedic patients Appropriate use of resources Increased productivity in orthopaedic services across the Midland Region ESPI 2 and 5 compliance 	June 2013	Orthopaedic Working Group
Chronic Pain Services	Develop a Working Group chaired by an SMO to consider: <ul style="list-style-type: none"> Capacity Workforce SIRs SDRs Access criteria/thresholds Prioritisation tool(s) use Exit criteria IDFs Access to ACC funding 	Regional suite of information/guidelines/tools developed to support delivery of chronic pain services	Consistent standard of care in place across the Midland Region supporting equitable access, improved outcomes and quality care for patients with chronic pain	June 2013	Chronic Pain Working Group

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Research and Evaluation					
Capacity	Work with NHB to develop a comprehensive view of capacity across the Midland Region	Regional capacity information validated and available for local and regional use	Regional capacity information used to support service delivery decisions	December 2012	NHB
Enablers/support					
Capacity information is available electronically across the Midland DHBs	Tool/user requirements scoped and developed	DHB ES Capacity tool in place	<ul style="list-style-type: none"> The Midland DHBs fully utilise available capacity ensuring effective use of available facilities and workforce Patient access is optimised 	October 2012	ES Action Group with Regional IT Manager
Explore opportunities for a web-based shared communication/information sharing tool	Shared electronic workspace/tool in place	Mechanisms are in place for discussion and dissemination of data, guidance or guidelines, innovative practice, new research, and local initiatives to consumers, hospital and community-based practitioners/stakeholders	Consistent standard of care in place across the Midland Region supporting equitable access and outcomes for ES patients	June 2013	ES Action Group with Regional IT Manager

Stroke Services Work Programme 2012/2013

Chair: TBC

Project Manager: Cathy Taylor

Vision: To develop a vision for Stroke Services in the Midland Region aligned to the New Zealand Clinical Guidelines for Stroke Management 2010.

Key Objectives: There are consistent systems and processes in place across the Midland Region to ensure that:

1. All Midland residents have access to a designated stroke service with a lead stroke physician and lead stroke nurse
2. All Midland residents have access to an acute TIA service
3. All Midlands residents to have access to acute intravenous thrombolysis by optimising transfer to a skilled thrombolysis unit within 3.5 hours of stroke onset
4. All Midland residents have access to appropriate rehabilitation under the care of an interdisciplinary team beginning in a geographically defined dedicated stroke unit
5. All Midlands DHBs have established investigation and treatment algorithms to optimise medical and lifestyle change to prevent stroke recurrence
6. All staff, patients and their families/caregivers have access to on-going education

Measures:

Outcome Measures
<i>Given the variation in data collected across the 5 DHBs suitable regional outcome measures for stroke will be investigated during 2012/13</i>

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Governance					
Midland Region Stroke Action Group establishment	Establish Clinical Network with agreed Terms of reference and work plan	Network in place with agreed meeting schedule and work plan for 2012/13	Clinical leadership across the continuum of care contributing to service delivery, sustainability and redesign	September 2012	Portfolio Managers, HealthShare Project Manager
Quality and Safety					
Education for staff, patients and primary carers	<ul style="list-style-type: none"> Identify education needs/competency requirements for staff, patients, and families Develop education programme Implement education programme 	Education programme in place	<ul style="list-style-type: none"> People who experience stroke and their primary carers have a full understanding of the assessment, diagnosis, treatment, and support services available Clinicians, health professionals and providers are confident in how to meet the needs of people and their primary carers following stroke 	December 2012 June 2013	Stroke Action group
Service Delivery					
Stroke services	<ul style="list-style-type: none"> Review national stock take of current stroke services across the Midland Region Stroke services are described as a region Identify service gaps Establish three regionally-agreed protocols, processes and systems to ensure people with a stroke can receive care within an appropriately configured organised stroke service (aligned to national activity) Develop long term plan for stroke service development Identify lead stroke physician and lead stroke nurse for each DHB 	<ul style="list-style-type: none"> Stock take validated Lead stroke physician and lead stroke nurse identified for each DHB A clear description of stroke services is achieved Care pathways and processes are clear Long term plan developed which ensures Midland Region patients have access to appropriate stroke services 	Patients who experience stroke have access to a designated stroke service with a designated lead stroke physician and lead stroke nurse (aligned to national guidelines)	December 2012 December 2012 March 2013 June 2013	Stroke Action group

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
TIA pathway development	Identify what is required to develop and implement a TIA pathway (aligned to national guidelines) which identifies best practice in TIA care across the continuum	Barriers and requirements identified to ensure Midland Region patients have access to appropriate care following TIA	<ul style="list-style-type: none"> • People who experience TIAs and their primary caregivers have early access to assessment, diagnosis, treatment, information and support services • Clinicians, health professionals and providers are confident in how to meet the needs of people following TIA 	June 2013	Stroke Action group
Acute thrombolysis pathway development	Identify what is required to develop and implement an acute thrombolysis pathway (aligned to national guidelines) which ensures timely and equitable access to thrombolysis for all Midland Region patients.	Barriers and requirements identified to ensure Midland Region patients have access to an acute thrombolysis service	Acute thrombolysis available to those patients that need it in a timely manner (within 4.5hrs)	June 2013	Stroke Action group
Rehabilitation	<ul style="list-style-type: none"> • Review national stock take of current rehabilitation services across the Midland Region • Services are described as a region • Identify service gaps • Establish one regionally-agreed protocol, process and system to ensure people can appropriately receive rehabilitation services • Develop long term plan for rehabilitation service development 	<ul style="list-style-type: none"> • Stock take validated • A clear description of services is achieved • Rehabilitation pathways and processes are clear • Long term plan developed which ensures Midland Region patients have access to appropriate rehabilitation 	Patients who experience stroke have access to acute and post-acute rehabilitation under the care of an interdisciplinary team experienced in stroke rehabilitation in a dedicated area	December 2012 March 2013 June 2013	Stroke Action group

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Research and Evaluation					
Develop consistent and aligned data collection systems and standards to enable regional benchmarking and reporting	<ul style="list-style-type: none"> Identify Stroke clinical indicators and establish what is already collected/where Ensure regionally consistent approach to data collection and reporting Data collated and analysed both locally and regionally to allow for local and regional approach to service improvement where appropriate 	<ul style="list-style-type: none"> An overview of local stroke demographics and outcomes is available Collection of consistent and comprehensive stroke data occurs Analysed Data and information used to prioritise quality improvement activities Processes to audit and improve the quality of data collection, storage and reporting are in place 	Mechanisms in place to measure and match client need, service gaps and standard of service delivery across the Midland Region enabling a targeted approach to achieving equitable access and outcomes for people who experience stroke	June 2013	Stroke Action Group
Consistent approaches to audit and evaluation are developed	Current audit/evaluation activity reviewed and regional schedule agreed	Audit/evaluation schedule developed for agreed areas	Schedule agreed and implemented using national templates/tools	June 2013	Stroke Action Group with DHB Audit teams
Enablers/support					
Explore opportunities for a web-based shared communication/information sharing tool (aligned to national developments)	Shared electronic workspace/tool in place	Mechanisms are in place for discussion and dissemination of data, guidance or guidelines, innovative practice, new research, and local initiatives to consumers, hospital and community-based practitioners/stakeholders	Consistent standard of care in place across the Midland Region supporting equitable access and outcomes for stroke patients	June 2013	Stroke action Group with Regional IT Manager

Cancer Network 2012/2013 Work Programme

Chair: to be appointed

Programme Manager: Jan Smith

Vision: Better Sooner More Convenient Health Services for New Zealanders in relation to cancer means all New Zealanders can easily access the best services, in a timely way to improve overall cancer outcomes.

Key Objectives: A health system that functions well for Cancer is one that ensures all:

- people get timely services
- people have access to services that maintain good health and independence
- people receive excellent services wherever they are
- services make the best use of available resources.

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Regional collaboration and governance <ul style="list-style-type: none"> • Integration • Sustainability • Value for money <p>Midland Cancer Network work plan 2012-13 provides more detail for cancer continuum. The work plan aligns with the Midland Cancer Network Strategic Plan 2009-2014 and the National Cancer Programme Work Plan. Regional cancer control planning is supported by service / tumour improvement work groups / initiatives. Work is supported by regional Consumer/Carer Work Group and Māori Advisory Work Group. Regional cancer control aligns with local, regional and national governance structures Monitoring and evaluation.</p>	<p>Implement the regional priority initiatives identified in the National Cancer Programme Work Plan with regional cancer networks / DHBs. This will include:</p> <ul style="list-style-type: none"> • sustain performance against radiotherapy and chemotherapy wait time targets • develop and implement regional plan that aligns the priority areas identified in the report New Models of Care for Medical Oncology • implement and further develop the Midland Chemotherapy Nursing Certification Framework (developed 2011-12) • support implementation of recommendations from the Tairāwhiti DHB tertiary cancer review • support development of radiotherapy service with regional integration of services approach with possible entry of a private radiotherapy provider into BOPDHB • support development of Midland and local palliative care services 	<ul style="list-style-type: none"> • 100% of people ready for radiotherapy start their treatment within four weeks of their First Specialist Assessment (FSA) • 100% of people requiring chemotherapy are treated within four weeks of decision to treat • regional radiation oncology plan phase one priorities implemented by June 2013 • regional medical oncology plan phase one priorities implemented by June 2013 • regional palliative care service plan annual priorities implemented by June 2013 	<p>More people have improved access to services that maintain good health and independence.</p> <p>More people have shorter waiting times for cancer treatment meaning people receive better health services.</p>	June 2013	Midland cancer network

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Regional collaboration <ul style="list-style-type: none"> • Integration • Sustainability • Value for money <p>Develop a regional patient pathway approach across the cancer continuum by:</p> <ul style="list-style-type: none"> ○ commencing implementation of the faster cancer treatment (FCT) indicators initiative ○ support the development and implementation of national tumour stream service frameworks and standards for multidisciplinary teams 	<ul style="list-style-type: none"> • undertake baseline stock take of systems capability to capture regional data for national minimum cancer data and business processes and FCT indicators • cooperatively MCN, DHBs and Ministry of Health work to develop a regional implementation plan to commence implementing the agreed faster cancer treatment indicators with available resources • begin implementing regional clinical data repositories for cancer within available resources (refer footnote 3) • continue improving the functionality and coverage of regional cancer treatment multidisciplinary meetings (MDMs) within available resources (refer footnote 3) • service improvement initiatives to continue to improve timely access to services for priority cancers (lung and bowel) • host the National Lung Cancer Work Group and agreed work programme • Meet requirements of the NZ tumour stream standards and patient pathways project plan 	<ul style="list-style-type: none"> • Baseline data stock take completed; regional implementation plan developed by 1 July 2012 and phase one priorities of plan implemented by June 2013 • increased percentage of lung and bowel cancer presented at MDMs • improve compliance for lung & bowel cancer; baseline FCT indicators data collection for other cancers: <ul style="list-style-type: none"> ○ 62 day indicator – <i>proportion of patients urgently referred who receive their first cancer treatment within 62 days</i> ○ 31 day indicator – <i>proportion of patients with confirmed diagnosis of cancer who receive their first cancer treatment within 31 days</i> ○ 14 day indicator – <i>proportion of patients urgently referred who have FSA within 14 days</i> 	<p>More people have improved access to prompt and early diagnosis meaning better outcomes and improved quality of health services.</p> <p>More people have timely access to cancer treatment resulting in better cancer outcomes.</p>		

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Regional collaboration <ul style="list-style-type: none"> Value for money DHBs improve wait times and the quality of colonoscopy and endoscopy services and colorectal cancer (note footnote 3)	<ul style="list-style-type: none"> support DHBs to implement systems to record and monitor colonoscopy wait times and achieve wait time target (TBC) support DHBs to implement national colonoscopy prioritisation tool (TBC) support Lakes as a trial site to complete implementation of the Global Rating Scale (GRS) endoscopy services quality tool support the elective services Enhanced Recovery After Surgery (ERAS) initiative³ with pilot sites at BOP (lead) and Waikato Resubmit endoscopy reporting system for regional IT prioritisation 2013-14. 	<ul style="list-style-type: none"> Colonoscopy wait time indicators – patients accepted for diagnostic colonoscopy receive their procedure for; <ul style="list-style-type: none"> Priority 1 within 2 weeks Priority 2 & above within 6 weeks Patients accepted for surveillance/ follow-up colonoscopy receive their procedure within 12 weeks of planned date 100% of DHBs implemented national prioritisation tool 	<p>More people have shorter waiting times for colonoscopy services meaning improved outcomes for people who are, or go on to be, diagnosed with bowel cancer.</p> <p>More high risk people have timely access to surveillance colonoscopy and reduce the risk of getting cancer or improve outcomes for people who go on to be diagnosed with bowel cancer.</p>		

³ Refer to Midland electives service section for further action detail, performance measure and outcomes

Regional Activities



Mental Health and Addictions Network 2012/2013 Work Programme

Chair: Professor Graham Mellsop

Project Director: Eseta Nonu-Reid

Vision: Living well with supportive systems:

- Quality services
- Sector infrastructure
- Integration and social inclusion
- Workforce capacity and capability
- Health system integration
- Early detection and intervention focusing on recovery
- Information Management

Key Objectives:

- Leading regional mental health and addiction planning
- Leading service improvement
- Supporting the achievement of health targets and policy priorities
- Linking to national and regional governance structures and processes
- Leading and/or supporting the development of nationally consistent approaches to mental health and addiction
- Reducing inequalities in mental health and addiction outcomes

This plan is inclusive of primary, secondary and the tertiary mental health and addiction sectors.

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Implementation of the Midland Clinical Governance Network	Ensuring that mental health and addiction clinical governance is aligned to the National Health Boards expectations	The Clinical Governance Network endorsement and sign off process is established for all regional project work undertaken	Regional project Implementation Plans have agreed ways of working involving clinical technical experts and signed off by the Clinical Governance Network Project are undertaken with sufficient time factored in to allow for consultation with the Clinical Governance Network	30 June 2013	Midland Mental Health and Addictions Network and Midland Clinical Governance Network MH&A
Support the implementation of the Midland Primary Health Network Proof of Concept Sites	Ensuring that mental health and addictions services support the Proof of Concept Sites as funding becomes available.	Model of care development discussion is undertaken Agreed ways of working are identified	An agreed Model of Care is available to serve as framework to deliver services pertaining to the Midland Primary Health Network Proof of Concept Sites The MoH Service Plan provides clear statement and time frames for primary mental health implementation There is a willingness to follow MoH direction of travel for the integration of primary-secondary services and “better, sooner, more convenient”	June 2013/14	Midland Mental Health & Addictions Network and Midland Clinical Governance Network MH&A
Capacity and Capability of specialist Child & Youth Forensic Services Implement the Youth Forensic Mental Health and addiction project as per national direction	Ensuring that current Community Youth Forensic/youth court liaison FTEs are integrated with FTEs allocated from new MOH Youth Forensic funding	A Midland Youth Forensic project is undertaken and the project report will make recommendations that is cognizant of cross sectorial collaborations	Involvement of clinical and sector technical experts to guide the project to ensure that the report has clinically led Recommendations from the report are implemented Involvement of CYFs, Justice and Corrections in the Technical Reference Group	1 July 2012 June 2015	Midland Mental Health and Addictions Network and Midland Clinical Governance Network MH&A

[illegible]

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Mental Health and Addiction Services	Monitor quality of PRIMHD data across the region	100 percent of contracted mental health and addiction secondary/ specialist service and NGO providers (who are within the scope of the PRIMHD project) report to PRIMHD	Data quality is monitored Data reports are analysed and regional reports completed Access to MoH PRIMHD reports is essential to be able to monitor quality monthly. Sustainable funding for the Midland PRIMHD -coordinator	Quarterly throughout 2012 /13	Mental Health and Addictions Network and Midland Clinical Governance Network
Addictions Services	Improve clinical governance of Midland regional addiction services	Access and utilisation of Midland Regional Addiction Services are monitored Letters of service agreement with Addictions services purchase outside of the Midland on the behalf of Midland DHBs are established and reviewed. This is inclusive of data reporting.	Regional Addiction services will have agreed ways of working that align to local continuums of care Letters of Agreement will be in place and reviewed annually	June 2013 June 2013	Mental Health and Addictions Network and Midland Clinical Governance Network
Improving access to interventions for Child and youth populations	Child and Adolescent funding is applied that as per the Minister of Health's project for youth mental health and addiction	<ul style="list-style-type: none"> • Implement funding for the Prime Minister and department of cabinet funding as directed • % of children and adolescents accessing for service • Wait times to access secondary MH and Addiction services • Average length of inpatient Starship stay • Investigate the establishment of consistent Primary Mental Health reporting 	Data quality is monitored Data reports are analysed and regional reports completed Access to MoH PRIMHD reports is essential to be able to monitor performance. Individual P&F can report bullet points 1&2 Data for bullet point 3 is dependent on reports from ADHB Primary mental health reporting into PRIMHD and involved in the KPI project will ensure consistency	Six monthly 2012 /13 June 2013	Mental Health and Addictions Network and Midland Clinical Governance Network

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Blueprint Development and MoH Service Implementation II	Workshops are undertaken to determine the impacts of the Blueprint II and MoH Service Plan documents on the region	Regional projects are identified from the priorities Projects are time-framed and planned ahead of time Midland MH&A Strategic Plan is re-written involving region wide consultation	Midland MH&A services will have a clear direction of travel	June 2013	Midland Mental Health and Addictions Network and Midland Clinical Governance Network MH&A
Compulsory Alcohol and Other Drugs Treatment Act Implementation	The Medical Detox project report recommendations are implemented	Midland has a regional agreed way of working to ensure that robust medical detox is part of the addictions continuum of care	Midland MH&A services will have a clear direction of travel	January 2013	Midland Mental Health and Addictions Network and Midland Clinical Governance Network MH&A
Midland Workforce Development Initiatives	Midland Regional mental health and addictions network funding for workforce development is fully utilised by Midland mental health and addictions services	Return on investment review is undertaken Midland MH&A workforce development initiatives align to the regional Training Hub programme	Annual planning for workforce initiatives is completed and linked to national initiatives Retention of the Midland Workforce Coordinator is essential to ensure that MH&A initiatives are well linked to the national Workforce Centres and continues to meet the needs of the Midland workforce	June 2013 June 2013	Midland Mental Health and Addictions Network and Midland Clinical Governance Network MH&A

Smokefree Network 2012/2013 Work Programme

Project Director: Gary Thompson

Vision: “Our vision is for a Smokefree, Tobacco Free Midland by 2025. Our children and rangatahi deserve a future where smoking is history.”

Key Objectives:

1. Challenge DHB and Iwi governance members to demonstrate overt and strong smokefree leadership
2. Reduce the number and density of dairies and service stations selling tobacco in our communities’ e.g. Target and work with one or two dairies to ban displays etc with the assistance of HSC and Local Authorities
3. Explore the feasibility of working with a smaller community to become totally smokefree e.g. all stores selling tobacco to have no displays.
4. Challenge DHBs and Health Providers to set a target to employ only non-smokers and phase that in with steps to improve smoking cessation options for existing staff and new recruits
5. Gain leverage from working with traditional and contemporary models of Maori leadership e.g.: Iwi, hapu, urban and community
6. Build on existing services to empower communities to reduce the affects of addictions such as, tobacco, gambling, drugs and alcohol
7. Build on sector relationships to work with and gain support from the following:
 - Tertiary Education
 - Territorial Local Authorities
 - Business Sector
 - Central Government Agencies

Outcome Measure	BOP DHB		Lakes DHB		Tairāwhiti DHB		Taranaki DHB		Waikato DHB	
	Target		Target		Target		Target		Target	
	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13
Providing Smokers with Smoking Cessation advice and support - Hospitalised Total	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
90 percent of patients seen by a health practitioner in primary care are offered brief advice and support to quit smoking	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Additions programme for Tobacco Control	<ul style="list-style-type: none"> Explore feasibility of developing an integrated addiction programme that seeks to empower whanau affected by issues relating to smoking, gambling, drugs and alcohol Align with the progress and recommendations of the Addictions Intervention Competency Framework 	One integrated addictions programme piloted in the Midland region	Pilot evaluations informs a regional programme expansion plan	30 June 2013	Pilot Steering Group Midland Mental Health and Addictions Tobacco Control Reference Group
Maori and Pacific Women	<ul style="list-style-type: none"> Target and increase the availability and reach of successful cessation and support services aligned with healthy lifestyles programmes to Maori and Pacific women particularly pregnant and young mothers Align with proposed review of cessation services by Ministry of Health 	A minimum of four community programme pilots aimed at supporting Maori and Pacific women to stop smoking	<p>Primary Care and community organisation document increase cessation activity for Maori and Pacific women</p> <p>Improvements are monitored and reported</p>	30 June 2013	<p>District Tobacco Control Coalitions and Steering Groups</p> <p>Funding and planning</p> <p>Regional PHO networks</p>
Pacific Leadership	<p>Identify, support and work with Pacific communities to:</p> <ul style="list-style-type: none"> Identify strategic opportunities to create momentum for local Smokefree pacific leadership Identify incentives and support key Pacific community leaders to champion healthy lifestyles and promote Smokefree messages and strategies 	A minimum of two Pacific communities are funded to provide integrated healthy lifestyles inclusive of cessation service options	<p>Primary Care and community organisation document increase cessation activity for Maori and Pacific women</p> <p>Improvements are monitored and reported</p>	30 June 2013	<p>District Tobacco Control Coalitions and Steering Groups</p> <p>Funding and planning</p> <p>Regional PHO networks</p>

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
Local Integration	<ul style="list-style-type: none"> Explore feasibility of integrating existing community programmes ie; Tobacco, HEHA, Immunisation and Screening programmes that aim to improve health outcomes for communities particularly for Maori and Pacific Develop measureable and achievable outcomes that aim to integrate existing Tobacco, HEHA, Immunisation and Screening programmes 	A minimum of two community programme pilots in the Midland Region	<p>A better sooner more convenient services are provided for a range of primary health issues</p> <p>Pilot evaluations informs a regional programme expansion plan</p>	30 June 2013	<p>District Tobacco Control Coalitions and Steering Groups</p> <p>Funding and planning</p> <p>Regional PHO networks</p>
Regional Primary Care Networks	<p>Identify opportunities to enhance Smokefree Primary Care developments through integrated Family Health Teams</p> <ul style="list-style-type: none"> Smoking and healthy lifestyles programmes Health screening programmes ABC Training for frontline staff 	Regional PHO networks prioritise smoking outcomes across Primary Care service delivery	A better sooner more convenient services are provided for a range of primary health issues	30 June 2013	<p>District Tobacco Control Coalitions and Steering Groups</p> <p>Regional PHO networks</p>
Smokefree Supermarkets, Dairies and Service Stations	<ul style="list-style-type: none"> Target and work with supermarkets, dairies and service stations to reduce and then cease the sale of tobacco products by firstly banning displays..... Initial work may be prioritised at tobacco retailers close to schools Link with national awards and communication that promotes supermarkets, dairies and services station who are demonstrating an effort to cease the sale of tobacco products 	At least one retail outlet eg; supermarket, dairy and service station in each major town in the Midland Region is supported by the DHB to cease the sale of tobacco products	<p>Reduced availability of tobacco products across the Midland Region</p> <p>Improved commitment by the retail sector of the Midland Smokefree Vision</p>	30 June 2013	<p>District Tobacco Control Coalitions and Steering Groups</p> <p>Regional Public Health Units</p> <p>Regional DHB CE</p>

Key themes	Actions to deliver improved performance	Measured by	Outcomes	Timeline	Project Team
District Councils	<ul style="list-style-type: none"> Identify, target and work with key District Councils to develop and implement Smokefree outdoor plans by utilising the learning processes from other successful projects such as Rotorua and Opotiki District Councils Develop regional awards and promotions that identify District Councils who demonstrate and implement Smokefree outdoor plans Continue to advocate at local and regional level for Smokefree environments, parks, sporting venues, shopping complexes etc. 	At least one District Council per DHB within the Midland Region have Smokefree outdoor policies	<p>Reduced impact of second hand smoke for whanau</p> <p>Improved commitment by the District and Regional Councils of the Midland Smokefree Vision</p>	30 June 2013	<p>District Tobacco Control Coalitions and Steering Groups</p> <p>Regional Public Health Units</p> <p>Regional DHB CE and Boards</p>

Trauma System 2012/2013 Work Programme

Chair: Grant Christey

Vision & Mission: The mission of MRST is to ensure application of world's best practice in trauma care to patients from the point of injury to optimal function. .

Key Objectives: Midland Regional Trauma System (MRTS) was launched in March 2010 by the Minister of Health with the aim of ensuring consistent application of best practice in care to trauma patients across the Midland Region.

The function of the trauma teams is to provide support to major trauma patients and their families by visiting them as soon as possible after admission and performing multidisciplinary needs assessments, developing individual risk profiles and ensuring that the input of all departments and subspecialties are maximised within a comprehensive holistic framework.

The core group provides ongoing professional support and clinical advice as required, administers the central trauma registry and Trauma Quality Improvement Programme (TQIP) based on registry data and manages the MRTS education programme.

Outcome Measures:

Trauma Registry

Detailed, high quality trauma registry data is collected on all admitted patients. This is then used for patient tracking, system analyses and quality improvement based on evidence. Aggregated data can be used in the longer term for preventative strategies and resource planning by agencies approved by the MRTS Strategic Group. Clinical work and registry activities are coincident and inseparable.

Trauma Quality Improvement (TQIP)

The MRTS registry has been significantly upgraded to form the platform for a regional Trauma Quality Improvement Programme (TQIP) which is currently operational but undergoing further development. TQIP relies on a formal reporting and loop closure process to ensure that identified weaknesses are addressed and reported on. All persons who collect registry data are expected

Also under development is a specialised data warehouse programme named T-Qual, which will import data from multiple authorised data sources to inform TQIP and will enable detailed analyses on patient safety, quality of care and cost effectiveness. It will be designed to link multiple authorised data sources

along the entire patient journey so that complex relationships can be described, and focused interventions can be initiated.	
Deliverables in MRTS Strategic Plan for 2012-2013	Timeline
<ol style="list-style-type: none"> 1) Consolidate funding for MRTS staff. 2) Gain commitment for Regional Trauma Verification from DHBs. 3) Complete and implement registry functions: <ol style="list-style-type: none"> a. Trauma Registry upgrade b. T-Qual development c. Regular and ad-hoc reporting templates and processes 4) Continue building the Trauma Quality Improvement Programme. 5) Continue developing regional major trauma education programme. 6) Establish Trauma Hotline 7) Engage Tairāwhiti in MRTS 8) Establish Midland Trauma Research Unit. 9) Position MRTS appropriately in district and regional planning processes. 10) Explore opportunities for MRTS to contribute to regional and national disaster management plans. 11) Continue to provide objective and subjective evidence of the cost savings and clinical effectiveness resulting from regional trauma system development 	<p>July 2012 November 2012 August 2012</p> <p>June 2013 June 2013 Dec 2012 June 2013 July 2012 June 2013</p> <p>June 2013</p> <p>June 2013</p>

NOTE: The Midland Region Trauma Service currently has informal links to the RSP; opportunities for more formal alignment will be explored during 2012/13.

Section 5 – Key Enablers and Priorities

Regional infrastructure priorities

This section identifies the actions that the region will work cooperatively to achieve as part of its regional plan.

Clinical Information Systems

This workstream will implement the Midland Region Information Services Plan and advance NHITB priorities, specifically the implementation of the NHIT Plan priority areas. This includes implementing regional connectivity as a first phase of the Midland Connected Health programme, allowing health service providers to exchange information and data securely. Development of a Clinical Workstation Programme across the region will allow clinicians to have access to common tools. The Medications Management Programme will include agreed region configuration /architecture for ePharmacy. A Clinical Data Repository with secure access to core clinical information will also be developed.

Workforce

In common with other developed health systems New Zealand faces a major challenge in acquiring a clinically skilled health workforce. Population demographics; service and workforce affordability and global shortages further compound an already demanding situation. Improving the supply of the health workforce is only part of the answer. To find enduring solutions service providers will need to strengthen innovation, new ways of working and the development of sustainable workforces into the future.

The regional workforce programme will address the workforce change required to meet current and future service need, and address the most commonly raised issues across the region, relating to the future sustainability of the workforce. This includes the need to better anticipate future states and investigate regional cooperative activity that supports this approach. Workforce development activity underpins the collective response required to ensure access to quality, sustainable services across the whole region. Midland DHBs share responsibility for planning and undertaking forward-looking action on workforce development that minimises duplication. This includes regional cooperation to investigate the impact of reducing the rate of growth in health spending on design, capacity and workforce utilisation in general.

To ensure that we have planned and developed a workforce that meets our future needs in 2012/13 the regional workforce programme will focus on:

- Planning to support best use of available workforce capacity and skills
- Building workforce intelligence to facilitate decision making
- Providing tools and systems to progress opportunities for workforce innovation.

A range of activities to address workforce challenges and to continue to progress sustainable workforces will be lead by regional executive forums with the support of the regional workforce programme in 2012/13.

Detailed information is appended to this document.

Māori Health

A reduction in health inequalities must remain a core focus of regional work, ensuring that DHBs pool their resources and understanding of how to reduce health inequalities, and implement a monitoring

plan to ensure health inequalities are addressed at all organisational levels. Our Maori Health Plans prioritise improving Māori health and reducing Māori health outcome disparities by focusing on the key indicators where the health inequalities experienced are the greatest between Māori and non-Māori.

The Midland DHBs have been working cooperatively during 2011 and 2012 to develop a shared monitoring framework for the Maori Health Plan within each DHB. The aim of the Midland Maori Health monitoring framework is to collect the mandatory reporting measures such as Maori Health Plan national indicators and indicators of DHB performance (IDPs). When complete, the Midland framework will collate regional Maori Health Plan indicators, and other priority information related to investment, Whanau Ora, and workforce development. This information will be used to identify the leading performers among the Midland DHBs, facilitate sharing of best practice models of service delivery, and provide assistance where relevant.

The Māori Health Plans are informed by:

- Current and future district population characteristics including demography, socio-economic determinants, health status and demand for health services in the district.

The MHPs describes our Māori health focus areas during 2012-13 and is made up of three parts:

- A brief profile of our population.
- A collection of national-level Māori health indicators.
- A collection of Regional Māori health indicators.
- A collection of local Māori health indicators.

The Māori Health Accountability Framework

The Māori Health Accountability Framework will be further developed during 2012; the intent is to ensure that:

- All health priority workstreams are aligned to the intent detailed in respective Māori Health Plans across the five Midland DHB's
- All workstream developments include the active participation of Māori at all levels (Māori reps on workstream priority areas, GM Māori on Steering Group, Iwi Governance). All Māori representation will be endorsed by Te Tumu Whakarae the Midland Māori GM's Forum
- All workstreams integrate into their work the targets detailed in the RSP Māori Health Accountability Framework
- All proposed models of care have an integrated Māori Model of Care aligned to their development, that upholds Tikanga Best Practise standards
- Regional cultural audits are conducted across clinical service areas
- MOH National Health Indicators are tracked across Midland DHB's via the Midland Māori Health Monitoring Framework
- Māori Health Workforce Development remains a priority
- Workstreams ensure that primary care interface includes active participation and integration with Māori providers and Māori PHOs within Midland
- IT systems are able to track access, utilisation, intervention and outcome rates for Māori relative to the rest of the population

Key Enablers

HQSC

The Health Quality and Safety Commission NZ in partnership with the NHB have agreed a New Zealand 'Triple Aim'. This has been adopted by all agencies including DHBs:

- Improved quality, safety and experience of care

- Improved health and equity for all populations
- Best value from public health systems and resources

As a region we are working in partnership with HQSC, details are listed in individual service action plans and the Workforce section.

National Health Committee

We are committed to working with the National Health Committee across the regional network to ensure any regional decision making on prioritising investment is aligned to national processes.

Asset management

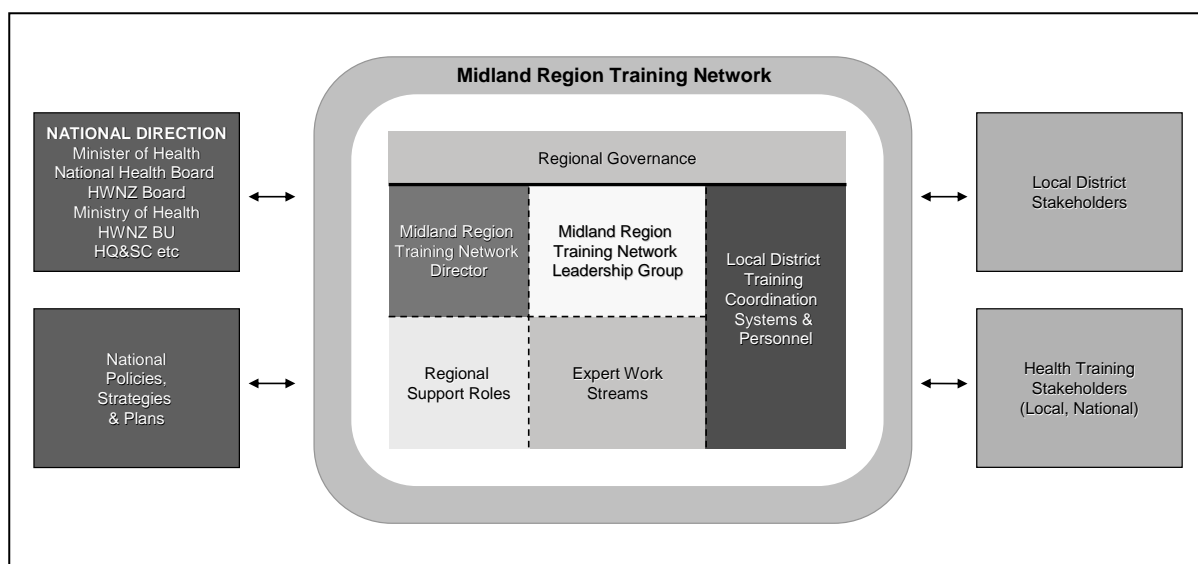
Our DHBs are producing capacity material to be considered as part of national planning activity. We will provide a regional commentary to sit above these individual Asset Management plans. This content is being developed with the NHB and will be appended to this document once completed.

Midland Region Training Network

The Midland Region Training Network is a cooperative system of interacting roles and functions. The components operate autonomously in a virtual and adaptive model. Mechanisms connect the components at a base level, while the Midland Region Training Network Leadership Group provides the overarching direction in agreement with Regional Governance. Externally a number of factors shape the network such as national direction, policies, strategies and plans. The network provides an interface for relationships with local district stakeholders and health training stakeholders more generally.

The aim of the establishment model is to build on the already effective infrastructure within the Midland region, in line with national direction, local advice and expertise. By enhancing what works now, we will be able to better meet the future health workforce needs of our hospitals and community

The diagram below outlines the cooperative systems, which define the Midland Region Training Network.



The Midland Region Training Network will deliver a range of programmes and initiatives in 2012/13 and provide the Midland Region DHBs with a mechanism for working together on clinical training. Regional resources will build on local infrastructure to establish a platform for regional cooperative activities.

Further information is appended to this document.

Primary Care Partnership

As a region we are working closely with our primary care partners to achieve the strategic goal of systems integration. The Primary care Leadership Forum, comprising representatives from each PHO in the Midland Region meets to discuss common work programmes and cooperation opportunities.

Objective	Actions to deliver improved performance	Measured by
Improve primary care innovation across the region through the Midland Regional Plan	<p>Implement a regional approach to primary care innovation through a joint DHB/PHOs working group with the following actions:</p> <ul style="list-style-type: none">• Investigation of tools for implementing clinical pathways across the region (e.g. Map of Medicine)• Sharing of resources and information on IT• Development of Performance framework for measuring outcomes• Share long term conditions frameworks across PHOs	<ul style="list-style-type: none">• Midland PHOs to meet quarterly to share innovation• Range of clinical pathways shared• Range of clinical pathway tools investigated and shared• PHO input into regional ISSP

Regional Implementation of the National Health IT Plan

The development and implementation of the Regional Information Services Plans (RISPs) is a key enabler of the Regional Services Plan (RSP). The RISP is a component of the RSP through which the regions document their IT capacity planning and action, bringing together the National Health IT Plan and regional priorities. Detailed schedules are appended to this document.

Appendices

Appendix 1

Regional Prioritisation Framework

We operate within a highly specialised, complex and demanding industry. There are a large number of national, regional and local strategies which influence how we plan, fund, provide, protect and promote health for our population. There are many competing demands for an already highly stretched and contestable pool of funding. To assist in balancing these demands and to provide some clarity, the Midland chief Executives have adopted a regional Prioritisation Framework

This Framework allows us to prioritise the work we do and provide a lens through which we view projects. While they are not an absolute in themselves, they help us rate one project against another and facilitate a robust discussion on which projects will be accepted, how we will review existing projects and which projects will be closed or discontinued. They provide a clear and simple guide that identifies issues of importance to us as a region against which decisions can be measured, tested and prioritised; as well as providing consistent direction.

Funding Implications

Each of the workstreams may, through the process of implementing their action plans, identify projects or initiatives that may require regional investment. A standardised process via the prioritisation framework described above will ensure these funding proposals are escalated through the governance groups as per the agreed processes.

It is important to refer back to the principles, that work driven through the RCSP is cost-neutral where possible, and the purpose of the action plans are to drive both clinical suitability and financial viability in the Midland DHBs where DHBs have agreed that regional action is required.

For 2012/13 full costings have not been produced as these are not in addition to that agreed by component DHB budgets. Funding is not generally pooled across the region, although an exception to this would be the funding for the implementation of maternity standards across our DHBs. Each DHB prioritises funding to meet the needs of its local population and meet national targets. Funding is increased where outcomes fall below national intervention rates.

Risk Management

Key risks identified and mitigation strategies

	Risk	Mitigating action
1.	NHB feedback requires extensive rework in a short time frame	CEs meeting with NHB face to face to discuss feedback and timing.
2.	Lack of agreement / endorsement by individual DHBs on action plans leads to only superficial changes to services	Continue to keep stakeholders engaged (Boards and CEs). Ensure understanding of legislative and NHB requirements. Explore sub-regional options for implementation of individual services.
3.	Not enough time resources available from key individuals to develop and action any real change	Understand developing resource need as implementation develops and address accordingly; seek CEs/Clinical endorsement on the importance of this work.

4.	Detailed plans are developed and costed but are ultimately rejected by CEs	Ensure the scope and TOR for each action group understood by all parties; regular progress report to CEs asking for general endorsement as work plans develop.
5.	Action plans are developed but do not have clinical endorsement	Ensure clinicians in each clinical service are well briefed by the group as planning develops and are given the opportunity to contribute.
6.	Time is wasted by 'starting from scratch' in developing action plans	The framework developed for the RSP is employed, clear terms of reference, experienced action group members, thorough evaluation of earlier work completed on regional service plans, implementation and local vulnerable services plans (rural health).
7.	Implementation is unsuccessful due to financial constraints	Prepare resourcing documents including financial and time commitments for acceptance and endorsement by Chief Executives / HealthShare Board as the programme develops. Include clear costs and timeframe.

Appendix 2

HealthShare Limited

HealthShare, established in 2001, is a regional Shared Services Agency jointly owned by Waikato, Bay of Plenty, Lakes, Taranaki and Tairāwhiti District Health Boards (shareholding DHBs).

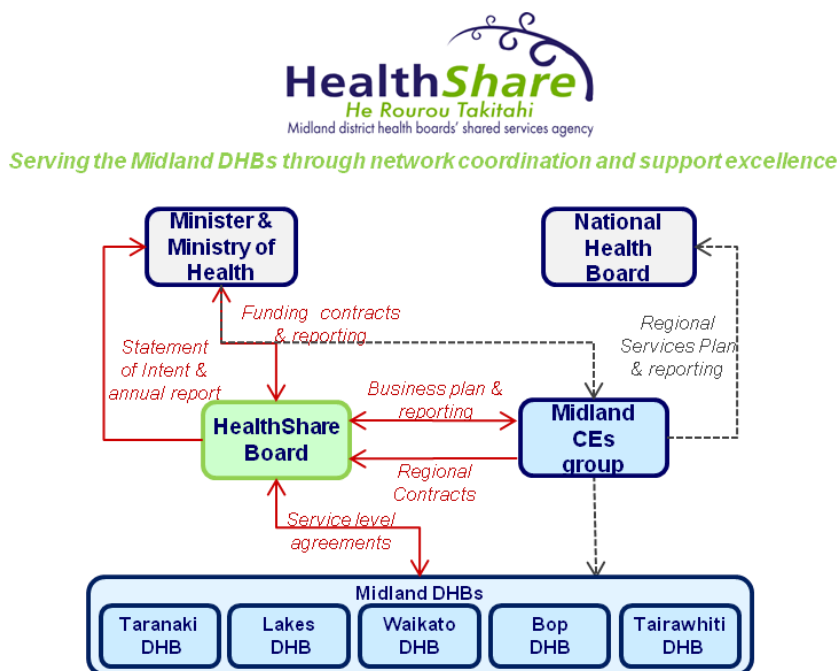
Until mid-2011 HealthShare operated as a single function shared service agency with the primary purpose of assisting the shareholding DHBs in meeting their statutory and contractual obligations to monitor the delivery and performance of services through the provision of routine audit programmes.

From August 2011 HealthShare has taken on an expanded role and now provides operational support to the Shareholding DHBs in a number of areas identified as benefiting from a regional solution. Where HealthShare provides services to non-shareholding DHBs, (eg. Audit and Assurance) this support is provided under contract.

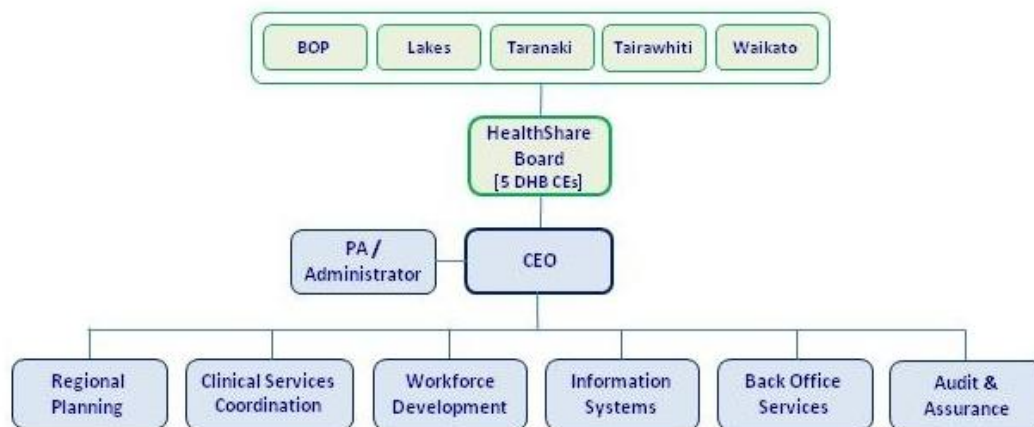
The services that HealthShare delivers to the region will continue to increase as national back office solutions are developed by HBL and future regional cases for change are approved. HealthShare continues to liaise directly with HBL as regional business cases are nominated, developed and approved. At the time of writing HBL has not begun to directly engage with HealthShare as the regional representative for future national business case implementation.

DHB staff from across the region continue to work alongside HBL on individual business case development. Savings targets for the Finance, Procurement and Supply Chain business case currently sit with individual DHBs.

HealthShare's Statement of Intent specifies the company's performance framework; the work to be undertaken in 2012/13 and the associated performance measures. HealthShare's Business Plan details, at a service level, the activities that have been purchased by the shareholding DHBs. The figure below is HealthShare's planning and reporting framework.



HealthShare's transition structure below shows the key functions areas as at 30 June 2012.



HealthShare will be in a state of evolution during the 2012/13 and 2013/14 years. The following regional services will be provided from HealthShare in 2012/13:

- Regional service planning and reporting facilitation
- Clinical Service Network facilitation
- Workforce planning and development services [components of the function in transition in 2012/13]
- Regional clinical information systems development support [components of the function in transition in 2012/13]
- Audit and Assurance service
- Internal Audit regional coordination [2012/13 transition]
- Recruitment and Selection regional service [2012/13 transition].

Appendix 3

Regional Workforce Planning and Development

In common with other developed health systems New Zealand faces a major challenge in acquiring a clinically skilled health workforce. Population demographics; service and workforce affordability and global shortages further compound an already demanding situation. Improving the supply of the health workforce is only part of the answer. To find enduring solutions service providers will need to strengthen innovation, new ways of working and the development of sustainable workforces into the future.

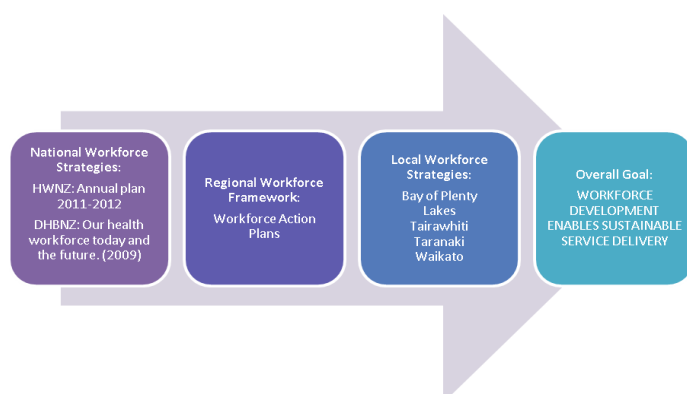
The region is highly rural and some of the provincial DHBs have long experienced difficulties of recruitment and retention. Travel times around the region (for both patients and staff) can be taxing and there are limited flight options between, for example Hamilton and either Gisborne or New Plymouth.

There is an uneven distribution of some professions (e.g. general practitioners) both across the region and within districts, leading to an uneven spread of workload and on-call requirements. There is a higher reliance on international medical graduates than for other regions – 50% versus 40% across the country.

Many small secondary services across the region, characterised by low FTE numbers, are vulnerable from a workforce perspective. Such services can be impacted by: significant disruption if one person leaves or is ill; unreasonable on-call requirements; limited professional support and development opportunities; and potentially insufficient clinical volumes to maintain competencies or develop new skills. There can be problems with credentialing and accountability for clinicians working in isolation. For such reasons, recruitment and retention of staff may be difficult.

Generalists with a sub-specialty interest are an important feature of Midland region clinical delivery, with increasing sub-specialisation in areas such as Taranaki and Tauranga. To ensure sustainable resourcing of a sub-specialised model, further regional clustering of services linked to the generalist specialist services may help to provide on-going access to scarce skill sets.

A range of workforce strategies at local, regional and national levels is needed to respond to the challenges of sustainable service delivery. The diagram highlights the interdependent nature of workforce strategies and the overarching goal of workforce development supporting sustainable service delivery.



National Context

Health Workforce New Zealand (HWNZ) - was set up in 2009 to provide national leadership on the development of the country's health and disability workforce. HWNZ has overall responsibility for planning and development of the health workforce. HWNZ aims to ensure that New Zealand has a fit-for-purpose, high quality and motivated health workforce, keeping pace with clinical innovations and the growing needs and expectations of service users and the public. HWNZ is a business unit of the National Health Board. Its work is overseen by an independent board with board members from business and across the health sector.

The establishment of HWNZ acknowledged the growing reality that a 'traditional' response to workforce planning would not meet New Zealand's future health and disability workforce demands. HWNZ are leading changes that will see New Zealand moving away from thinking only of increasing workforce numbers and towards investing in innovation and new roles, as well as continued development of the workforce.

HWNZ have identified and set key enablers and priorities to support regional workforce activity for implementation in Regional Service Plans across the 2011/12 and 2012/13 planning cycles.

Health Quality & Safety Commission - The Commission is responsible for assisting providers across the whole health and disability sector – private and public – to improve service safety and quality and therefore outcomes for all who use these services in New Zealand. The Commission is keen to work with regions to link local and regional initiatives with national work programmes being undertaken by the Commission during 2012/13 to:

- Build competency and capability in workforce.

Health Benefits Ltd - Health Benefits Limited (HBL) was established in July 2010 to reduce costs and deliver savings in administrative, support and procurement services for the health sector. HBL's role is to facilitate and lead initiatives that result in savings and efficiencies for District Health Boards (DHBs) on non-clinical initiatives. HBL will optimise the leverage opportunity available to 20 DHBs working as one.

State Services Commission - The State Services Commission (SSC) has a leadership role across the State sector. With the other central agencies - the Treasury and the Department of the Prime Minister and Cabinet - they work across the system with agencies to improve their performance and the quality of services they deliver to New Zealanders.

The State Services Commission requires all DHBs to produce a workforce strategy aligning business priorities, projected results and approaches to managing the people aspects of their business in the medium-long term. Health Workforce New Zealand (HWNZ) has developed an overarching national strategy and guidelines specific to the health sector to support DHBs to meet this requirement within their annual planning process.

Regional Context

The Midland DHBs have a history of working cooperatively in a range of areas and all five DHBs have agreed to progress activities towards regional cooperation in a planned manner.

Midland Region Clinical Services Plan (2010) – The Midland Regional Clinical Services Plan (MRCSP) describes a vision for the future of health services in the Midland Region. The plan provides a framework for DHB planning and acting co-operatively on a regional basis. The MRCSP (2010) contains actions which formulate the basis of our collective road map and describes what we will do, and when in order to implement our regional plan and to achieve our long-term goals.

Collective Action Framework - The *Midland Region Clinical Services Plan (2010)* outlines an approach to regional collective action.

The approach to collective actions builds on the current, substantial regional collaborative activities. These include the Regional Services Plan Steering Group, Clinical Networks and Action Groups and regular regional forums including:

- Chief Executives;
- Chief Medical Advisors;
- Directors of Nursing;
- Allied Health Leads;
- Chief Operating Officers;
- Māori Health Managers;
- Human Resources Managers;
- Planning and Funding Managers;
- IS Managers; and
- Chairs / Chief Executives

By working together as a region we will strengthen our health workforce in relation to culture, capability, capacity and change leadership. The four domains will be further developed and implemented through the strategic directions of regional workforce framework.

Regional Workforce Framework – The regional workforce framework is a key enabler of the Regional Services Plan. It provides our region with an overarching workforce development pathway. The pathway aligns with national direction and will assist Midland DHBs to continue to work together to strengthen innovation, new ways of working and the development of sustainable workforces into the future. The goal, outcomes, principles and strategic directions that will support the development of the Health Workforce in Midland Region are outlined in the diagram.



Local Context

All Midland Region DHBs engage in a range of workforce development activities as part of their day to day business. Mechanisms exist in all localities for DHB staff to participate in workforce planning and development activity whether through committees, professional groups, work streams or dedicated

roles. Each of the DHBs will continue to progress a range of workforce development initiatives. Further details can be found in each of the Midland DHBs Annual Plans 2012/13.

What We Will Do in 2012/2013

The table outlines the priority workforce initiatives that we will progress in 2012/13 through Regional Forums including Clinical Networks and Action Groups and through our dedicated regional workforce programme.

Deliverables	Lead	Timeline
Regional initiatives to progress sustainable service delivery		
Build workforce profiles to inform regional workforce planning and strategic assessment of future workforce requirements in the following areas: <ul style="list-style-type: none"> Rural Health and Cardiac. 	Regional Workforce Programme	June 2013
Develop a workforce planning methodology to address utilisation of existing workforce and the development of new workforce in the following areas: <ul style="list-style-type: none"> Renal Services and Radiology. 	Regional Workforce Programme	June 2013
Progress the development of a regional workforce action plan for maternity services.	Regional Workforce Programme	December 2012
Regional initiatives to address workforce challenges		
Compare current credentialing ⁴ processes for medical, nursing, midwifery and allied health clinical groups. Identify areas of regional consistency across these four areas.	Chief Medical Advisors Directors of Nursing & Midwifery Allied Health Leads	June 2013
Identify opportunities for regional or sub-regional joining up of sole practitioners / smaller services into arrangements of sustainable size and to meet professional body guidelines. <ul style="list-style-type: none"> Identify services where there are small workforce groups using an agreed regional measure. Progress regional clinical appointments across vulnerable services where there is agreement at an SMO and DHB level to do so. 	Chief Medical Advisors Chief Operating Officers Clinical Networks and Action Groups	June 2013
Progress initiatives towards regionally consistent recruitment services.	Human Resources Managers	June 2013
Consider options for how DHBs can work together to improve utilisation of medical locums. <ul style="list-style-type: none"> Explore regional utilisation patterns Identify target areas and develop strategies to optimise regional efficiencies. 	Medical Management & RMO Units Chief Operating Officers Human Resources Managers	December 2012 June 2013

⁴ Credentialing in this table is used broadly to encompass a range of activities supporting fit for practice assurance processes.

Deliverables	Lead	Timeline
Building regional workforce capacity, capabilities and focus		
Continue the Kia Ora Hauora Programme.	Māori Health Managers	Full year
Provide information and support uptake of new workforce roles where relevant, including the non-regulated workforces. <ul style="list-style-type: none"> Progress the development of at least three innovative clinical placements. 	Regional Workforce Programme	Full year
Work with the Health, Quality & Safety Commission to link local and regional initiatives with the national work programme to build competency and capability in workforce.	Regional Workforce Programme	Full year
Stock-take current workforce initiatives across the region.	Regional Workforce Programme	December 2012

Appendix 4

Information Services

As the Midland Regional Information Services Plan (MRISP) has begun to be implemented, recognition of the need to have integrated, multi-disciplinary, executive level governance and leadership has become clear.

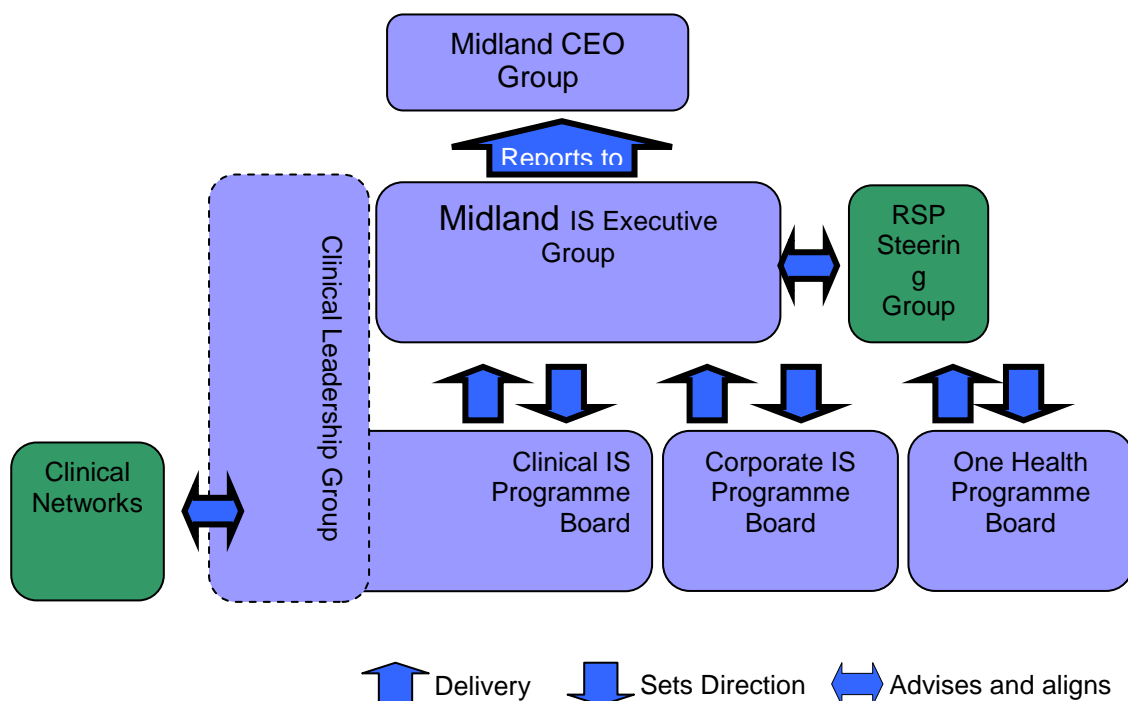
Additionally the need for strong clinical leadership and governance across the multiple activities in the clinical programme of work has become apparent, however given the work demands and time pressure that clinical leaders find themselves under, this leadership must be applied judiciously to ensure maximum return on the time invested.

With this in mind a delineation of the governance that will be applied to the work programmes being undertaken within the MRISP remit is required to ensure strong executive leadership is in place across all activities, and that the outcomes from the time available from the clinical leaders is maximised.

The purpose of the IS Executive group is to provide overarching guidance to all regional IT activities to ensure that the Midland IT programme of work is executed across the Midland DHB areas of accountability in line with Midland and National Clinical and Business directions.

The IS Clinical Leadership Group will provide clinical leadership to ensure clinical alignment across all aspects of the MRISP and other Midland region IS initiatives – definition, ongoing refinement and implementation. It has strong linkages to the RSP Clinical Leadership Group and other clinical groups in the region. It will be made up of a diverse range of clinical stakeholders from health organisations across the Midland region to provide a comprehensive, region-wide, and multi-disciplinary approach to clinical leadership of the implementation of the MRISP.

IS Portfolio Prioritisation



All capital IS investment in Midland region is prioritised through the IS Executive and Clinical Leadership groups. This process informs the annual capital planning and budgeting processes at each DHB, and for the region.

Prioritisation applies a consistent methodology and is based on the following principles:

- Prioritisation of IT investment is a business function not an IS one
- Resources are scarce; demand exceeds capacity
- IT services will be delivered from the region therefore all IT investment must be prioritised in one place, at a regional level
- The portfolio of investments will include a mix of strategic and tactical, local and regional and national
- Business priority, affordability and achievability must be considered
- IT assets require on-going investment and projects frequently cross multiple years. Investments must therefore be planned on a 4 year horizon

Requests for IS Investment are evaluated based on Business Priority, Affordability and Achievability. The aim of the methodology is to use a consistent approach to evaluating requests for investment and to provide input into the prioritisation process. It is only a tool to inform the prioritisation decision making process; it does not make the decision.

Metrics are used to establish the intent of the portfolio and ascertain alignment with target investment mix. The three metrics are:

1. Proportion of investment by organisation: Local vs Multi-organisation
2. Proportion of investment by programme: Clinical, Corporate, One Health
3. Proportion of planned investment in maintaining service: Lifecycle investment vs. other investment

The National Health IT Board (NHITB) priorities for 2012/13 will build on the 2011/2012 priority programmes (see below):



National Health IT Board Priority Programmes for 2011/12

eMedicines Programme

1. Community E-prescribing
2. Inpatient e-prescribing
3. Medicines reconciliation, medication management and administration
4. Universal List of Medicines
5. NZ Medicines Formulary

Regional Information Platform (DHBs)

1. Clinical Data Repositories/ Clinical Workstation
2. Patient Administration Systems
3. Imaging/PACS
4. Clinical support – Labs/Pharms
5. Continuum of care:
 - eReferrals and eDischarges

National Solutions

1. Oncology
2. Cardiac Health
3. InterRAI for Aged Care
4. Health Identity
5. Connected Health

Integrated Care Initiatives

1. Shared Care
 - Long Term Conditions
 - Maternity
 - Emergency View (Canterbury)
2. Primary Care
 - BSMC Initiatives
 - Patients First Initiatives (eg. GP to GP)

**Supported by ICT Infrastructure / Back Office - Finance & Supply-Chain, Data Centres.*

ITHealthBoard

Building on the above diagram, the National Health IT Board priorities included in the Midland IS Portfolio through to FY15/16 are:

- eMedicines programme

- Inpatient prescribing
- Medicines reconciliation, medication management and administration
- Universal List of Medicines
- NZ Medicines Formulary
- Regional Information Platform (DHBs)
 - Clinical Data Repositories
 - Clinical Workstation
 - Imaging/PACS
 - Laboratory
 - Pharmacy
 - eReferrals
 - eDischarges
- National Solutions
 - Cardiac Health
 - Health Identity
 - Connected Health
- Integrated Care Initiatives
 - Maternity

Implementation Programmes

Project/Programme	One Health programme
Description	<p>The key purpose of the programme is to provide the infrastructure base from which the provision of infrastructure services to the region is delivered. It includes:</p> <ol style="list-style-type: none"> 1 A secure and trusted data network 2 a single user sign-on capability 3 Core infrastructure services (e.g. regional data centre, storage, etc.) 4 Regional capabilities in the form of videoconferencing, secure email 5 Regionally delivered service management 6 Integration Services for regional and DHB specific applications 7 Disaster recovery and continuity of services. <p>Key projects included within the programme are:</p> <ul style="list-style-type: none"> ● Midland Connected Health ● Core Infrastructure Services ● Identity Management ● Integration <p>Future programme scope includes Advanced Service Management, Advanced Identity Management and Disaster Recovery.</p>
Key Milestones/timeline	<p>Forecast project timelines are as follows:</p> <ul style="list-style-type: none"> ● Midland Connected Health: in progress, due to complete in 2011/12 ● Core Infrastructure Services: May 2012 - November 2012 ● Identity Management: May 2012 - November 2012 ● Integration: May 2012 - April 2013 <p>Key milestones in 12/13 are:</p> <p>Q1 Sep 2012</p> <ul style="list-style-type: none"> ● Regional Platform design complete ● Regional authentication service design complete ● Regional integration platform design complete <p>Q2 Dec 2012</p> <ul style="list-style-type: none"> ● Regional Platform live and supporting ePharmacy project ● Regional Authentication Service live and supporting PACS and ePharmacy projects

	<ul style="list-style-type: none"> POC integration platform live <p>Q3 Mar 2013</p> <ul style="list-style-type: none"> Integration platform live and supporting ePharmacy project <p>Q4 Jun 2013</p> <ul style="list-style-type: none">
Risks/issues/ constraints/dependencies	<p>Key risks and issues are:</p> <p>R01 National agency and NHITB misalignment with Midland direction. Mitigation: Engage early with national agencies.</p> <p>R02 Midland not being able to establish effective governance arrangements and/or executive leadership. Mitigation: IS Executive, Clinical Leadership Group and Programme Boards established.</p> <p>R03 Insufficient investment (financial and people) capability. Mitigation: Funding has been prioritised by the IS Executive and Clinical Leadership Group.</p> <p>R04 Organisational changes impacting on regional delivery timeframes and approach. Mitigation: Programme is being governed and delivered as a regional programme independent from individual DHBs.</p> <p>R05 Vendors being unable to support this plan (due to resourcing, financial constraints, volume of change). Mitigation: Include vendor capability assessment in procurement processes. Align to national infrastructure initiatives.</p> <p>R06 Stakeholders not agreeing on requirements and/or approach. Mitigation: Programme is being governed and delivered as a regional programme independent from individual DHBs. Agreed requirements are a pre-requisite for programme participation.</p> <p>R07 Local priorities not aligning to regional / national priorities and there are delivery delays or show-stoppers. Mitigation: Programme has been prioritised by the IS Executive and Clinical Leadership Group, including consideration of competing local priorities. Programme is being governed and delivered as a regional programme independent from individual DHBs; local dependencies to be managed as part of the programme.</p> <p>R08 Securing resources becomes a constraint to progress. Mitigation: Programme has been prioritised by the IS Executive and Clinical Leadership Group</p> <p>R11 Technology does not meet the business "fit for purpose" requirements. Mitigation: Agreed requirements are the basis for solution design. Business requirements form the basis of the procurement processes.</p> <p>R12 Legacy system implications increase time, cost, scope of delivery. Mitigation: Solution design needs to consider legacy systems and be completed early in the project.</p>
Budget allocation by DHB	<p>Core infrastructure services Capital: 12/13 \$2.2m Annual operating cost: \$1m - 4m</p> <p>Identity management Capital: 12/13: \$1.1m Annual operating cost: \$500k</p> <p>Integration Capital: 12/13 \$940k</p>

	<p>Annual operating cost: \$500k</p> <p>DHB allocation for regional programmes is based on a PBFF share as follows:</p> <table border="1"> <thead> <tr> <th>DHB</th><th>Apportionment</th></tr> </thead> <tbody> <tr> <td>Bay of Plenty DHB</td><td>25%</td></tr> <tr> <td>Lakes DHB</td><td>13%</td></tr> <tr> <td>Tairāwhiti DHB</td><td>6%</td></tr> <tr> <td>Taranaki DHB</td><td>13%</td></tr> <tr> <td>Waikato DHB</td><td>43%</td></tr> <tr> <td>Region Total</td><td>100%</td></tr> </tbody> </table>	DHB	Apportionment	Bay of Plenty DHB	25%	Lakes DHB	13%	Tairāwhiti DHB	6%	Taranaki DHB	13%	Waikato DHB	43%	Region Total	100%
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Benefits and enablers from implementation and measures	<p>Key benefits are:</p> <ul style="list-style-type: none"> Improved IT support for regional and shared service priorities, access to systems and information, and implementation of business processes Improved business efficiencies through an ability to replace manual processes with electronic Improved cooperation Increased support for mobility of clinicians and delivery of tele-health solutions Increased trust and confidence in how access to IT services and information is managed Increased efficiency and productivity through less time spent logging into systems, searching for information and accessing support tools More cost effective deployment, management and maintenance of technology solutions Increased ability to consistently deliver new functionality to clinicians across the region Sharing learning's and resources (people and technical) effectively across the region Increased leverage of IT infrastructure across the region resulting in better management of operational costs Increased IT infrastructure capability such as disaster recovery and the provision of hosted solutions <p>The success of the programme will be measured through its enablement of regional projects that deliver direct business benefit. Key success measures are:</p> <ul style="list-style-type: none"> A single logon across the region and being able to access regional and DHB based applications Number of regional applications deployed, and non-DHB organisations/users using services delivered by One Health Ability for regional application delivery projects to be unconstrained by Infrastructure capacity Increased Infrastructure availability and reduced unplanned outages impacting the business 														
Health Priorities supported by implementation	<p>Connected Health</p> <p>Core infrastructure supporting all the NHITB priorities listed</p>														

Project/Programme	Medications Management Programme
Description	<p>The purpose of the Midland Regional Medication Management Programme is to determine and agree cost effective business process, information and technology solutions that best meet clinical and business needs and priorities in Midland Region and support local, regional and national service plans.</p> <p>It will prescribe the regional information services approach to delivering an environment (people, process, technology and structure) in which to implement medication management to the Midland region, and will govern medication management systems implementation across the Midland region.</p>

	<p>The programme objectives are:</p> <ul style="list-style-type: none"> • Agreement and implementation of regional standards for medication management business processes, policies and protocols, and access to information • Improved business efficiencies through replacing manual and/or inconsistent processes with consistent electronic processes across the region, and considering regional functions where appropriate • Access to medication management information and tools by any authorised health practitioner in Midland region • Implementation of hospital pharmacy systems based on an agreed regional configuration • Implementation of medicine reconciliation systems that allow clinicians to see an up-to-date list of a patient's medications based on an agreed regional configuration • Implementation of electronic prescribing systems in hospital and community settings for medication information transfer and decision support for clinicians • Implementation of medication administration systems, such as unit dose packaging, that provide a safer way to ensure that patients receive the prescribed medication at the prescribed dose. • Implementation of other medication management systems to support improved clinical and business processes such as clinical interventions systems, decision support and reporting and analysis • Alignment with national initiatives and the National Health IT Plan • Standard regional configuration and support processes • Strategic relationships with the key system suppliers • Business efficiencies through shared learnings and resources (people and technology) • Consolidation, where appropriate, to less instances of high cost information systems <p>Key projects included within the programme are:</p> <ul style="list-style-type: none"> • Midland Region Hospital Pharmacy • Taranaki DHB Medicines Reconciliation/ePrescribing • Midland rollout of Medicines Reconciliation/ePrescribing <p>Future programme scope includes Community ePrescribing.</p>
Key Milestones/ timeline	<p>Forecast project timelines are as follows:</p> <ul style="list-style-type: none"> • Midland Region Hospital Pharmacy: April 2012 – Dec 2013 • Taranaki DHB Medicines Reconciliation/ePrescribing: current – Dec 2013 • Midland rollout of Medicines Reconciliation/ePrescribing: TBC (not scheduled to start in 12/13) <p>Key milestones in 12/13 are:</p> <p>Q1 Sep 2012</p> <ul style="list-style-type: none"> • Hospital Pharmacy design complete • Software developments completed • ePrescribing/Medicines Reconciliation live in TDHB pilot wards <p>Q2 Dec 2012</p> <ul style="list-style-type: none"> • Hospital Pharmacy system testing complete • TDHB pilot wards evaluation completed <p>Q3 Mar 2013</p> <ul style="list-style-type: none"> • Hospital Pharmacy Acceptance testing complete • TDHB integrated medication management implementation complete <p>Q4 Jun 2013</p>

	<ul style="list-style-type: none">First two DHBs live on Hospital Pharmacy solution																														
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Budget allocation by DHB	<p>Hospital Pharmacy Capital: 11/12 \$1.3m 12/13 \$2.5m 13/14 \$2.4m Annual Operating: \$936k</p> <p>DHB allocation for regional programmes is based on a PBFF share as follows:</p> <table><tr><td>DHB</td><td>Apportionment</td></tr><tr><td>Bay of Plenty DHB</td><td>25%</td></tr><tr><td>Lakes DHB</td><td>13%</td></tr><tr><td>Tairāwhiti DHB</td><td>6%</td></tr><tr><td>Taranaki DHB</td><td>13%</td></tr><tr><td>Waikato DHB</td><td>43%</td></tr><tr><td>Region Total</td><td>100%</td></tr></table> <p>Taranaki DHB Medicines Reconciliation/ePrescribing Capital: 11/12 \$700k 12/13 \$600k 13/14: \$100k Annual Operating: \$28k</p>	DHB	Apportionment	Bay of Plenty DHB	25%	Lakes DHB	13%	Tairāwhiti DHB	6%	Taranaki DHB	13%	Waikato DHB	43%	Region Total	100%																
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Benefits and enablers from implementation and measures	<p>The programme benefits of an integrated Midland Region approach to the planning and delivery of medication management are:</p> <p>1. Increased business efficiency and reduced costs through:</p>																														

	<ul style="list-style-type: none"> • Reduced adverse drug events through medication reconciliation aids and decision support resources • Improve the use of medicines to treat patients • Reduce pharmaceutical wastage • Reduce administrative overhead and manual handling • Decreased medication errors in hospital and at the primary – secondary patient interface • Increased efficiency and productivity through less time spent searching for medications information and accessing support tools • Agreement and implementation of regional standards for medication management business processes, policies and protocols, and access to information • Improved business efficiencies through replacing manual and/or inconsistent processes with consistent electronic processes across the region, and considering regional functions where appropriate • Access to a common and consistent set of regional Medication Management services for clinical staff across organisational boundaries • Standardised systems and processes across the Midland region • Improved information that may be used for analysis <p>Cost reductions are difficult to assign directly to this programme as they are dependent on business change and the extent to which efficiencies are used to support improved safety or better meeting patient demand, rather than financial savings.</p> <p>However, financial benefits will be achieved in the potential for reduced length of stay, lower re-admission rates, and productivity gains in allowing clinical staff to focus on direct patient care rather than administrative tasks, establishing regional functions and reducing wastage.</p> <p>2. Improved patient safety through:</p> <ul style="list-style-type: none"> • Enhance the robustness of the inpatient medication administration process through bedside verification, unit dose packaging and other technologies (eg. Smart Pumps) • Maintain a clear electronic record of a patient's medication history, linked to other clinical information, which is accessible to all stakeholders – community and hospital based, providers and patients • Improved clinical decision making • Support the changing role of pharmacists from a reactive to proactive clinical role <p>Improved patient safety, and reduced risk, will deliver quality improvements which in turn will deliver downstream financial benefits.</p> <p>3. Increased implementation and support capability and reduced costs through:</p> <ul style="list-style-type: none"> • Standard regional configuration and support processes • Sharing learning's and resources (people and technical) effectively across the region • More cost effective deployment, management and maintenance of medications management systems • Increased ability to consistently deliver new functionality to clinicians across the region • The ability to gain economies of scale benefits of aggregating IT spend with vendors/suppliers • Removal of duplicated "same or similar" project activity and costs by having a single agreed implementation plan and better applying learning's and expertise across the region • Potential cost savings through combined purchasing power (supply chain)
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- Expected costs saving through standard implementations
- Reduced risk of fragmented funding across organisations and being unable to provide the minimum standard of service required in clinical service delivery, and of local, regional and national medication management activities not being aligned

It is estimated that a regional approach to implementation will deliver 25% savings when compared to undertaking multiple local implementations. The challenge is that current DHB budgets do not include provision for many components of a full medication management programme (for example, medicine reconciliation and ePrescribing solutions are not used by Midland DHBs) therefore any costs are additional to current DHB budgets rather than being a reduction in real terms.

4. Increased vendor capability and reduced costs through:
- Strategic relationships with the key system suppliers
 - Increased ability influence the development of new functionality and improve speed of delivery to the region
 - Potential cost savings through combined purchasing power. Commercial negotiations have already resulted in DHBs accepting a 50% reduction in ePharmacy licensing costs
 - Reduced risk of reliance on aging systems that have risks of decreasing vendor support resources
 - Opportunity for coordinated cooperation for application development with other DHBs. This will ensure the best use of resources and funds and maximise opportunity for savings by joint purchasing and sharing of information

It is estimated that a regional approach to implementation will deliver 25% savings when compared to undertaking multiple local implementations. Current DHB budgets do not include provision for many components of a full medication management programme and already include some of the regional benefit (for example, ePharmacy license costs in Midland DHBs are already based on a regional procurement decision) so the real impact on DHB budgets will be somewhat lower.

5. Alignment with national standards and strategies:
- Alignment with the national expectation of shared implementations of major applications
 - Alignment with national SMM initiatives such as the Universal List of Medicines, National Medicines Formulary, Primary / Community Care ePrescribing

Alignment with national standards by DHBs is expected. A regional programme approach will simplify their adoption.

Benefits for the Hospital Pharmacy project are:

Benefit	Amount
Reduced IT Support costs	\$247,170
Reduced IT Implementation Costs	\$1,729,658
Reduced Vendor support and maintenance costs	\$278,601

These benefits are cost avoidance benefits when compared to the replacement and upgrade costs of five DHB pharmacy systems. They are not a reduction from current costs.

Type	Benefits
Strategic Benefits	<ul style="list-style-type: none"> • Enabler for inter DHB cooperation and cooperation. This is the first regional IS project within the Midland region and will set a precedent for a number of other regional initiatives, increasing the ability to deliver future regional IS solutions. • This is the first step towards implementing the End-to-End NZ

		<p>Medication Safety Programme hospital solution in the Midland Region.</p> <ul style="list-style-type: none"> • Enabler for future supply chain management efficiency enhancements in the region. It would be possible to consider Just-In-Time ordering or bulk ordering of stock. This could also drive down overall stock levels and overall stock expiry in the region. • Increased vendor capability.
	Clinical Benefits	<ul style="list-style-type: none"> • Improved patient outcomes • Reduced clinical risk • Reduced medication errors • Sharing of pharmacy best practice across the region • Increased access to clinical information – e.g. sharing of patient script history.
	Risk Reduction Benefits	<ul style="list-style-type: none"> • Removal of risk of having unsupported pharmacy systems across four Midland DHBs - Waikato, Lakes, Bay of Plenty and Tairāwhiti. • More robust regional infrastructure will likely provide higher availability and more DR options in the case of a disaster. • Support resource sharing across the region, which would reduce overall HR risk. • Possibility of facilitating sharing of stock in emergencies.
	Standardisation and Consolidation Benefits	<ul style="list-style-type: none"> • Standardisation of medication related treatment guidelines and treatment protocols. • Access to treatment guidelines and protocols to those DHBs without the resources to generate these themselves. • Provides a common business language across the Midland region – e.g. sigs, C&A messages, etc. • Centralised drug reference information. • Regional PML. • Consistent electronic processes across the region, and considering regional functions where appropriate (e.g. the generation and maintenance of formularies, centralised purchasing functions, standard repackaging processes). • Standardised provision of drug information reducing cost and improving access and efficiency, improving patient outcomes and safety. • Centralised System upgrades and user support. • Consolidated Vendor support. (See hard benefits above) • Alignment of regional product development prioritisation. • Consolidation and rationalisation of IT infrastructure and IT support. • Shared training resource and reduction of overall training requirements across the Midland region. • Possibilities of reporting on a regional and individual DHB level. • Cost avoidance because of some of the efficiencies gained through regional cooperation. • Reporting on a regional level with consequent advantages in forward planning and budgeting. • Provides for future implementation of emerging national standards such as NZULM, NZTM.
	<p>Benefits for the Taranaki DHB Medicines Reconciliation/ePrescribing project are:</p> <ul style="list-style-type: none"> • Reduction in medication prescribing error <p><i>Computerised decision support at the time of prescription will reduce a number of prescribing errors:</i></p>	

	<ul style="list-style-type: none"> ○ Dangerous medicine to medicine automatic interactions checking ○ Dangerous medicine to allergy interactions checking. ○ Dose range checking ○ Guaranteed legibility ○ Instant access to past medication history – able to access previous electronic charts from previous admissions ○ Reduced transcribing and recharting errors. ● Reduction in medicine administration error for inpatients <ul style="list-style-type: none"> ○ Tracking and highlighting of missed dose administrations ● Improvement in clinical workflow – faster admissions and discharges, <ul style="list-style-type: none"> ○ Reduced time wastage in seeking drug charts ○ Ability to access drug charts from remote locations (e.g. clinician can access drug chart from home over citrix, or from other area in hospital campus) ○ Pharmacy review of drug charts can be done remotely ○ Where necessary, medicines could be dispensed to the ward from pharmacy in a more timely fashion through integration of the prescribing and pharmacy dispensing/stock control systems. ● Improved report and audit capability of medicines and drug usage in real time. <p>Taranaki DHB quantified benefits will be aligned with the national eMedicines Programme and based on the NZIER and NZ MSP analysis that shows a total NZ benefit based on 7475 beds NZ wide of \$91.7m.</p>
Health Priorities supported by implementation	<ul style="list-style-type: none"> ● eMedicines programme <ul style="list-style-type: none"> ○ Inpatient prescribing ○ Medicines reconciliation, medication management and administration ○ Universal List of Medicines ○ NZ Medicines Formulary ● Regional Information Platform (DHBs) <ul style="list-style-type: none"> ○ Pharmacy

Project/Programme	Clinical Information Systems Programme
Description	<p>The purpose of the Midland Clinical Information Systems programme is to support clinical priorities in Midland by providing clinicians with access to information, tools and functionality for clinical decision making, appropriate to their role(s).</p> <p>Clinical Information Systems must ensure access to information and functionality for an increasing community of users so as to drive sector productivity, contribute to reduced patient safety risk, support patient care across a regional setting, and support cross-regional referencing of key information by health care providers within and across Midland region organisations.</p> <p>The programme will prescribe the regional approach to the delivery, and ongoing service management of, Clinical Information Systems across the Midland region.</p> <p>The programme delivers the key national priorities of eReferrals, eDischarges, Clinical Data Repository and Clinical Workstation. The Clinical Data Repository is a key building block for patient access to their health information in line with the National Health IT Board 2014 Vision.</p> <p>The CIS programme recognises that investment in clinical information systems must be aligned with the priorities of clinicians in the Midland area. However, clinical information systems must be integrated and CIS investments cannot be made in isolation of each other.</p> <p>Regional Priorities are:</p> <ul style="list-style-type: none"> ● Identification of clinical future state and design required for CIS and how to get there.

	<ul style="list-style-type: none"> • Deployment of the Orion Concerto Clinical Workstation across the region • Primary care access to timely electronic discharge summaries. • Primary to secondary care Referrals management (Note: The management of the primary care end of the referral management process is being run as a separate project by the Midland Health Network. The CIS programme will ensure connectivity with the primary systems and the management of primary to secondary referrals once they hit the secondary/tertiary hospitals as well as within hospital and inter-hospital referrals). • Regional access to laboratory results information including primary access to hospital results. <p>It is important to note that there are also local priorities for clinical information systems. Some that have been identified so far are noted below; this is not an exhaustive list.</p> <p>To meet these priorities the CIS programme must, as a minimum, deliver Clinical Workstation and Clinical Data Repository components. Other clinical systems, especially those with a regional focus will be brought into scope as agreed regionally.</p> <p>The priorities above will be confirmed and/or updated after the Scope, Planning and Analysis stage of the programme has been completed.</p> <p>Where local priorities must be met solutions will be designed with regional input and be aligned to the regional architecture for clinical information systems. Regional priorities will be designed and delivered based upon regional requirements but may be implemented DHB by DHB to ensure progress and to test any application before widespread implementation.</p> <p>Key projects included within the programme are:</p> <ul style="list-style-type: none"> • Clinical Workstation • Access to Laboratory Results (CDR establishment) • eReferrals: primary care rollout completed in 11/12 • Medication Management (described fully in the section above) <p>Future programme scope includes rollout of the regional RIS/PACS solution to Lakes and Taranaki DHBs and extension of the regional CDR.</p>
Key Milestones/timeline	<p>Forecast project timelines in 12/13 are as follows:</p> <ul style="list-style-type: none"> • Clinical Workstation: TBC • Access to Laboratory Results (CDR establishment): TBC <p>Key milestones for Clinical Workstation and Clinical Data Repository in 12/13 are subject to completion of the scoping which is due to be completed in 2011/12.</p> <p>Clinical Workstation and eReferrals has no funding currently allocated in 12/13.</p> <p>Access to Laboratory Results is forecast to deliver a foundation CDR by June 2013.</p>
Risks/issues/constraints/dependencies	<p>Key risks and issues for the programme are being defined as part of CIS Scoping.</p>

Budget allocation by DHB	<p>Access to Laboratory Results Capital: 12/13 \$1.1m Annual Operating: \$340k</p> <p>DHB allocation for regional programmes is based on a PBFF share as follows:</p> <table data-bbox="632 398 1166 645"> <tr> <th>DHB</th><th>Apportionment</th></tr> <tr> <td>Bay of Plenty DHB</td><td>25%</td></tr> <tr> <td>Lakes DHB</td><td>13%</td></tr> <tr> <td>Tairāwhiti DHB</td><td>6%</td></tr> <tr> <td>Taranaki DHB</td><td>13%</td></tr> <tr> <td>Waikato DHB</td><td>43%</td></tr> <tr> <td>Region Total</td><td>100%</td></tr> </table>	DHB	Apportionment	Bay of Plenty DHB	25%	Lakes DHB	13%	Tairāwhiti DHB	6%	Taranaki DHB	13%	Waikato DHB	43%	Region Total	100%
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Benefits and enablers from implementation and measures	<p>CDR benefits are</p> <ul style="list-style-type: none"> • Access to a wide range of clinical information on a patient/consumer resident in the region • Improved clinical decision making • Increased efficiency and productivity through less time spent searching for core clinical information • Increased support for mobility of clinicians • Reduction in duplicate clinical procedures such as laboratory tests • Increased visibility of the parties engaged in an individual's healthcare leading to improved coordination of care • Support for out of region clinical transactions • Increased trust and confidence in how health information is managed and accessed • Increased patient engagement and empowerment • More cost effective deployment, management and maintenance of clinical data repository technology <p>CWS benefits are:</p> <ul style="list-style-type: none"> • Improved clinical decision making • Increased support for mobility of clinicians • Increased efficiency and productivity through less time spent searching for core clinical information and accessing support tools • Increased ability to consistently deliver new functionality to clinicians across the region • Improved support for priority services • Increased trust and confidence in how health information is managed and accessed • More cost effective deployment, management and maintenance of clinical workstation technology • Adoption of national configuration as the regional CWS solution 														
Health Priorities supported by implementation	<ul style="list-style-type: none"> • Regional Information Platform (DHBs) <ul style="list-style-type: none"> ○ Clinical Workstation ○ Clinical Data Repository ○ eReferrals ○ eDischarges 														

Medicine Safety Programme

In response to a joint National Health IT Board (NHITB) and Health Quality and Safety Commission priority of Medicine Safety Programme, DHB regions are expected to invest regionally in 2012/13 to have e-medicine capability to support the roll out of the national *Medicine Safety Programme* over 2012/13 and 2013/14. The IT cost to each region is approximately \$5 million..

The Midland Region Information Services Plan 2011-2014 (MRISP) identifies the delivery of standardised Medication Management systems across the region as a goal that directly supports the Midland Clinical Services Plan future vision for 2021 and the National Health IT Plan vision for 2014.

The purpose of the Midland Regional Medication Management Programme is to determine and agree cost effective business process, information and technology solutions that best meet clinical and business needs and priorities in Midland Region and support local, regional and national service plans.

It will prescribe the regional information services approach to delivering an environment (people, process, technology and structure) in which to implement medication management to the Midland region, and will govern medication management systems implementation across the Midland region.

The Midland IS Portfolio identifies support of the Taranaki DHB e-medicines implementation as a funding priority for 2011/12 and 2012/13 and full regional rollout in subsequent years. Implementation of a regional hospital pharmacy solution is a funding priority for 2011/12 to 2013/14.

Appendix 5

Midland Region Training Network

This section outlines how the Midland Region Training Network (MRTN) intends to work. It defines the purpose and how it needs to function to deliver support for our health workforce.

Principles

These principles govern the way the MRTN works:

- build on existing training systems and pathways
- best use of workplace education and training resources
- work together to enhance what we do
- demonstrate added value.

Core activities of the network

Core activities include:

- identify regional training priorities
- provide strategies and direction to enhance training outcomes
- promote information flow and coordination
- engage with relevant stakeholders
- facilitate regional consistency and deliver mechanisms for cooperation across the network
- identify opportunities to share resources
- enhance and simplify systems and processes
- set priorities that are reflective of regional population needs, the requirements of the workforce and national and regional directives

Key functions of the network:

The Midland Region Training Network will:

1. Provide the structures and processes to promote effective coordination for the Midland Region by:
<ul style="list-style-type: none">- leading and contributing to relevant strategic planning across the region- focusing on practical solutions and what works for the region- maintaining a focus on the multidisciplinary environment and all service settings.
2. Plan and set the priorities that reflect the needs of the workforce by:
<ul style="list-style-type: none">- using high quality evidence and intelligence to determine priorities for the region and inform workforce education and training planning- agreeing deliverables and milestones- establishing mechanisms for monitoring outcomes and reporting.
3. Influence better training outcomes by:
<ul style="list-style-type: none">- aligning outcomes with regional priorities- providing advice and expertise- facilitating changing environments and technology advancement, such as e-learning- promoting continuous improvement
4. Work with health, education and training providers to support training system pathways by:
<ul style="list-style-type: none">- aligning with what works now and adapting to meet future needs- providing strong links and liaising with regional and national health and education leaders- offering specialist knowledge and guidance related to educational matters.

Midland Region Training Network Leadership Group membership

The Midland Region Training Network Leadership Group is an essential element of the MRTN. They form an interface with stakeholders and are the source of strategic direction that shapes the network and its work. The Midland Region Training Network Leadership Group will provide the oversight mechanism for coordinating and monitoring activity.

The purpose of the Midland Region Training Network Leadership Group is to:

- deliver an effective leadership structure for workplace education and training
- provide advice and expertise to influence better training outcomes for the Midland Region health workforce
- establish the priorities that reflect the needs of the regional workforce
- work with health and education providers to enhance current and future mechanisms supporting training systems and pathways
- coordinate plans based on local, regional and national innovation, strategies and approaches.

Governance

The Midland Region Training Network Leadership Group will contribute to governance by:

- developing a strategic perspective and formulating recommendations
- providing information both formally and informally, through reports and discussion.

Service interface

The ability of the network to positively interface with existing and new service providers is fundamental to its success. A constructive interface ensures on-going development and the realisation of effective training systems and pathways.

This will be achieved by:

- establishing effective communication mechanisms with stakeholders
- identifying and communicating national and regional training priorities
- fostering the relationship with local, regional and national health education and training stakeholders including the health workforce
- sharing a clear and common understanding of the respective expertise and perspectives
- streamlining regional process design and models.

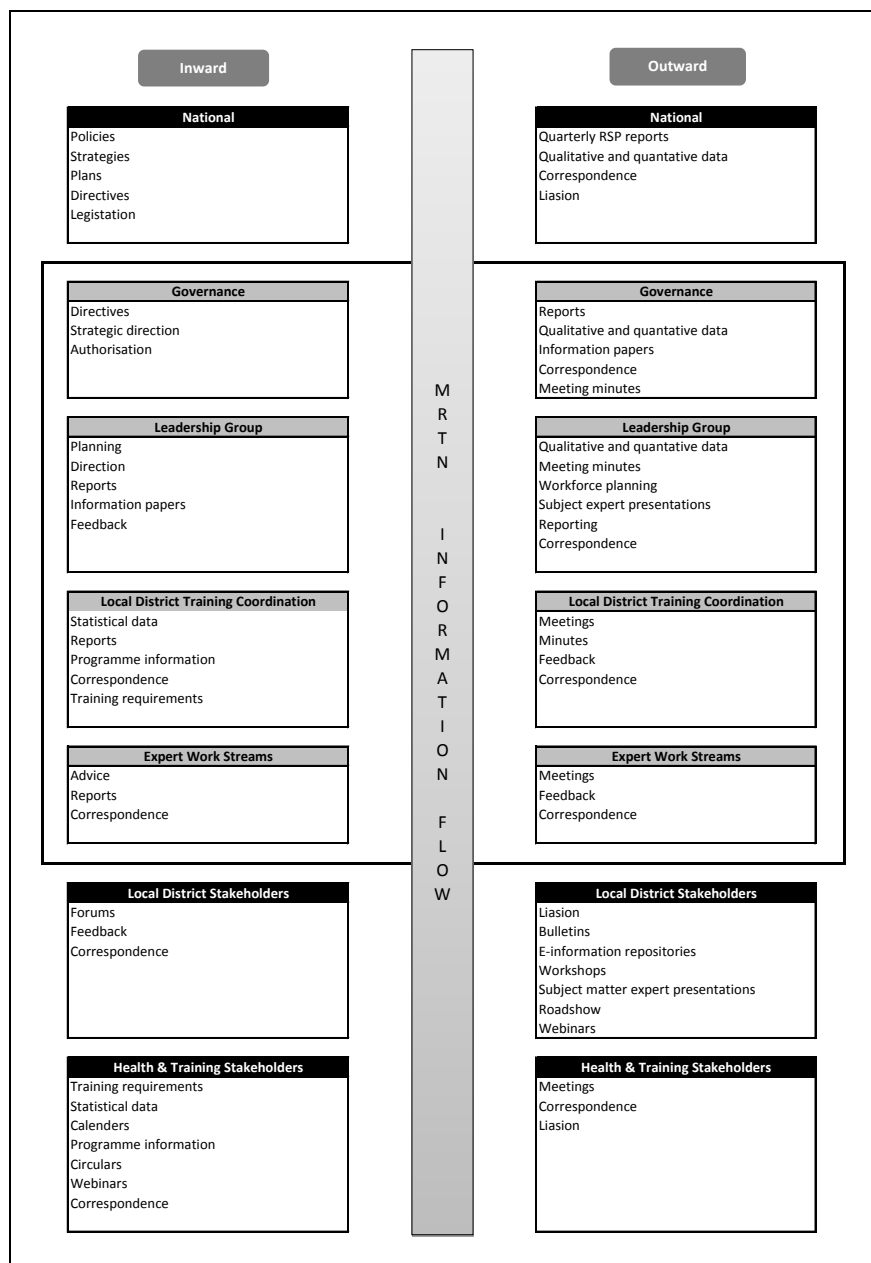
Collaboration with regional training hubs across the country will occur through information exchange, regular engagement and joint activity where there is consensus and agreement to do so.

Information flow and reporting

The MRTN will require effective and efficient two way communication channels to build an integrated approach to information flow. The communication model will be based on the development of standard reporting mechanisms and metrics. The model must meet the needs of stakeholders, the leadership group, reflect good business practice and implement an agreed communication plan.

Reporting, focuses on opportunities for improvement, sets targets, measures against those expectations, and provides a history for trend analysis and output results. Monitoring outcomes against set targets will focus informed decision making.

The diagram on the following page outlines the flow of information including external stakeholders.



Work streams

The MRTN will deliver some activities via specific work streams. In the first year the focus will be to improve the coordination and integration of training and education for:

- PGY1 and PGY2 medical trainees. In line with national guidance we will aim for a minimum of three programmes by 1 July 2013.
- Primary care including GP training with a focus on enhancing current systems and processes.

Work stream success is reliant on the effective implementation of the MRTN infrastructure. The work streams are expected to:

- deliver improvements in education and training
- maximise knowledge sharing
- support better access to expert knowledge
- assist flexible training opportunities.

The anticipated outcome will be the provision of systems and pathways that promote the best possible training opportunities for the regions health workforce.

2012/13 outputs

The table summarises core outputs to build Midland Training Network functions until 30 June 2013.

The proposed activity aims to build on and enhance local infrastructure, establish a platform for regional cooperative activities and to satisfy national requirements. The core outputs were informed by a wide range of local district contributors and detailed analysis of current arrangements with each DHB.

MRTN PRINCIPLES	CORE OUTPUTS	RESPONSIBILITY	HWNZ ROLE LINK
Training and Education Programmes <ul style="list-style-type: none"> Optimisation of current systems and processes as the basis for standardisation Optimisation at the right level and in the right areas to achieve improvement rather than creating complexity and inefficiencies 	<ol style="list-style-type: none"> Stock take current education and training programmes aligned with clinical training pathways Establish a shared e-calendar of e-courses Regional best practice evaluation framework developed Scope and implement the work programme for the PGY1 & 2 work stream Scope and implement the work programme for the primary care including GP training work stream 	MRTN Leadership Group MRTN Director Regional Support Roles PGY1 & 2 Expert Work Stream Primary Care Expert Work Stream Local District Training Systems & Personnel	Standardising training and education programmes
Clinical Placement Coordination Build on rather than duplicate existing systems and processes	<ol style="list-style-type: none"> Develop regional strategy, communication channels and e-repositories to support the local district coordination role Stock take current coordination systems supporting specialist training programmes Undertake work flow analysis of core system processes Review resource requirements for the adequate support of the local district coordination role including supervision and mentoring 	MRTN Leadership Group MRTN Director Regional Support Roles Local District Training Systems & Personnel	Coordinating clinical placements to support specialist training programmes
Career Planning <ul style="list-style-type: none"> Enhance current systems and processes Align with National Engagement Group position for Doctors 	<ol style="list-style-type: none"> Review career planning arrangements in each local environment and identify key learning's that could be shared regionally to assist with optimising the current processes Establish central web access for sharing career planning information and resources Implement regional status reporting mechanism Support Midland DHBs to ensure 100% of trainees in receipt of HWNZ funding have career plans Outline mentoring processes regionally and key learning's that could help improve current processes Explore options to provide supports for self-mentoring 	MRTN Leadership Group MRTN Director Regional Support Roles Local District Training Systems & Personnel	Supporting trainees to develop and implement career plans and provision of mentoring services
Accredited Placements Focus and activity is delivered without detracting from meeting local need	<ol style="list-style-type: none"> regional repository of current Establish accredited trainee placements Identify potential non-traditional settings and opportunities Map funding streams for potential placements including review of employment and professional requirements to inform recommendations Scope and implement the work programme for the primary care including GP training work stream 	MRTN Leadership Group MRTN Director Regional Support Roles Primary Care Expert Work Stream Local District Training Systems & Personnel	Sourcing traditional and non-traditional accredited student placements

Workforce Initiatives <ul style="list-style-type: none"> Demonstrate added value Processes enhance local systems 	<ol style="list-style-type: none"> Review resource requirements for the adequate support of the local district administration function Regional coordination of the Midland Leadership Programme Outline local district information requirements for HWNZ workforce initiatives 	MRTN Leadership Group MRTN Director Regional Support Roles Local District Training Systems & Personnel	Administering workforce initiatives, for example, voluntary bonding, leadership development, Advanced Trainee Fellowship Scheme and HWNZ innovations e.g. the Physician Assistant role
Trainee Planning <ul style="list-style-type: none"> Take a whole of systems view to developing a more integrated regional approach to service and workforce planning Best use of resource 	<ol style="list-style-type: none"> Develop matrix clearly outlining workforce planning needs, activity, requirements, functions and responsibilities Produce workforce planning methodology for region Develop tools and processes to support workforce planning functions specific to identifying trainee volumes Use workforce intelligence to determine priorities for the region and inform workforce education and training planning 	MRTN Leadership Group MRTN Director Regional Support Roles	Ensuring workforce training aligns with national service delivery needs and regional clinical service plans
Skills and Simulation Focus and activity is delivered without detracting from meeting local need	<ol style="list-style-type: none"> Representation in national SSC processes Establish regional information on: <ul style="list-style-type: none"> Current use of simulation based education Future needs of simulation based education Current resources Scope requirements for mobile skills and simulation 	MRTN Leadership Group MRTN Director Regional Support Roles Local District Training Systems & Personnel	Implementing and overseeing a national skills and simulation based education strategy.

Indicative resources for year one (12-18 months)

The Midland Region Training Network will be resourced to ensure that it is in a position to respond to national direction and proactively plan and implement core activity. Regional resources will build on local infrastructure to establish a platform for regional cooperative activities.

The following roles will support the Midland Training Network to deliver the expected functions:

ROLE	PURPOSE
Midland Region Training Network Director	Work in partnership with the MRTN Leadership Group and Regional Workforce Development Manager to provide strategic oversight of clinical training activity for the Midland Region Training Network. This role will be the key link and liaison with health training stakeholders for the Midland Region.
Executive Assistant	Administrative support for the Midland Region Training Network Director and regional support roles.
Midland Region Training Network Secretariat	Provide secretariat services to the Midland Training Network including policy, technical and administrative advice; information and communication flow; MRTN work streams; and facilitating delivery of the MRTN outputs.
MRTN Programme Coordinator	Support and progress implementation of the MRTN 2012/13 outputs.
MRTN Information Analyst	Support the Midland Region Training Network with informed intelligence including the preparation and interpretation of workforce needs, modeling and forecasting data; and advice for training purchasing, innovation and strategic projects.

Appendix 6

Outcomes Framework

The key to understanding this Plan and the associated annual plans for our DHBs is our Intervention Logic Diagram or Outcomes Framework.

The health system is necessarily complex, with a number of organisations, strategies and priorities, the key elements of which can be represented in an outcomes framework, or intervention logic diagram. The following diagrams illustrate how (a) the national, regional and local elements align; and (b) how they contribute to positive outcomes for the population we serve. Each Midland DHB also has an Outcomes Framework aligned with this regional version and can be found in the corresponding section in each Midland DHB Annual Plan.

For a definition of terms like “intervention logic”, “measures”, “outputs” etc., please refer to the appendices.

National Outcomes

Our overarching health and economic strategies are developed at a national level by the New Zealand Government. Health cannot be considered in isolation from our economic strategies – health consumes approximately 9% of New Zealand’s GDP (gross domestic product). We are stewards of our share of that funding and must be accountable to the population we serve, as well as to the New Zealand taxpayer.

Ministry of Health's Performance Story

Ministry of Health's Performance Story				
Health & Disability System Outcomes	All New Zealanders lead longer, healthier and more independent lives		New Zealand's economic growth is supported	
Overarching health sector goals	Better, Sooner, More Convenient Health Services for all New Zealanders			
Policy Drivers	Regional Cooperation	Integrated Care	Value for Money	
Ministry of Health Intermediate Outcomes	Good health and independence are protected and promoted	A more unified and improved health and disability system	People receive better health and disability services	The health and disability system and services are trusted and can be used with confidence



Regional Outcomes

Our regional outcomes must align with our overarching national health and economic strategies. As a region our DHBs collectively contribute to our strategic outcomes, indicators and objectives, all of which will assist us to contribute to the national outcomes.

Midland Vision	All residents of Midland District Health Boards lead longer, healthier and more independent lives				
Regional Strategic Outcomes	To improve the health of the Midland population		To reduce or eliminate health inequalities		
Regional Outcome Indicators	To increase our average life expectancy		To reduce premature death rates		To improve our amenable mortality rate
Regional Strategic Objectives	To build the workforce	Systems Integration across the continuum of care	To improve quality across agreed regional services	To improve clinical information systems	To improve Māori Health outcomes
By focusing on these objectives, we will be able to drive change that enables us to live within our means.					



RSP Focus Areas	Vulnerable Services	National Priority Services	Workforce	Information Systems	Key Enablers
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Our Strategic Outcomes

The Midland DHBs are working together to deliver a clinically and financially sustainable Midland health system, where services are provided as close to people's homes as possible. To this end, the Midland DHBs have agreed two strategic outcomes:

Strategic Outcome 1: To improve the health of the Midland population

Taking positive steps about how we live and what decisions we make right now is very important to our future health and wellbeing. Our services, programmes and initiatives will enable people to increase their skills and confidence to maintain good health or manage their health problems.

Strategic Outcome 2: To reduce or eliminate health inequalities

We are committed to moderating the effects of disparity through, firstly, *identifying* health disparities and, secondly, *funding and providing* programmes that target inequalities and improve access to services.

For each of these Strategic Outcomes, the Midland DHBs have identified a core set of performance measures, which will demonstrate whether we are achieving our goals of making a positive difference in the health of our population and reducing health inequalities.⁵

These link with the roles and functions DHBs are legislated to provide. These measures are:

- Life expectancy - Life Expectancy is a calculation of life expectancy at birth based on the mortality rates of the population in each age in a given year
- Premature death- Early death is the rate of deaths before the age of 75 years amendable mortality
- Amendable mortality- are deaths that could in theory be averted by good health care

These indicators will provide a high level a whole-of-system view of the health sector in the Midland region. Monitoring those over time will give us a picture of the health of the Midland DHB region with logic suggesting that the activities, actions and initiatives DHBs implement will impact on these indicators.

Looking at the life expectancy differences, early death rates, amenable mortality and infant mortality between populations and geographical areas as well as comparing our results to other regions and national averages will enable us to plan and target resources and activities where the most health gain can be made.

⁵ While we have developed a set of regionally consistent measures, there will be variation, allowing for local initiatives, responding to the needs of the population.

Appendix 7

Glossary of Terms

Activity	What an agency does to convert inputs to Outputs.
Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver the outputs required to achieve the Government's goals.
Efficiency	Reducing the cost of inputs relative to the value of outputs.
Effectiveness	The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
Intervention logic model	A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes
‘Living within our means’	Providing the expected level of outputs within a break even budget or National Health Board (NHB) agreed deficit step toward break even by a specific time.
Management systems	The supporting systems and policies used by the DHB in conducting its business.
Objectives	Is not defined in the legislation. The use of this term recognises that not all outputs and activities are intended to achieve “outputs”. For example, increasing the take-up of programmes; improving the retention of key staff; improving performance; improving Governance etc. are ‘internal to the organisation and enable the achievement of ‘outputs’.
Outcome	<p>Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to a end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome. (Refer http://www.ssc.govt.nz/glossary/)</p> <p>A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989).</p>
Outputs	Final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).
Performance measures	Selected measures must align with the DHBs Regional Service Plan and Annual Plan. Four or five key outcomes with associated outputs for non-financial forecast service performance are considered adequate. Appropriate measures should be selected and should consider quality, quantity, effectiveness and timeliness. These measures should cover three years beginning with targets for the first financial year (2012/13) and show intended results for the two subsequent financial years. (Refer to www.ssc.govt.nz/performance-info-measures)

Productivity	Increasing outputs relative to inputs (ie: either more outputs produced with the same inputs, or the same output produced using fewer inputs)
Regional cooperation	<p>Regional cooperation refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist.</p> <ul style="list-style-type: none"> • Northern: Northland DHB, Auckland DHB, Waitemata DHB and Counties Manukau DHB • Midland: Bay of Plenty DHB, Lakes DHB, Tairāwhiti DHB, Taranaki DHB and Waikato DHB • Central: Capital and Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, MidCentral DHB, Waitemata DHB and Whanganui DHB • Southern: Canterbury DHB, Nelson Marlborough DHB, South Canterbury DHB, Southern DHB and West Coast DHB <p>Regional cooperation for some clinical networks may vary slightly. For example Central Cancer Network contains eight DHBs, Taranaki DHB and Tairāwhiti DHB in addition to the Central Region DHBs.</p>
Results	Sometimes used as a synonym for 'Outcomes'; sometimes to denote the degree to which an organisation successfully delivers its outputs; and sometimes with both meanings at once. (http://www.ssc.govt.nz/glossary/)
Strategy	See Ownership (http://www.ssc.govt.nz/glossary/)
Sub regional cooperation	Sub regional cooperation refers to DHBs working together in a smaller grouping to the regional grouping, typically in groupings of two or three DHBs and may be formalised with an agreement. For example a Memorandum of Understanding. Examples of sub regional cooperation include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (Central Alliance), Capital and Coast, Hutt Valley and Wairarapa DHBs and Canterbury and West Coast DHBs.
Targets	<p>Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets.</p> <p>A target can also be in the form of a standard or a benchmark.</p>
Values	The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which, in turn, tend to be drawn from social norms, democratic principles and professional ethos. (http://www.ssc.govt.nz/glossary/)
Value for money	The assessment of benefits relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

ⁱⁱ Ministry of Health, HDI Technical note (August 2009), Life expectancy in New Zealand, 2005-07

ⁱⁱⁱ The graphs are sourced from Mortality and Demographic Data 2006, Ministry of Health. Age standardisation calculations use population data sourced from Statistics New Zealand, standardised to the New Zealand population age distribution.