

Midland District Health Boards
Regional Services Plan
2014/15





Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

2 JUL 2014

Mr Ron Dunham
Chief Executive Officer
Lead Chief Executive Officer for Midland Region District Health Boards
Lakes District Health Board
Private Bag 3023
ROTORUA 3046

Dear Ron

2014/15 Regional Services Plan

This letter is to advise you that I approve the 2014/15 Midland Regional Services Plan (RSP). I appreciate the significant work that has been undertaken and I thank you for your effort.

As greater integration between regional DHBs supports more effective use of clinical and financial resources, I expect DHBs to make significant progress in implementing their RSPs during 2014/15. Improving the alignment between DHB Annual Plans and RSPs is an important planning priority and I understand the alignment is better than in 2013/14, however we must continue to strengthen this alignment if we are to achieve the best use of resources.

Improving major trauma services is an important Government initiative as it is the leading cause of disability and death for people under 45 years of age. Regions were asked to focus on this area as a new priority for regional planning in 2014/15. I note there are variations in the approach across the four regions to implement regional major trauma systems and I expect you to continue to work collaboratively with the Clinical Leader for Major Trauma, and with the Ministry to implement and/or improve regional major trauma systems.

Regional Service Plan Agreement

My agreement does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board (NHB). All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework and the NHB will contact you where change proposals need further engagement or are agreed subject to particular conditions. You will need to advise the NHB of any proposals that may require my approval as you review services during the year.

In addition, my agreement of your RSP does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependent on both completion of a sound business case, and evidence of good asset management and health service planning by your DHBs. Approval for equity or new lending is also managed through the annual capital allocation round.

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

Yours sincerely

A handwritten signature in black ink, appearing to read 'Ryall', with a stylized, cursive script.

Hon Tony Ryall
Minister of Health

cc: DHB Chairs and Chief Executive Officers in Midland region



Sally Webb, Chair



Phil Cammish, Chief Executive



Deryck Shaw, Chair



Ron Dunham, Chief Executive



David Scott, Chair



Jim Green, Chief Executive



Pauline Lockett, Chair



Tony Foulkes, Chief Executive



Bob Simcock, Chair



Craig Climo, Chief Executive



Date: June 2014

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INTRODUCTION



1. Message from DHB board chairs and chief executives

The 2014/15 Regional Services Plan (RSP) describes the collective direction of the five District Health Boards (DHBs) in the Midland region. The region has a long history of working together in a spirit of cooperation.

An example is Midland Region Renal Services (see box).

Differences in access to health services result in poor health outcomes. And some people need earlier access to services than others if they are to achieve the same health outcomes. Therefore, eliminating inequalities in health outcomes remains the top priority for the region.

New ways of working across government departments are being ushered into the health sector through the Better Public Service projects and other initiatives such as social sector trials. DHBs and Primary Health Organisations (PHOs) are working in a spirit of partnership using an alliancing approach to service planning: alliance leadership teams involve the appropriate clinicians and managers from primary care and hospitals to jointly agree service priorities along with appropriate funding levels.

Regionally, our networks and action groups are the mechanism through which we strengthen and change health services to meet the changing needs of our **region's populations. Similar to alliance leadership teams,** these are groups of clinicians and managers working together to review, plan and implement necessary change to services within the available resources.

Midland DHBs have agreed a strategic approach to assist the region to move forward in the same direction. This includes a shared vision, two strategic outcomes, six regional objectives, and three regional outcome indicators. An outcomes framework (Figure 6) demonstrates how national, regional and individual objectives are aligned.

Midland Region Renal Services

Significant variation in access to life-preserving renal dialysis prompted a plan to be developed in 2009. This also led to renal services being regarded as being a vulnerable service in our first Regional Services Plan in 2010.

Three years on, after much focused effort by clinicians and managers, as well as investment by DHB Boards, there is now a network of renal dialysis services in place across the region, particularly in Tairāwhiti and Whakatane Hospitals. Waikato Hospital clinicians oversee the service network in partnership with clinicians from hospitals in the other DHBs.

Access to renal services for the entire region has significantly improved and the service is no longer regarded as being vulnerable. While the regional action group will continue to monitor progress, the regional approach to this service has become part of usual business and renal services no longer need to be included in the Midland Regional Services Plan.

1.1 Achievements 2013/14

Midland DHBs continue to work together to improve patient health outcomes. Two examples from the past year are:

- » Lakes and Waikato hospitals working together in a different way to enable the people of Tokoroa to receive faster access to non-urgent orthopaedic surgery.
- » A reduction in numbers of sudden unexplained death in infants (SUDI) in the region due in part, we believe, to the distribution of Pepi-pods and discussions about safe sleeping behaviour. DHB Māori Health Services and the Midland Maternity Action Group have worked together to implement this initiative.

1.2 Our challenges

Keeping healthy and well is a top priority for people of the Midland region. We all must play our part to manage our wellbeing. An example is people not smoking. Smoking has a significant impact on individual health and wellbeing and places a large impact on our health system; an impact that is avoidable. Smoking during pregnancy has harmful effects on unborn children; inhaling second-hand smoke carries harmful effects; and the rates of smoking correlate highly with levels of health inequalities and people that have poorer health outcomes.

Our challenge, therefore, is to help people not to smoke. We are committed to achieving our vision for a Smokefree, Tobacco-free Midland region by 2025 although we recognise that our current performance is not on track to achieve this vision. We need to do better; we need to show leadership to positively influence our community leaders. Within the health sector the systems and processes for providing smoking cessation support are to be streamlined during this coming year to make sure that help is provided quickly to people who have spoken to hospital clinicians about quitting smoking. We also need to continue to be innovative with the way that we support our communities to quit smoking; ways that meet their needs and which are within available health resources.

Other significant challenges we are working on together as a region include:

- » Ensuring our elective surgery, cancer and cardiovascular targets are met across the region.
- » Meeting the challenge regarding the financial environment. Wise choices need to be made about what we invest in and how we work together to support each other and collectively be more efficient.
- » Responding to the changing age profile of our communities and the impact that this may have on the right mix of health workforce and the appropriate skills to respond to the health needs of populations.
- » Better supporting clinicians to make quality clinical decisions by having the tools and information at their fingertips when they need it.
- » Meeting the increasing demand for hospital clinical services and balancing this need with the need to help people keep well and healthy and proactively manage symptoms and conditions to avoid deterioration in health and then hospital care.

- » Influencing the things that have an impact on the health and wellbeing of our populations, for example a healthy diet, healthy alcohol consumption, and healthy homes and family environments.

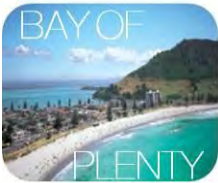
More regional and sub-regional cooperation and collaboration will need to occur if we are to deliver a health system that responds to the clinical and financial challenges being faced by DHBs.

We have called this '**healthy communities – integrated healthcare**'. It is about working together in a more joined-up way and in new ways to solve problems that are common to each DHB.

Recently, the Midland Region DHB chairs and CEOs agreed to develop a more strategic and consistent direction for the delivery of health services. We have chosen to focus on practical health issues that can improve the health of our children, and we have a Child Health Action Group already beginning the work. This group has **some of the region's most informed people** on it to assist us with understanding the needs of children and in planning the appropriate health response to meet the current and future needs.

As a region we have made some significant progress in working together. 2014/15 promises to build on the foundation that has been laid.

EXECUTIVE SUMMARY



2. Executive summary

Our shared vision is for all residents of Midland District Health Boards (DHBs) to lead longer, healthier and more independent lives. For this to occur, the health of the Midland populations needs to improve (Strategic outcome 1) and the health system of Midland DHBs needs to eliminate health inequalities (Strategic outcome 2).

This is summarised as 'healthy communities – integrated healthcare'.

Six regional objectives are being used as stepping stones to help us achieve our vision and the two strategic outcomes. These are:

1. Improve **Māori** health outcomes.
2. Integrate across continuums of care.
3. Improve quality across all regional services.
4. Build the workforce.
5. Improve clinical information systems.
6. Efficiently allocate public health system resources.

There are also six indicators that help the region to monitor progress:

1. 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.
2. Premature death – early death is the rate of deaths before the age of 75 years.
3. Amenable mortality – are deaths that could in theory be averted by good healthcare.
4. Fewer people smoke.
5. Reduction in vaccine-preventable diseases.
6. Improving health behaviours – as measured by the **percentage of obese of New Zealand's 5-14 years population and the percentage of obese of New Zealand's 15+ years population.**

2.1 Structure of this plan

The structure of the document begins (section 3) with a focus on the populations in the Midland region. **There is a brief look at the region's** populations and the characteristics of each DHB.

Next the RSP describes the region's strategic health approach (section 4). This includes the **region's vision, strategic outcomes and objectives. The outcomes framework links national,** regional and individual strategic priorities and objectives to demonstrate clarity of purpose. The strategic impacts of the Midland DHBs are included as proxy medium-term measures of the **region's health status** and some key health outcome measures are provided. The direction of travel of the Midland DHBs is also described, including the regional planning approach, defining a continuum of care and the shift in emphasis to focus on actions for prevention, early detection, and the management of health and wellbeing.

Section 5 forms the main body of the Regional Services Plan by outlining the actions being undertaken in 2014/15 to improve the health of the people of the Midland region populations and to ultimately eliminate inequalities in health outcomes. Actions include the strengthening of services through workforce or IT initiatives and improving access to health services for **populations. The actions are arranged against the region's six strategic objectives.**

The **appendices outline the region's governance arrangements, the trends** influencing health, a description of the health services in the region, the work programmes of each regional network and action group, and a glossary of terms.

THE MIDLAND REGION



3. The Midland region

3.1 Overview of the Midland region

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 more rural nature of the Midland populations create particular challenges in getting services to individuals, and individuals to services. For example, home haemodialysis usually requires an urban water supply.

Figure 1: Map of the Midland region DHBs



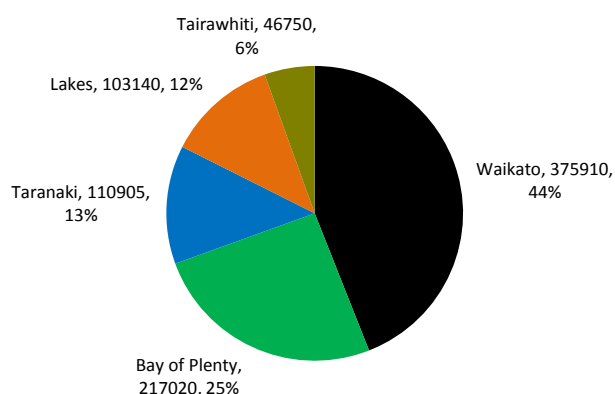
Population: There are approximately 853,725 people living in the Midland region (see the pie chart opposite for individual DHB populations).

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

Māori populations: The number of residents in the Midland region identifying as Māori is 205,590 (approx.) or 24 percent of the total population. By DHB this is (from largest to smallest number) Waikato DHB 78,010, Bay of Plenty DHB 51,960, Lakes DHB 35,190, Tairāwhiti DHB 22,150, Taranaki DHB 18,280.

Midland Region Populations per DHB for 2014

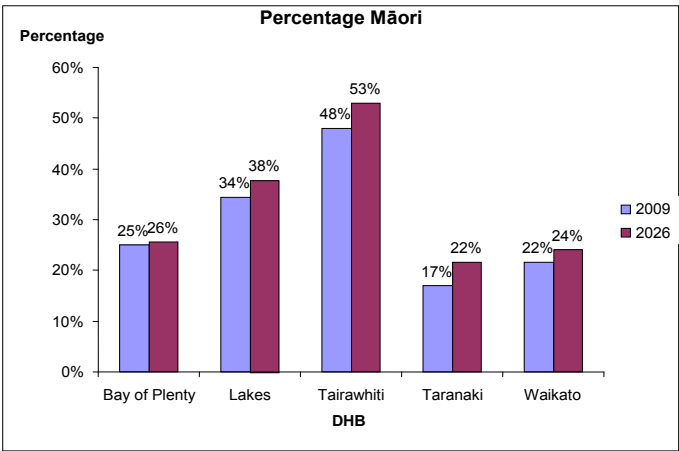
(Projected on 2006 census, MOH NHB)



The proportion of Māori to non-Māori in the Midland region is much higher than the proportion in the national population, with the percentage of Māori in each DHB exceeding the national average.

Tairāwhiti has the highest percent of the population identifying as Māori at 48 percent, and Taranaki the smallest at 17 percent. Taranaki’s percentage is still greater than the overall New Zealand percent of the population identifying as Māori of 15 percent. This proportion of the populations in the Midland region identifying as Māori is expected to increase over time (Figure 2).

Figure 2: Proportion of Māori 2009 and 2026



Tairāwhiti DHB

Ngāti Porou, Ngāi Tamanuhiri, Rongowhakaata, Te Aitanga-a-Mahaki, Ngāti Kahungunu

Lakes DHB

Te Arawa, Ngāti Tuwharetoa, Ngāti Manawa

Bay of Plenty DHB

Waitaha, Tapuika, Tuwharetoa-ki Kawerau, Tuhoe, Ngaiterangi, Te Whānau –ā- Apanui, Te Whānau –a- Te Ēhutu, Ngaitai, Whakatōhea, Ngāti Pukenga, Ngāti Mākinu, Ngāti Manawa, Ngati Whakaue ki Maketu, Ngāti Rangitihi, Ngāti Whare, Ngāti Awa, Ngāi Tai, Ngāti Ranginui, Ngāti Whakahemo

Waikato DHB

Waikato, Hauraki, Ngāti Maniapoto, Ngāti Raukawa, Ngāti Haua, Tuwharetoa, Whanganui, Maata Waka

Taranaki DHB

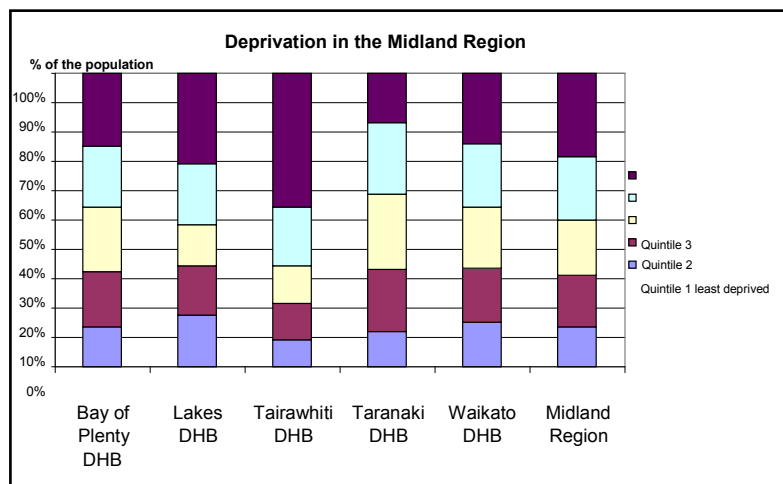
Ngāti Tama, Ngāti Mutunga, Te Atiawa, Ngāti Maru, Taranaki, Ngaruahinerangi, Ngāti Ruanui, Ngā Rauru

Deprivation: The Midland region has a higher proportion of the population with higher quintile deprivation scores (Figure 3). Quintile 5 is most deprived, quintile 1 is least deprived.

Tairāwhiti in particular has 65 percent of its population in quintiles 4 or 5 (versus 40 percent for New Zealand 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.

Figure 3: Deprivation quintiles by DHB



DHBs such as Waikato and Bay of Plenty have smaller pockets of very high deprivation. The three Territorial Local Authorities with the largest proportion of people in deprivation 5 quintiles are Kawerau and Opotiki 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.

Deprivation is an important indicator, as the higher the deprivation the higher the morbidity and mortality, and the lower life expectancy. People living in lower economic circumstances may find accessing health services more difficult, and their circumstances may impact on their knowledge of available services and their confidence to seek those services.

3.2 Characteristics of each DHB

A snapshot of each DHB is provided below and more detail is provided in section 1 of each **DHB's Annual Plan**.

Some features of the Midland region compared to New Zealand as a whole:

- » The highest proportion of **Māori**.
- » A low proportion of the population identifying as Asian or Pacific peoples.
- » A 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).

Many of the issues related to the mortality and morbidity of DHB populations are related to preventable lifestyle factors – in particular tobacco use and obesity rates. Also, with the

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
- » 17 people die

significant economic burden borne by many communities, socio-economic factors have a bearing on their health needs, including poor housing.

Bay of Plenty

- » **Population:** Bay of Plenty DHB region has a population of approximately 216,040 people. The east and west parts of the district have a very different demographic makeup – some 75 percent of the population living in Western Bay of Plenty. An estimated 21 percent of the DHB population live in rural areas, compared to the national figure of 15 percent. In the Western Bay of Plenty, 17 percent of the population identify as **Māori** compared with 50 percent of the Eastern Bay of Plenty population. The population is ageing, and the proportion aged over 75 years group is projected to grow the most (51.3 percent total, 65 percent **Māori** over the next 13 years). Total population growth by 2026 is forecast to be 20.5 percent, higher for this DHB than for the rest of New Zealand as a whole.
- » **Health status:** Life expectancy for the district is close to national average. Key points relevant to the health status of the population include: smoking in pregnancy – with 25 percent of total pregnant women and 48 percent of **Māori** pregnant women being recorded as smoking two weeks after birth; oral health concerns; rates of chronic obstructive pulmonary disease 10 percent higher than the national average; avoidable hospitalisation; diabetes and chronic renal disease and cardiovascular disease.

Lakes

- » **Population:** Approximately 103,750 people live in Lakes DHB region. **Māori** currently make up approximately 35.2 percent of the population and are estimated to increase to 37.5 percent by 2026. Those under 15 years make up just over one fifth of the population (22.2 percent) although this proportion is predicted to drop to 20.1 percent by 2026. Currently, an **estimated 52.9 percent of this age group are Māori. Those aged 75 years and over constitute 6.0 percent of the Lakes population at present but this percentage is expected to increase to 9.3 percent by 2026. It is estimated that currently only 9.7 percent of this age group are Māori.**
- » **Health status:** The life expectancy of the population is around two years lower than the national average. Babies born in Lakes DHB have the second lowest life expectancy of the Midland region. The mortality rate for **Māori** in the Lakes region is nearly twice that of non-**Māori**. The 2006 Census notes that 27.2 percent of the Lakes population were regular smokers against 20.7 percent nationally, although the 2013 Census data suggest these figures are dropping. In Lakes, 49.3 percent of **Māori** females were shown to be 'regular' smokers against 23.0 percent for non-**Māori females**. The equivalent smoking figures for males were 39.9 percent and 22.8 percent.
- » Other outcomes of concern (where the DHB compares poorly against the national average) include: high obesity rates; diabetes rates; cancer mortality; low birth weight babies; oral health; the all-cause all-intent fatal and non-fatal crude injury rates are higher in Lakes than for New Zealand as a whole; the cases of acute rheumatic fever (ARF) have been steadily increasing in Lakes from 2000-2012 with generally more male, more young and more **Māori** being affected; and in terms of the health of young people, oral health, breast feeding rates and levels of poverty remain challenges.

Tairāwhiti

- » **Population:** Tairāwhiti DHB serves a population of 46,7531 and is the most sparsely populated North Island area, with a population density of 5.6 people per square kilometre. Tairāwhiti has a high proportion of the population (48 percent) identifying as **Māori** – three times the national average. A large proportion of the population live outside the main urban areas (approximately 27 percent)². The large rural population presents diverse challenges in service delivery and accessing health services. The Tairāwhiti district has an average deprivation score of 7, where 1 indicates least deprived and 10 most deprived. 67 percent of **Māori** and 30 percent of non-**Māori** are considered to live in the most deprived areas – this is living in areas with deprivation deciles 9 or 10. 52 percent of children, 0-14 years, live in these most deprived areas.
- » **Health status:** **Māori** rates of suicide in Tairāwhiti are above that for non- **Māori**. Smoking rates in Tairāwhiti are higher than the national average for both **Māori** and non-**Māori**, with **Māori** rates being higher than that for non-**Māori**. Rates of obesity are significant for **Māori** in Tairāwhiti. Four-year-old children have the highest rate of obesity nationally (as measured through the B4 School programme).
- » Analysis of the health needs of people of the Tairāwhiti has indicated that circulatory system diseases, including ischaemic heart disease and cerebrovascular disease, accounted for over 40 percent of deaths. Cancer is the second most common cause of death in Tairāwhiti, accounting for 25 percent of all deaths, with cancer of the digestive system and lung being the most common. There is a significant burden on **Māori** from deaths related to cancer than non-**Māori**. There is a large and disproportionate burden of disease related to diabetes (including diabetes renal failure) and its long-term complications for **Māori**. Cellulitis is a significant issue for children under 5 years.

Taranaki

- » **Population:** Taranaki DHB serves a population of 109,608, has smaller populations of Pacific and Asian people and a larger population of European people when compared to the national average. Some 17.4 percent 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 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.
- » **Health status:** Within Taranaki, 28 percent of **Māori** live in the most deprived 20 percent of areas compared to 10 percent of non-**Māori**. In contrast, 4.2 percent of **Māori** live in 20 percent of the most affluent areas compared to 12.2 percent of non-**Māori**. **Māori** in Taranaki

¹ 2013 population from the 2012 population projections prepared for MoH by Statistics NZ

² MoH PHO Enrolment Demographics 2013Q4 (Oct- Dec 2013)

experience a shorter life expectancy than non-Māori. Based on the 2011/12 HNA3, Māori females have a life expectancy of 75.5 years compared to 82.5 years for non-Māori, a difference of 6.9 years. Based on the 2011/12 HNA Māori males have a life expectancy of 72.4 years compared to 79.0 years for non-Māori, a difference of 6.6 years. This difference is less than that for the general New Zealand population at 7.7 years for females and 7.9 years for males. The leading causes of avoidable mortality in Taranaki DHB for non-Māori are ischaemic heart disease, cerebro-vascular disease and chronic obstructive pulmonary disease (COPD) and lung cancer. For Māori in the Taranaki District, the leading causes of avoidable mortality are ischaemic heart disease, lung cancer, diabetes and chronic obstructive pulmonary disease (COPD).

- » In 2011/12 Taranaki DHB completed a **Whānau Ora** health needs assessment on the Māori population in the Taranaki areas. The following areas were identified as priorities in terms of protective and risk factors and preventative care: smoking, alcohol and drug issues, breastfeeding, immunisation, breast screening and cervical screening. Priority health conditions identified were: diabetes, cardiovascular disease, lung cancer, breast cancer, respiratory disease (i.e. COPD and asthma), oral health, mental health and disability.

Waikato

- » **Population:** Waikato DHB serves a population of 375,910 and approximately 60 per cent live outside the main urban areas. The population is expected to increase in Waikato but at a slower rate than the rest of New Zealand and the Māori population is growing at a slightly faster rate than other population groups and is estimated to be 23.3 per cent by 2026. Pacific people make up an estimated 2.5 per cent of the population. A higher percentage of people live in areas of low socio-economic status compared to the New Zealand average (24.10 percent live in areas classified as quintile five or most deprived, compared to a national average of 20 percent). High numbers of the Māori population in our district live in areas identified as quintile four and five.
- » **Health status:** The main cause of early death is cardiovascular disease followed by cancer. **One in five people in the 'Other' ethnicity grouping are cigarette smokers, for Māori one in two smoke and for Pacific people one in three smoke; Māori women continue to have the highest smoking prevalence. Higher percentages of Māori and Pacific children are overweight or obese, compared to 'Other', but in all ethnic groups there has been a significant increase in overall body weight. Cardiovascular disease mortality rates increased with increasingly low socio-economic status among both Māori and non-Māori. Māori were diagnosed with type 2 diabetes at a mean age of 48 years, Indians at 49 years and Pacific people at 50 years compared with Europeans at 59 years. Dental caries (tooth decay) is one of the top five causes of preventable hospital admissions for children. Māori and Pacific children have a lower percentage of caries-free teeth, and a higher rate of missing and filled teeth.**

³ Taranaki DHB's Whānau Ora Health Needs Assessment† (Ratima and Jenkins, 2012)

THE REGION'S STRATEGIC APPROACH



4. The region's strategic approach

Midland DHBs have agreed a strategic approach to assist the region to move forward in the same direction. This includes a shared vision, two strategic outcomes, six objectives and three regional outcome indicators. An outcomes framework (Figure 6) demonstrates how national, regional and individual objectives are aligned.

4.1 Vision

The Midland region has adopted a Ministry of Health long-term outcome statement as its initial vision. DHBs will consider a suitable alternative for the region for the 2015/16 Regional Services Plan.

The vision statement speaks of life in two aspects that exist together simultaneously:

- » Leading **a longer life** refers to an increasing quantity of life, or increasing life expectancy.
- » The second aspect relates to an increasing quality of life, or health expectancy – being **healthier and more independent**. Health expectancy (or independent life expectancy) is the number of years a person can expect to live in good health and without an impairment needing assistance. It therefore refers to an individual's state of function, rather than not being part of a family, **whānau** or community.

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

4.2 Our strategic outcomes

Strategic outcome 1: Improve the health of the Midland populations

Health and wellbeing is everyone's responsibility. Individuals and family and **whānau** are to actively manage their health and wellbeing; employers and local and central body regulators and policy makers are expected to provide a safe and healthy environment that communities can live within.

A core function of DHBs is to **promote, protect and improve our population's health and wellbeing** through health promotion, health protection, health education and the provision of evidence-based public health initiatives. As a region we work collaboratively with local and central government agencies to provide leadership that can influence the environment for individual and collective 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: Eliminate health inequalities

The New Zealand health service has made good progress over the past 75 years⁴. However, an area that is an ongoing challenge is to reduce ethnic inequalities in health outcomes for populations, particularly **Māori** and Pacific peoples.

As a key focus the region will work to eliminate health inequalities in its populations. A core function of DHBs is to plan the strategic direction for health and disability services. This occurs in partnership with key stakeholders and our community (i.e. clinical leaders, iwi, Primary Health Organisations and non-Government organisations) and in collaboration with other DHBs and the Ministry of Health regional and national work.

Eliminating health inequalities is the goal. This **recognises the challenges that the region's** geography creates for access to health services, and that to achieve an elimination of inequalities there may need to be a more significant health response for some populations or a response that is specifically tailored. Having identified health inequalities, the region is committed to partnering with populations and with appropriate providers to assess the causes of inequalities (e.g. using the Health Equity Assessment Tool) and to provide programmes that will ultimately eliminate health inequalities.

4.3 The Triple Aim

The New Zealand Triple Aim for quality and safety outcomes is central and **underpins the region's activities**. The Triple Aim means:

- » improved quality, safety and experience of care
- » improved health and equity for all populations
- » better value for public health system resources.

The three objectives, applied in a consistent manner to quality improvement initiatives, challenge us to ensure all New Zealanders receive the best health and disability care within available resources.



⁴ Toni Ashton (August 2013) *The New Zealand health system after 75 years: let's stop and smell the roses* The New Zealand Medical Journal, , Vol 126 No 1380; ISSN 1175 8716 Page 6 URL: <http://journal.nzma.org.nz/journal/126-1380/5787/> ©NZMA

4.4 Our regional objectives

The region has agreed six regional objectives, which are described briefly in this section. Initiatives relating to these objectives are outlined in Section 5.

Regional objective 1: Improve Māori health outcomes

Eliminating health inequalities and improving the health status for **Māori** is a priority. As a region we will work with **Māori** on:

- » Iwi governance – to ensure iwi have active input into regional planning/strategies and initiatives
- » Quality assurance – to develop tools that support **Māori** health gain
- » **Māori health gain** – activities that seek to lift Midland DHB performance in regard to priority indicators
- » **Māori** health workforce capacity development – build both the numbers and capability of the **Māori** health workforce within Midland.

SIX REGIONAL OBJECTIVES

1. **Improve Māori health outcomes.**
2. **Integrate across continuums of care.**
3. **Improve quality across all regional services.**
4. **Build the workforce.**
5. **Improve clinical information systems.**
6. **Efficiently allocate public health system resources.**

A core function of DHBs is to plan the strategic direction for health and disability services. DHB **Māori** Health Plans prioritise improving **Māori** health and eliminating **Māori** health outcome disparities. The focus is on key indicators where the greatest health inequalities are experienced between **Māori** and non- **Māori**. DHB **Māori** Health Plans are developed in partnership with key stakeholders and our community (i.e. clinical leaders, iwi, Primary Health Organisations and non-Government organisations) and in collaboration with other DHBs and the Ministry of Health, regional and national work.

He Raranga-A-Tira is the Regional Services Plan **Māori** Health Accountability Framework and Midland regional services **Māori** Health Action Plan (see Section 5).

Objectives 2 to 5 align with the core function of DHBs to provide hospital and specialist services primarily for their populations but also for people referred from other DHBs.

Regional objective 2: Integrate across continuums of care

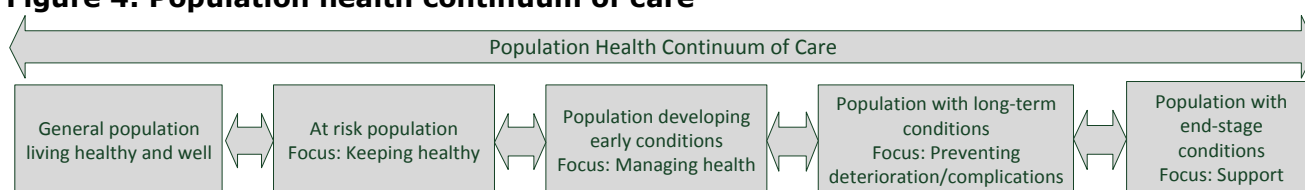
Midland region is committed to developing integrated services across continuums of care. This provides improved quality, safety and experience of care for patients. It also leads to more timely treatment and care, which in turn can result in better patient outcomes. Improved system integration also supports clinical and financial sustainability of the service.

Midland DHBs are supporting integration across continuums of care by implementing agreed pathways using Map of Medicine and Bay Navigator. DHBs and PHOs are actively working to integrate services between primary and community care and hospital care. Regional clinical groups are reviewing systems and processes across hospitals in the region to improve the flow of information, patients and clinicians.

Figure 4 (below) describes a population health continuum of care. Reading from left to right, it describes various stages in decline in health and wellbeing, from being healthy and well to having end-stage conditions. It is important to note that everyone will not experience all stages equally. For example, the length of time spent living healthy and well may differ for individuals, as may the length of time with end-stage conditions.

This simple diagram is useful as a starting place to then add health activities along the continuum. Participants that provide the health activities can also be added (see Figure 11). As part of the direction of travel as a region there is also an emphasis added in Figure 11 to keep people healthy and to proactively manage health to prevent deterioration and complications.

Figure 4: Population health continuum of care



Regional objective 3: Improve quality across all regional services

Quality in health is a fundamental expectation. Yet what is quality? Figure 5 provides two views of quality, both of which are valid and applicable as DHBs work together as a region. The region is committed to improving both views of quality in health for all regional services.

<p>Figure 5: Two views of quality in health.</p> <p>1. Six areas or dimensions of quality:</p> <ul style="list-style-type: none"> • effective, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need • efficient, delivering health care in a manner which maximizes resource use and avoids waste • accessible, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need • acceptable/patient-centred, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities • equitable, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status • safe, delivering health care which minimizes risks and harm to service users. <p>(Reference: World Health Organization (2006) Quality of care: a process for making strategic choices in health systems.)</p>	<p>2. Quality in health systems: Roles and responsibilities in the various parts</p> <ul style="list-style-type: none"> • The role of policy and strategy development is to engage the whole health system, with lead responsibilities normally resting at national and regional levels. The main concerns are to keep the performance of the whole system under review, and to develop strategies for improving quality outcomes which apply across the whole system. • The core responsibilities of health-service providers (Providers may be seen as whole organizations, teams, or individual health workers) will be to ensure that the services they provide are of the highest possible standard and meet the needs of individual service users, their families, and communities. Improved quality outcomes are not, however, delivered by health-service providers alone. • Communities and service users are the co-producers of health. They have critical roles and responsibilities in identifying their own needs and preferences, and in managing their own health with appropriate support from health-service providers. <p>While it is important to recognize these differences in roles and responsibilities, it is equally important to recognize the connections between them.</p> <ul style="list-style-type: none"> • Decision-makers cannot hope to develop and implement new strategies for quality without properly engaging health-service providers, communities, and service users. • Health-service providers need to operate within an appropriate policy environment for quality, and with a proper understanding of the needs and expectations of those they serve, in order to deliver the best results. • Communities and service users need to influence both quality policy and the way in which health services are provided to them, if they are to improve their own health outcomes.
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As mentioned previously, Midland DHBs have adopted the New Zealand Triple Aim. The region is committed to work with the Health Quality and Safety Commission in the development of a

quality framework for the New Zealand health system. This includes the development of DHB Quality Accounts and health quality and safety indicators (including Open For Better Care).

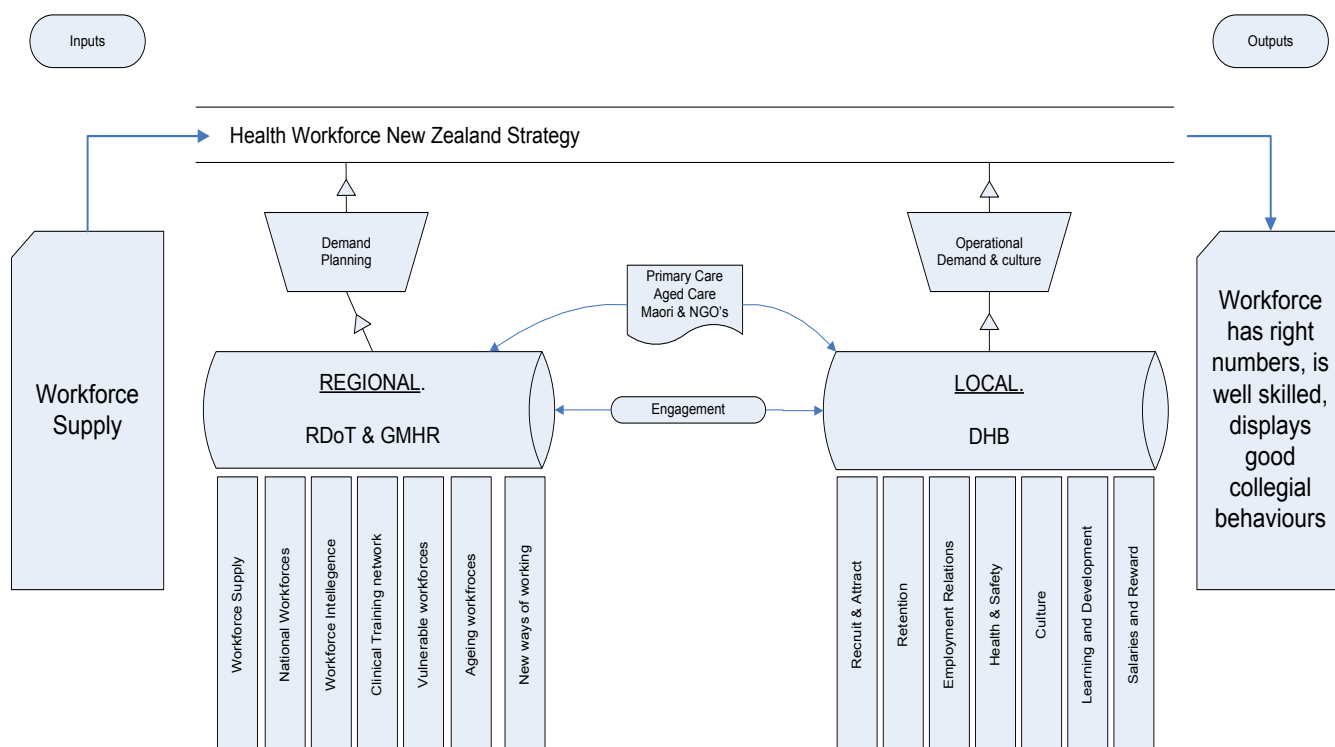
Regional objective 4: Build the workforce

Workforce planning and training is about ensuring that the Midland region has the right number of health professionals who are well skilled and display good collegial behaviours.

Workforce and training is a key enabler to ensure Midland DHBs deliver quality (as defined in objective 3) healthcare and to protect and promote health and wellness. The Midland Region has over ten thousand full-time equivalents employed by the DHBs to provide healthcare to its populations. The health workforce is large and complex and requires sound strategic planning in order to maximise the contribution to health and have a workforce ready to accommodate new ways of working.

<i>Discipline</i>	<i>FTE</i>
Nursing	3751.2
Corporate and other	2416.2
Allied & Scientific	1244.8
Care and support	1258.3
Senior Medical	641.8
Junior Medical	618.6
Midwifery	156.9

The workforce and training activities detailed in this plan illustrate initiatives to reshape the workforce to meet our current obligations and build and develop new workforces to accommodate changes in models of care and healthcare delivery. This workforce and training plan illustrates the collaborative work of the regional director of training and general managers of human resources building whole of health system solutions and also working alongside the clinical networks to meet some of their key deliverables that pertain to workforce and training.



Regional objective 5: Improve clinical information systems

Delivery of information system (IS) enablers to support clinical process change is a key regional priority. Investment logic mapping has been used to identify the key problems that improved clinical information systems will address:

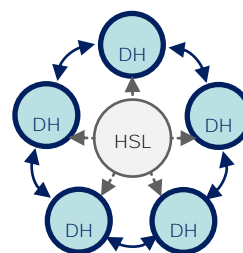
- » The current health IS environment cannot meet the need for agility and does not provide a growth path.
- » Lack of access and integration of health information leads to gaps in information and poor access to and poor visibility of information increasing risks to patients and clinicians.
- » Poor access to disparate and inaccurate information can lead to adverse patient outcomes.
- » The interrelationship between IS and clinical outcomes is not fully recognised in business change leading to ineffective implementation.
- » System workflow and business rules are not supported by IS leading to inefficient use of time and resources.

Regional clinical information systems will address these problems through four investment objectives:

- » Support integrated care and reduce risks to patients and clinicians by providing a complete and integrated view of patient information.
- » Support effective and efficient clinical practice by providing access to clinical information and tools that support optimised clinical processes.
- » Implement effective business change that recognises the interrelationship between IS enablers and clinical outcomes.
- » Develop an IS environment with a clear strategic path for growth while maintaining the agility to meet changing business and clinical needs.

Midland Region operates a coordinated services model for IS delivery focused on creating regional IS services that support clinical and business practice and deliver benefits to the Midland DHBs.

The coordinated services model recognises that there will continue to be a mix of local and regional/national IS demand requiring a combination of regional and local IS capability and focus. It also aims to effectively leverage the IS capability that exists across Midland DHBs for regional benefit.



Regional objective 6: Efficiently allocate public health system resources

The role of Midland DHBs is to fund the provision of the majority of the public health and disability services in the region through the contracts the five DHBs have with providers. Midland DHBs are working together to deliver a health system that is clinically and financially **sustainable, where safe and effective services are provided as close to people's homes as possible.**

Efficiently allocating public health system resources can occur in a variety of ways. Measuring efficiency savings may be difficult and can take time. This can apply to a number of the initiatives being undertaken by the regional networks and action groups. Ahead of the 2015/16 planning process Midland DHBs intend to adopt a regional planning methodology that integrates **the three aims of the NZ Triple Aim to help answer the question 'how is value defined better?'**

For the 2014/15 RSP, Midland DHB CEOs have reviewed the activities of the regional groups – both clinical and non-clinical. They have agreed that the initiatives contained in the 2014/15 RSP represent value.

Capital investment planning

Midland DHBs have recently drafted their first Midland Region Capital Investment Plan (MRCIP). The MRCIP provides an overview of capital intentions planned in the Midland region over the next ten years and is aligned with the strategic direction and objectives outlined in the 2014/15 RSP. The MRCIP represents a regional amalgam of the detailed capital expenditure plans that each DHB has completed according to local, regional and national objectives after taking account of affordability. Opportunities for more efficiently allocating resources for capital have yet to be determined.

National agencies

Midland DHBs are working with Health Benefits Ltd (HBL), a national agency that is standardising non-clinical services such as food services, laundry, procurement and the implementation of a financial information system. HBL is tasked with saving \$700 million over seven years.

The National Health Committee (NHC) is another national agency that Midland DHBs are working with to more efficiently introduce new technology or the expansion of existing technology in health. Midland DHBs are committed to working with the NHC and implementing recommendations in the prioritisation of new and existing technologies and interventions that are endorsed by the Minister of Health. Midland DHBs are working with the NHC to establish a regional prioritisation network.

4.5 Outcomes framework

The outcomes framework below (Figure 6) demonstrates how the regional vision, strategic outcomes, objectives and indicators are aligned with national outcomes and impacts, as well as the vision, strategic objectives and impacts of each DHB in the Midland region.

Each Midland DHB also has an outcomes framework aligned with this regional version which can be found in the corresponding section in their annual plans.

Figure 6: Outcomes framework

Health System Outcomes		New Zealanders live longer, healthier, more independent lives				The health system is cost effective and supports a productive economy					
Ministry of Health High-level Outcomes		New Zealanders are healthier and more independent			Health services are clinically integrated, more convenient and people-centred			The future sustainability of the health system is assured			
Ministry of Health Impacts		The public is supported to make informed decisions about their own health and independence			The public can access quality services that meet their needs in a timely manner where they need them			Provider efficiency and financial sustainability are enhanced			
		Environmental and disease hazards are minimised			Health services are clinically integrated and better coordinated			Clinical and financial gains are made from DHBs working together, delivering regional workforce, IT and capital			
		Integrated home care services are provided for older people			The health system is supported by suitable infrastructure and workforce			Quality, efficiency and value for money improvements are made for DHBs working with other health entities			
		Health services are closely integrated with other social services			The health system has fit-for-purpose regulatory settings						
Λ		Λ				Λ					
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 eliminate health inequalities				
Regional Long Term Impacts		People take greater responsibility for their health			People stay well in their homes and communities			People receive timely and appropriate care			
Regional Indicators		Fewer people smoke		Reduce vaccine preventable diseases	Improve health behaviours		Increase average life expectancy		Reduce premature death rates		Improve amenable mortality rate
Regional Strategic Objectives		Improve Māori health outcomes		Integrate across continuums of care	Improve quality across all regional services		Build the workforce		Improve clinical information systems		Efficiently allocate public health system resources
Λ		Λ				Λ					
DHBs Performance Story											
DHB Vision, Mission and Values		Bay of Plenty Vision : Kia momoho te hāpori oranga - Healthy, thriving communities			Mission : Enabling communities to achieve good health, independence and access to quality services			Values: CARE (Compassion, Attitude, Responsiveness and Excellence)			
		Lakes Vision “Healthy Communities, Mauriora!”									
		Working together to elevate the wellbeing of Tairawhiti Mahia nga mahi i roto i te kotahitanga kia piki ake to oranga o te Tairawhiti				Values (A Matou Uara): Hauora pai rawa/ Wellbeing, Partnership, Quality - Striving for Excellence, Integration, Choice, He tangata/ Responsiveness, Financial Responsibility					
		Taranaki Vision: Taranaki Together, a healthy Community – Taranaki Whanui He Rohe Oranga				Mission (Taranaki): Improving Promoting, Protecting and caring for the health and wellbeing of the people of Taranaki					
		Waikato Vision: Te Hanga Whaioranga Mo Te iwi - Building Healthy Communities									
DHB Outcomes		To improve the health of our population				To reduce or eliminate health inequalities					
DHB Strategic Priorities	Bay of Plenty	Health Targets	Māori Health / Reducing Health Disparities	Health of Older People		Wellness / Chronic Conditions		Primary Health		Child and Youth	
	Taranaki	Health Targets	Māori Health /Disparities	Health of Older People		Wellness/Chronic Conditions		Primary Health			
	Lakes	Financials	Regional Collaboration	Quality Improvement		Addressing Chronic Conditions		Organisational and Workforce Development			
	Tairawhiti	Financials	Regional Collaboration	Quality Improvement		Addressing Chronic Conditions		Organisational and Workforce Development		Integration	
	Waikato	Financials	Regional Collaboration	Quality Improvement		Addressing Chronic Conditions		Organisational and Workforce Development		Rural	
DHB Long Term Impacts		People take greater responsibility for their health			People stay well in their homes and communities			People receive timely and appropriate care			

DHB Annual Plan: Module 1

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DHB Intermediate Impacts	<ul style="list-style-type: none"> Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours 		<ul style="list-style-type: none"> An improvement in childhood oral health Long-term conditions are detected early and managed well Fewer people are admitted to hospital for avoidable conditions More people maintain their functional independence 		<ul style="list-style-type: none"> People receive prompt and appropriate acute and arranged care People have appropriate access to elective services Improved health status for people with a severe mental health illness and/or addiction More people with end-stage conditions are appropriately supported 		DHB Annual Plan: Module 3
DHB Outputs	<ul style="list-style-type: none"> Percentage of hospitalised patients who smoke and are seen by a health practitioner in public hospitals Percentage of eight months olds who will have their primary course of immunisation on time Number of people participating in the Green Prescription programmes 		<ul style="list-style-type: none"> Percentage of children (0-4) enrolled in DHB funded dental services Percentage of population enrolled with a PHO Percentage of rest home residents receiving vitamin D supplement from their GP Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months 		<ul style="list-style-type: none"> Acute re-admission rate Improving the percentage of long-term clients with up to date relapse prevention/treatment plans 		
Stewardship	<ul style="list-style-type: none"> Workforce 	<ul style="list-style-type: none"> Performance Management 	<ul style="list-style-type: none"> Collaboration/Partnerships 	<ul style="list-style-type: none"> Information 	DHB Annual Plan Module 5		

4.6 Key indicators of progress

A small set of health measures will help demonstrate whether Midland DHBs are achieving their goals of making a positive difference in the health of our populations and in eliminating health inequalities. The last three measures also provide a measure about how motivated people are to take care of their health and wellbeing. Further information about these measures is found in section 1.9 of each DHB Annual Plan. These measures are:

1. 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.
2. Premature death – early death is the rate of deaths before the age of 75 years.
3. Amenable mortality – are deaths that could in theory be averted by good healthcare.
4. Fewer people smoke – the percentage of year 10 high school students who have indicated they have never smoked.
5. Reduction in vaccine-preventable diseases – the 3 year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds.
6. Improving health behaviours – the percentage of obese of New Zealand's 5-14 years population and the percentage of obese of New Zealand's 15+ years population. (Obesity is defined as a body mass index (BMI) of 30 or more – **calculated by dividing a person's weight** in kilograms by the square of their height in metres. Measure 6 is a national measure taken from the New Zealand Health Survey.)

Monitoring these measures over time will give us a picture of the health of the Midland DHB region. 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 target resources and activities where significant health gain can be made.

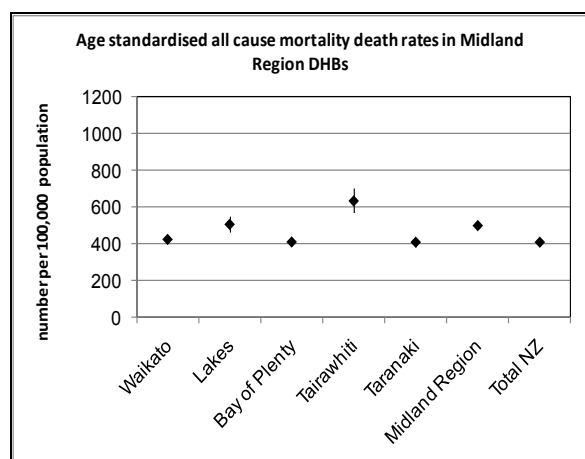
Life expectancy: Figure 7 shows that babies born in the Midland region (with the exception of females in the Bay of Plenty) have a lower life expectancy than average for New Zealand. Tairawhiti in particular stands out as having a life expectancy 4.2 years lower than the national average for both females and males.

Figure 7: Life expectancy for females and males by DHB

Average life expectancy at birth in the Midland region 2007-09 ⁱ						
	Bay of Plenty	Lakes	Tairawhiti	Taranaki	Waikato	NZ
Females	82.4	80.5	78.0	81.5	81.8	82.4
Males	77.5	76.4	73.8	77.2	76.9	78.4

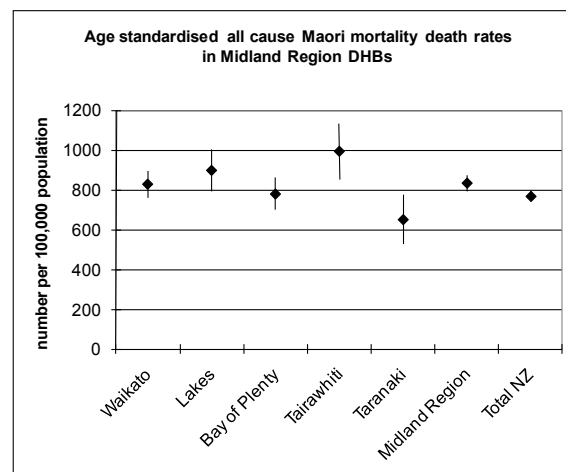
Mortality: Figure 8 shows the age standardised death rates from all causes in 2006 for the Midland DHBs and New Zealand as a whole. Tairawhiti stands out as having significantly higher mortality rates.

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



Māori have higher mortality rates at all ages with greater variability across DHBs. In New Zealand, Tairawhiti has the highest national age standardised Māori death rate, while Lakes DHB has the third highest (Figure 9).

Figure 9: Age standardised all cause Māori mortality in 2006 by DHB



4.7 The direction of travel: improving population health

Midland DHBs have agreed a strategic response to assist the region to move forward in the same direction. It includes a shared vision, two strategic outcomes, six objectives, an outcomes framework and three regional outcome indicators.

The region has worked together over the past two years to strengthen identified vulnerable services. In the 2013/14 financial year, four services were identified as vulnerable: maternity services, services for older people, radiology services and renal services. Service vulnerability was usually characterised by:

- » the service facing a workforce shortage which if left unresolved would lead to service access issues or service failure
- » access to the service by the region was unacceptable or highly variable
- » the demand for the services meant that a response was needed to enable the service to respond to this demand (or prepare for the future demand).

Progress continues to be made in all areas and renal services now have made sufficient progress that the regional approach to this service has become part of usual business and renal services no longer need to be included in the Midland Regional Services Plan.

Regionally, our networks and action groups are the primary response to strengthening services **and meeting the changing needs of our region's populations. These are groups of clinicians and managers working together to review, plan and implement necessary change to services within the available resources. The regional networks and action groups are:**

Networks/action groups delivering national initiatives:

- Midland Cancer Network
- Cardiac Services
- Elective Services – Ophthalmology, Chronic Pain, ENT, Vascular Surgery, Orthopaedics
- Health of Older People
- Mental Health & Addiction Network

- Midland Stroke Network
- Midland Regional Trauma System (MRTS)

Networks/action groups delivering regional initiatives:

- Child Health Action Group (CHAG)
- Midland Maternity Action Group (MMAG)
- Radiology
- Midland Smokefree Programme

Vulnerable populations: The region is now taking an agreed regional approach to identified vulnerable populations – those whose health status and issues are of possible concern. Using this information the region can then develop appropriate health responses and models of care that can be consistently implemented in each DHB.

Starting with populations and then determining the best health response is not a new idea (Figure 10). Demographics and epidemiology form the basis of an analysis of the health needs of a population. This incorporates national intentions and individual communities in DHBs and is informed by information about what is working well or new research. A service plan and

implementation plan are then developed to guide DHBs and health providers to implement this approach in a consistent manner.

This approach supports Midland region DHBs to work together, each playing a part to both inform the needs analysis and to deliver the implementation plan.

Clear measures of outputs and outcomes are to be developed as part of the planning process, and it is anticipated that a longer timeframe may be needed to demonstrate the benefits of implementation on the population that is in focus.

As a direction of travel, the agreed regional planning approach is expected to **move the region's focus** to target the underlying causes of health issues to prevent illness and to promote wellness, and to focus on the early detection and screening of at risk population groups and for managing conditions to reduce the deterioration in health (Fig11).

In 2014/15 the region has agreed to focus on children as a population group. The Child Health Action Group is tasked with developing a regional needs analysis, service plan and implementation plan.

Figure 10: Agreed Regional Planning Approach

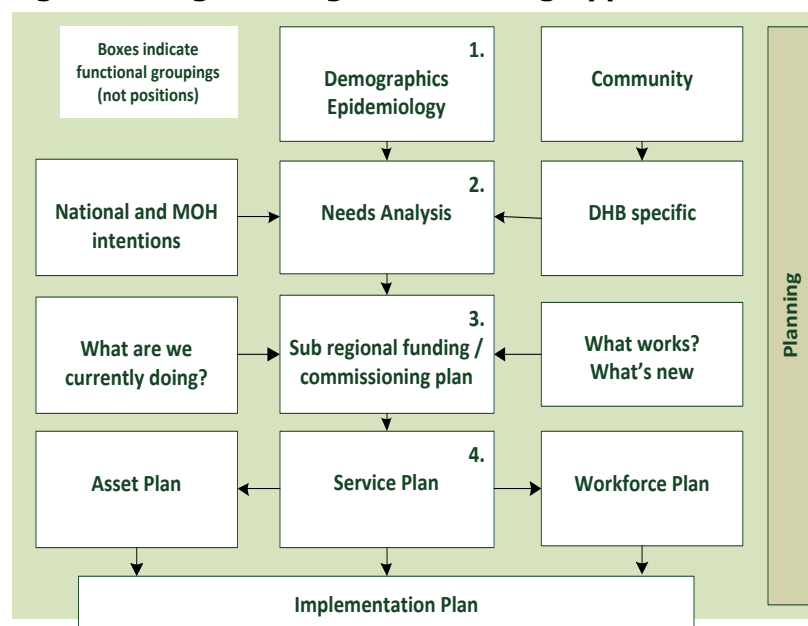
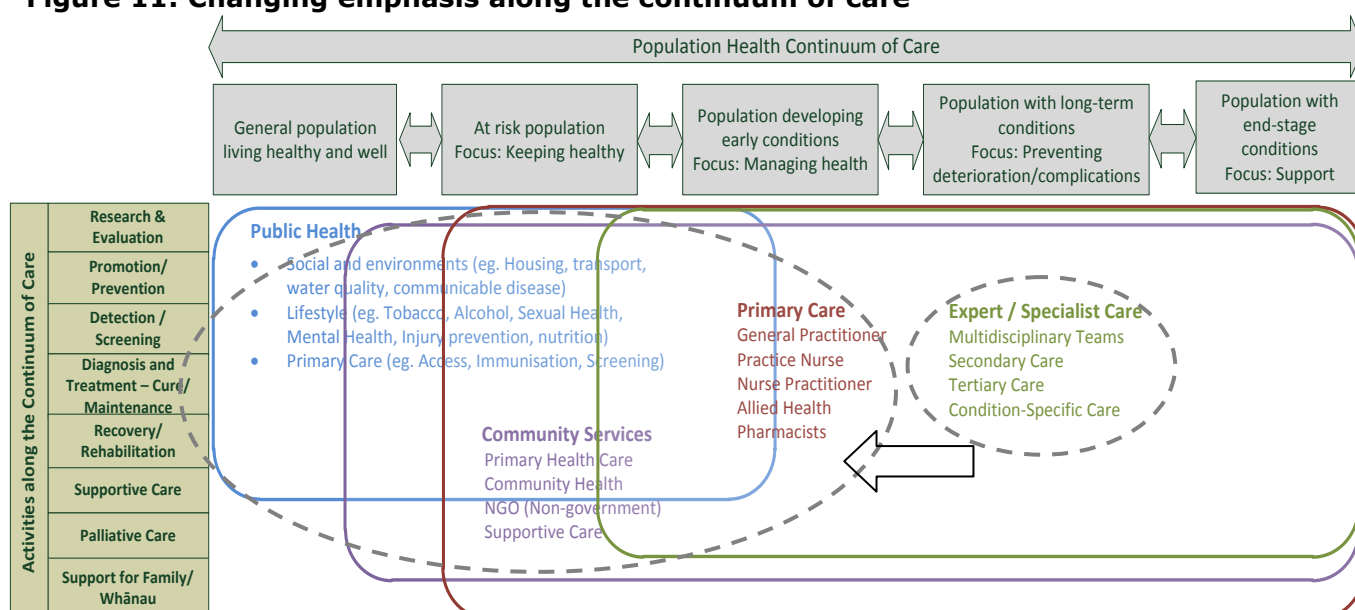


Figure 11: Changing emphasis along the continuum of care



Adapted from The Bay of Plenty District Health Board's Journey towards "Healthy Thriving Communities", Conceptual Frameworks developed by the Planning & Service Development Unit, Planning & Funding Group, April 2003

PRIORITIES, ACTIONS AND MEASURES



5. Priorities, actions and measures

The actions to be delivered in 2014/15 by each regional network and action group are outlined in this section. Together they demonstrate diversity and also how they are aligned to achieve **the region's vision, strategic outcomes and objectives**. The actions are arranged according to the six regional objectives:

1. Improve **Māori** health outcomes.
2. Integrate across continuums of care.
3. Improve quality across all regional services.
4. Build the workforce.
5. Improve clinical information systems.
6. Efficiently allocate public health system resources.

VISION

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

Objective 1: Improve Māori health outcomes

Four key strategies

Four key strategies have been identified within the Midland region, which collectively seek to enhance performance against specific health priority indicators detailed within Midland DHB **Māori** Health Plans. Specifically the four key strategies are:

1. Active participation by iwi governance – to ensure iwi have active input into regional planning/strategies and initiatives.
2. Quality assurance – to develop tools that support **Māori** health gain against priority health indicators.
3. **Māori health gain** – activities that seek to lift Midland DHB performance in regard to priority indicators.
4. **Māori** health workforce capacity development – build both the numbers and capability of the **Māori** health workforce within Midland.

In addressing health inequity within the Midland region, the strategies that should be given priority are those that are universal but are resourced and delivered with an intensity that is related to the level of healthy need (proportionate universalism). Health inequities between **Māori** and non-**Māori** across the Midland DHBs are viewed as unnecessary and avoidable but in addition are considered unfair and unjust. In order to elevate **Māori** health performance, and to strengthen alignment between our Midland **Māori** Health Plans and the Regional Services Plan, Ngā Toka Hauora the Midland GM's **Māori** have established a dedicated focus in key areas of **Māori** health. These **Māori** health priorities have been determined via the following evidence-based criteria:

- » impact on **Māori** morbidity and **Māori** mortality
- » an upstream intervention

- » a specific focus on the first 1000 days
- » of particular importance to **Māori**, i.e. a national MHP priority.

Role of leads and co-leads

Also identified is a lead and co-lead DHB for each of these priorities. The leads and co-leads will:

- » Identify relevant and appropriate activity to be undertaken so that all Midland DHBs benefit, i.e. by taking a regional focus.
- » Undertake a stocktake and identify common practice.
- » Develop a regional policy or model using best or common practice which can then be implemented locally, with local adaptations as appropriate.

Performance measures

The list of health indicator priorities and the regional lead and co-lead that are detailed below:

No.	Priority	Potential Measure(s)	Lead
1.	Smoking cessation	<p>Health target (Primary Care) / National MHP Priority / IDP: 90% of patients who smoke and are seen by a health practitioner in primary care, are offered brief advice and support to quit smoking</p> <p>Well Child / Tamariki Ora Quality Improvement Framework (WCTO QIF): 86% of mothers are smokefree at two weeks post natal (#19) 90% of children live in smokefree homes (age four years) (#20)</p>	Waikato
2.	Breast and Cervical Screening	<p>National MHP Priority 70% of eligible women have had breast-screening 80% of eligible women have had cervical screening</p>	Tairāwhiti
3.	Immunisation	<p>Health Target / National MHP Priority / IDP / WCTO QIF 90% of eight month olds have their primary course of immunisation at six weeks, three months and five months on time by July 2014 and 95% by December 2014.</p>	Lakes
4.	Breastfeeding	<p>National MHP Priority / WCTO QIF* 74% of infants are exclusively or fully breastfed at six weeks 63% of infants are exclusively or fully breastfed at three months of age 27% of infants are exclusively or fully breastfed at six months of age.</p> <p>WCTO QIF 74% of infants are exclusively or fully breastfed at two weeks (#11) 68% of infants are exclusively or fully breastfed at six weeks (discharge from LMC) (#12) 54% of infants are exclusively or fully breastfed at three months of age (#13) 59% of infants are receiving breast milk at six months (exclusively, fully or partially breastfed) (#14)</p>	Waikato
5.	Cardiovascular Disease	<p>Health Target/ MHP Priority 90% of the eligible Māori population who have had their CVD risk assessed within the past five years (ht) 70% of high-risk Māori patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') Over 95% of Māori patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days</p>	Bay of Plenty

¹ According to the New Zealand College of Public Health Medicine (Media Statement, 21 November 2013): “...Māori and Pacific babies are nearly twice as likely to die before reaching their first birthday as children of European descent.” Further: “There is increasing evidence that the first 1000 days is when a child is most vulnerable to the long term consequences of deprivation. This is the time from conception, through pregnancy, birth and up until a child’s second birthday. New Zealand has large inequities in children’s health and well-being with Māori and Pacific children having significantly higher rates of preventable illness, injury and early death.”

The **Māori** health indicator priorities detailed alignment with one or more of the following health targets:

- » National **Māori** Health Plan measures.
- » Annual Plan Performance Monitoring Framework (formerly known as IDP).
- » The Well Child Tamariki Ora Quality Improvement Framework.
- » Explore the development of a regional **Māori** health workforce profile tool.
- » Ensure that any policy, model or framework proposed leads to system improvement and advances these **Māori** Health Plan priorities.
- » Midland Cancer Network **Māori** Cancer Plan. The regional **Māori** health priorities focus on the front end of the cancer continuum while the Midland Cancer Service Plan predominately has a secondary/tertiary focus.

Actions to improve **Māori** health outcomes are provided in the following action tables. Nga Toka Hauora provide an oversight and advisory role to ensure that initiatives developed by regional networks and action groups are appropriate and will be effective. The ability for **Māori** health teams to be actively involved in all regional activities that could improve **Māori** health outcomes is challenging given their finite resources. The areas that will be actively led by Nga Toka Hauora are detailed in the action tables in the following pages (**Māori** health – actively supported initiatives).

Areas that fall outside the criteria for active participation are also detailed as “**Māori** health gain activities led by respective regional workstreams”. These initiatives which are to be led by respective workstreams will have an opportunity to meet with GMs **Māori** periodically on an ‘as needed’ basis (see **Māori** health – initiatives for GM **Māori** oversight only in the following table).

Māori health reporting

Priority Area	Outcome Reported	Timeframe	Responsibility	Link to Other Priority Areas
Regional Governance & Decision Making	<p><i>Ensure Iwi Governance actively participates in planning and decision making</i></p> <ul style="list-style-type: none"> Report on Midland Iwi Relationship Board (MIRB) participating in planning process at a regional level, and supporting Midland GMs Māori, Māori Health Plans, projects, initiatives and developments. 	Q2/Q4 2014/15	GM Māori	<ul style="list-style-type: none"> - RSP Action Plan 14/15 - Regional Services Plan 14/15
Quality Assurance	<p><i>Establish Regional Tools to Support Māori Health Gain</i></p> <ul style="list-style-type: none"> Maintain application of standard Māori Health Plan planning template within Midland Report against Midland DHB's performance against Māori Health Plan national indicators completed every 6 months (Midland Māori Health Indicator Report) Explore the establishment of a Regional Māori Health Workforce profile by professional group (annual report) Review He Ritenga Cultural Audit tool for greater alignment to Māori health Indicators and apply audit in one regional service 	<p>Q1 2014</p> <p>Q2/Q4 2014/15</p> <p>Q4 2015</p>	<p>GM Māori</p> <p>GM HR/ GM Māori</p> <p>GM Māori</p>	<ul style="list-style-type: none"> - RSP Action Plan 14/15 - Regional Services Plan 14/15 - Māori Health Plan 14/15 - Annual Plan 14/15
Māori Health Gain- Cancer (Breast and Cervical)	<p><i>Reduce Māori Cancer rates, specifically in the area of Breast and Cervical cancer</i></p> <ul style="list-style-type: none"> Establish Regional Work- Plan around Breast and Cervical screening Convene Health Excellence wānanga around best practice to improve Māori regional breast screening rates Convene Health excellence wananga around best practice to improve Māori regional Cervical Screening rates Deliver E te Iwi cancer health literacy initiative with Māori communities/ NGO's and the Cancer Society Report on Hei Pa Harakeke Māori Cancer Advisory Groups annual work plan, specifically complete 	Q2/Q4 2014/15	GM Māori/ Midland Cancer Network/ Breast Screening Midland	<ul style="list-style-type: none"> - RSP Action Plan 14/15 - Regional Services Plan 14/15 - Māori Health Plan 14/15 - Annual Plan 14/15
Māori Health Gain – Improve Māori Breastfeeding rates	<p><i>Report on activity to improve Māori breastfeeding rates</i></p> <ul style="list-style-type: none"> Complete Mama Aroha Breastfeeding training with key health practitioners inclusive of midwives including LMC's / Māori provider staff across Midland region (May 2015) Midland contribute to the establishment of a National Breast Feeding Policy (April 2015) Explore the development of technological solutions and resources to improve Māori access to breastfeeding information and support (June 2015) Convene Health Excellence wānanga around best 	Q2/Q4 2014/15	GM Māori/ Maternity Action Group	<ul style="list-style-type: none"> - RSP Action Plan 14/15 - Māori Health Plan 14/15 - Annual Plan 14/15

	<p>practice to improve Māori regional breastfeeding rates and develop models/ policies plans/ initiatives to improve Māori breastfeeding rates (June 2015)</p> <ul style="list-style-type: none"> Evidence of improving trend in Māori infant breastfeeding rates across Midland (% of Māori infants' breastfed at 6 weeks (68%), 3 months (54%), 6 months (59%)) 			
Priority Area	Outcome Reported	Timeframe	Responsibility	Link to Other Priority Areas
Māori Health Gain – Immunisation (8months)	<p><i>Enhance opportunity to attain Māori immunisation indicator for tamariki (8months)</i></p> <ul style="list-style-type: none"> Convene regional Health Excellence wānanga around best practice to improve Māori immunisation rates (June 2015) Best practice models / policies / plans are integrated into secondary and primary care to support the attainment of immunisation indicators for Māori (June 2015) Evidence of improving trend on attainment of 90% of tamariki up to 8 months being immunised, target moving to 95% by December 2014 	Q2/Q4 2014/15	GM Māori	<ul style="list-style-type: none"> - RSP Action Plan 14/15 - Māori Health Plan 14/15 - Annual Plan 14/15
Māori Health Gain – Reduce Māori SUDI rates	<p><i>Report on reducing Māori smoking and SUDI rates</i></p> <ul style="list-style-type: none"> Enable a training programme of safe sleep across Midland to reduce Māori SUDI rates in alignment with national indicator (<0.5 per 1,000 live Māori births) (May 2015) Report that minimum of 200 pepi-pods are distributed to high need whānau across the Midland region (June 2015) Enable training around best practise to support attainment of smoking quit support indicator for pregnant Māori women within Midland (95% of inpatient hāpu woman offered quit support) - (linked to SUDI model, June 2015) Pilot an initiative that incentivises smoking quit support uptake amongst pregnant women in Waikato. Evaluation used to inform regional roll-out/and or learnings (95% of inpatient hapū woman offered quit support) (linked to SUDI model, June 2015) Complete Mama Aroha Breastfeeding training with key health practitioners (% of Māori infants breastfed at 6 weeks, 3 months, 6 months improving trend evidenced (linked to SUDI model, May 2015)) 	Q2/Q4 2014/15	GM Māori/ Maternity Action Group	<ul style="list-style-type: none"> - RSP Action Plan 14/15 - Māori Health Plan 14/15 - Annual Plan 14/15

Priority Area	Outcome Reported	Timeframe	Responsibility	Link to Other Priority Areas
Māori Health Gain – Smoke-free Aotearoa by 2025	<p>Support attainment of Smoke-free Aotearoa by 2025</p> <p>Report on activities at a regional level to create a smoke free Aotearoa by 2025 (Refer to RSP Smoke Free section). Report against the Midland Smoke-free programme specifically will detail:</p> <ul style="list-style-type: none"> • <i>Evidence that the Midland Smoke-free Māori Caucus contributes to Midland Smoke-free planning and decision making (June 2015)</i> • <i>Evidence that Tupeka Kore is integrated into various settings within Midland DHB's (June 2015)</i> • <i>Māori Smoke-free Tobacco Free interventions are initiated with Te Kohanga Reo, Kura Kaupapa and Whare Kura, and tertiary education (June 2015)</i> • <i>Māori Smoke-free Tobacco Free interventions are initiated with Te Kohanga Reo, Kura Kaupapa and Whare Kura, and tertiary education (June 2015)</i> 	Q2/Q4 2014/ 15	Midland Smoke-free Director GM Māori/ Tobacco Steering Groups	<ul style="list-style-type: none"> - RSP Action Plan 14/15 - Māori Health Plan 14/15 - Midland Smoke-free Strategy - Annual Plan 14/15
	<p>Support attainment of Māori Quit Support Indicators in secondary and primary care</p> <ul style="list-style-type: none"> • Best practise models/policies/plans are integrated into secondary and primary care to support the attainment of quit support indicators for Māori (lift in performance evidenced for 90% of primary care patients being offered smoking quit support and 95% of secondary inpatients being offered smoking quit support) (June 2015) 	Q1/ Q4 2014/15		

Priority Area	Outcome Reported	Timeframe	Responsibility	Link to Other Priority Areas
Māori Health Workforce Capacity Development (linked to workforce section of RSP)	<i>Build Māori Health Workforce Capacity Development</i> <ul style="list-style-type: none"> Report (June 2015) against Kia Ora Hauora Midland Māori health workforce development initiative completed. Specifically key deliverables in the report will detail (by June 2015): <ul style="list-style-type: none"> <i>A minimum of 20 Midland KOH partner secondary schools engaged in the programme</i> <i>25 Midland Māori supported into first year of health related tertiary study</i> <i>Complete individual career plans with at least 40 Midland Māori students</i> <i>Provision of NCEA workshops and resources</i> <i>Co-ordination of student placement days, conferences, exposure activity and engagement with tertiary providers</i> <i>Liaison and funding of Māori tertiary student support groups at key Midland educational facilities</i> Report against two regional workforce development training sessions being completed for non-regulated Māori health workforce in two health priority areas associated with RSP (June 2015) Report that Te Tumu Whakarae Midland Maori GM's have Maori representation on the Midland Regional Training Network (MRTN). Report against regional E- Learning training utilised to provide training for staff around correct ethnicity data collection and cultural competence training (June 2015) Explore the establishment of an annual report on the Māorihealth workforce across all five Midland DHBs by professional group relative to non-Māori (June 2015) Evidence of improving trend in the total number/and or % of Māori staff employed across Midland DHBs (June 2015) 	Q2/Q4 2014/15	GM Māori/ Midland Training Network	- RSP Action Plan 14/15 - Māori Health Plan 14/15 - Midland Training Network Action Plan
Cardiovascular disease	<i>Cardiac</i> <ul style="list-style-type: none"> Cultural Competency - to implement a coordinated approach across the Midland region clinical networks to Health literacy, public awareness and education with an emphasis for Māori Health Literacy - implement an e-learning cultural competency programme (with a cardiac care focus) designed to be utilised in primary and secondary health care arenas <i>Stroke</i> <ul style="list-style-type: none"> Provide support for DHBs local work plans to implement the 2010 Stroke Guidelines. This will provide Māori with consistent standards of care. Support the NZ Stroke Foundation to develop a 	Q1-Q4 2014/15 Q1-Q4 2014/15 Q1,2,4	GM Māori/ Midland Stroke Network	- RSP Action Plan 14/15 - Māori Health Plan 14/15 - Annual Plan 14/15

	<p>primary stroke prevention education resource kit that supports stroke prevention for Māori and general population.</p> <ul style="list-style-type: none"> Ongoing implementation of education programmes for clinicians across the region, inclusive of education resources for Māori health key workers. Thrombolysis service in geographically remote areas of the Midland region. Discharge planning and post stroke care stocktake completed and plan developed to address gaps and issues <p>Stroke services are accessible and utilised by Māori within the Midland region.</p> <ul style="list-style-type: none"> Access to acute stroke services is monitored for Māori comparative to the non-Māori population (report every 6 months) Measures collected including audits are broken down to include ethnicity (report every 3 months via stroke work-stream) Initiatives to improve access to stroke and TIA services for Māori are developed (March 2015) Support the NZ Stroke Foundation to develop Māori health education resources post stroke (June 2015) To increase thrombolysis service provision to Māori and the general population that live in more rural areas with limited specialist services 	<p>Q1-4</p> <p>Q1-4</p> <p>Q2/4</p> <p>Q1-4</p> <p>Q2-4</p> <p>Q1-4</p> <p>Q4</p> <p>Q4</p> <p>Q4</p>		
Māori Health Gain activities led by regional groups-in areas outside the identified five priority areas	<p>Child Health</p> <ul style="list-style-type: none"> A regional Service Plan & Implementation Plan A review of paediatric activity and / or admission rates Review of paediatric activity and/or admission rates– Acute – 0-4 years, asthma and gastroenteritis diagnoses Ongoing monitoring of child and youth initiatives across the region and nationally Key outcome measures are monitored by the Child Health Action Group Well Child/Tamariki Ora Quality Improvement Framework <p>Child Health initiatives are to be led by the regional Child Health Action Group and supported by Nga Toka Hauora the Midland GM's Māori.</p>	<p>Q3/4</p> <p>Q2</p> <p>Q4</p> <p>Q1-4</p> <p>2014/15</p> <p>Q1-4</p> <p>Q1-4</p>	Child Health Action Group	<ul style="list-style-type: none"> - RSP Action Plan 14/15 - Māori Health Plan 14/15 - Annual Plan 14/15
Cancer Services alignment	<ul style="list-style-type: none"> Continue to facilitate Midland Māori Health Providers in the Kia ora - E te iwi (May 2015) Explore feasibility to increase the number of DHB whānau ora/ community/ Iwi workers whose contract agreements that include cancer component (April 2015) From FCT wait time data information and/or from regional tumour standards identify any equity issues and implement improvement strategies(June 2015) 	<p>Q1-4</p> <p>2014/2015</p>	Midland Cancer Network	<p>Midland Cancer Network Work Plan 2014/15</p> <p>Midland Māori Cancer Plan 2012-14</p>

Priority Area	Outcome Reported	Timeframe	Responsibility	Link to Other Priority Areas
Mental Health and Addictions	<ul style="list-style-type: none"> • Convene regional wananga/ Conference around Mental Health and Addictions (September 2014) • Māori Mental Health and Addiction is improved by the pilot implementation of Hua Oranga Māori Outcome Measurement tool which is piloted in one kaupapa Māori service in each of the Midland DHBs. Pilot sites are identified in partnership with Te Rau Matatini. • Regional reports are provided to Clinical Governance and a clear regional picture is developed on strategies for improving Māori access and treatment. Hua Oranga is implemented and clinician, whai ora and whānau outcomes are evaluated in partnership with Te Rau Matatini on (June 2015) • Stocktake to be undertaken to improve mental health and addiction service capacity for high and complex needs. Stocktake to include Māori access rates (July 2013 – June 2016) • Robust regional contribution to the national network for forensic inpatient services. 6 monthly stakeholder report will identify Māori access rates and length of stage (July 2013 – June 2016) • Develop and implement actions for a Community Youth Forensic Service Plan to increase access to community youth forensic services and availability of liaison officers in court. Reports provided quarterly to identify Māori access rates and length of stay (July 2013 – June 2016) • Establish a coordinated network for FTE working in Perinatal MH&A to support supervision and workforce development. Reports provided quarterly to identify Māori access rate and length of stay (July 2013 – June 2016) • Working group established through MH&A to develop a flexible solution for Orion Concerto implementation. Working group to consist of a clinical representation from each of the Midland DHBs (July 2015 – June 2016) • Regional stock on the Midland Workforce Development initiatives and Needs Analysis. Māori workforce barriers will be identified and articulated (July 2014 – June 2016) • MH&A regional summit undertaken to provide direction to the MoH and MHC on Māori mental health and addiction priority areas for development. Evaluation reports identify challenges for Māori and Addiction sector going forward. Solutions to reduce barriers for Māori and areas of best practice (June 2015) 	Q2-Q4	Mental Health and Addictions Network/ GM Māori Midland	RSP Action Plan 14-15

Whānau Ora	<p>Utilise Taranaki Whānau Ora Model as a framework to guide Whānau Ora initiatives/developments sub regionally across the Midland region</p> <ul style="list-style-type: none"> • Whānau Ora HNA completed (sub-regional) • Integrated Contracts in place • Results Based Accountability (RBA) outcomes integrated into Māori provider contracts • Support of Whānau Ora Collectives, through resources, information or initiatives 	Q2-Q4	GM Māori Midland	RSP Action Plan 14-15
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Objective 2: Integrate across continuums of care

Midland DHBs are committed to developing integrated services across continuums of care. This provides an improved quality, safety and experience of care for patients. It also leads to more timely treatment and care, which in turn can result in better patient outcomes. Improved system integration also supports clinical and financial sustainability of the service. The table below outlines regional initiatives to be progressed by regional networks and action groups that have a primary impact on the integration of health services in the Midland region. Further detail is provided in appendix 4 and this includes initiatives that are expected to have indirect benefits as well.

National Initiatives	Milestone			
	Q1	Q2	Q3	Q4
Midland Cancer Network Programme				
Shorter waits for cancer treatment - sustain performance targets for radiotherapy and chemotherapy				
Improve medical oncology services - continue to implement Midland Medical Oncology Service Plan				
Improve radiation oncology services – Waikato/Bay of Plenty DHBs transition service change				
Faster Cancer Treatment Health Target and wait time indicator and improvement plan				
Improve multidisciplinary meetings – develop MDM databases				
Regional DHBs review against national tumour standards				
National Lung Cancer Working Group initiatives				
Cardiac Services				
Integrated Care Management - CVD Pathway development				
Ischaemic Heart Disease - Regionally agreed guidelines, protocols, processes and systems.				
Strategic Midland Region Cardiac Regional Service Plan				
Elective Services				
Produce Maps of Medicine for Chronic Pain – one per annum				
Complete demand analysis to inform Chronic Pain Map of Medicine pathways				
Regional opioid policy is approved				
Attain demand analysis to inform Ophthalmology Map of Medicine pathways				
Produce Maps of Medicine for ENT – one per annum				
Develop network for ENT services				
Regional Mental Health & Addiction Network				
Eating Disorders Inpatient Care				
High and Complex Needs				
Forensic Inpatient Care				
Youth Forensic Implementation				
Perinatal / Maternal Mental Health & Addiction				
Regional Workforce Planning				
Mental Health and addiction strategic development				
Midland Regional Trauma System (MRTS)				
Guidelines and Clinical Transfer Matrices				
Midland Stroke Network				
Provide support for DHBs local work plans to implement the 2010 Stroke Guidelines				
Provide a conduit for information sharing and implementation of work programmes locally				
Discharge planning and post stroke care				
Māori Health				
Pacific Population Health				
Telestroke pilot				

Regional Initiatives	Milestone			
Child Health Action Group (CHAG)	Q1	Q2	Q3	Q4
A regional Service Plan & Implementation Plan				
A review of paediatric activity and / or admission rates				
Well Child/Tamariki Ora Quality Improvement Framework				
Midland Maternity Action Group (MMAG)				
Improve patient care, quality and safety through establishing a robust maternity/neonatal transfer system				
Radiology				
Midland Radiology Advisory Steering Group - support Ministry priorities & improve on CT/MRI Targets				
Scope and Implementation of regional e-referral and e-orders				
Completion of Primary Access Criteria				
Investigate funding options for radiology services				
Regional Benchmarking – staffing and service delivery models				
Midland Smokefree Programme				
Improve the referral process and pathway for hospitalized Māori smokers to cessation services				
Maternity - establish a referral pathway to ensure that Māori pregnant women who smoke are identified early and supported to take up cessation advice and services				
Rangatahi - Confirm a comprehensive annual calendar of rangatahi (youth) events and provide support				

Objective 3: Improve quality across all regional services

Midland DHBs are committed to improving quality in health services and working with others to do this.

Midland Quality Steering Group (MQSG) coordinates the delivery of the national Open for Better Care (Open) quality and safety campaign. The MQSG includes the quality leaders in each Midland DHB and is chaired by Jan Adams, chief operating officer, Waikato DHB and the quality sponsor for Midland DHBs.



Regionally, each DHB is taking a lead role with a topic in the campaign (falls – Tairāwhiti and Lakes; surgical site infection – Bay of Plenty; perioperative harm – Waikato) and is well linked to share the learnings from implementing this topic first with the other DHBs. Quality leaders in Midland DHBs work closely with other DHB quality leaders in New Zealand through the New Zealand DHB Quality and Risk Managers group and with the Health Quality and Safety Commission. Each of the Midland DHBs is recognised as being at a different starting position regarding quality. The engagement of consumers is supported and expected to increase as each topic in the DHBs quality and safety campaign matures.

Similarly each DHB is at a different place with regards to mortality review committees. Discussions held in these committees are embargoed as Protected Quality Assurance Activities under the Health Practitioners Competence Assurance Act (2003), and matters under review are specific to the systems and contexts of each DHB. As the more established mortality review committee and to help develop robust mortality review committees in the region, Waikato DHB is sharing its processes surrounding the functioning of its committee with other Midland DHBs.

The learnings from national mortality review committees are regarded as very important for Midland DHBs. Within regional networks and action groups there is a culture of quality improvement and self-reflection. Learnings from national mortality review committees are proactively incorporated into service improvement initiatives to facilitate system improvement. There is also a strong likelihood that these learnings become included as central policy or guidance for activity in DHB Regional Services Plans which are produced annually.

"Quality Accounts are annual reports from boards and leaders of health and disability healthcare organisations to assess quality across all of the healthcare services provided, and how each provider is progressing in terms of continuous quality improvement, the consumer experience and health outcomes." *Quality Accounts – A Guidance Manual for the New Zealand Health and Disability Sector (Health Quality & Safety Commission, July 2012).*

Midland DHBs would value an opportunity to include a regional perspective into their quality accounts to demonstrate how Midland DHBs are measuring and improving quality as a region.

The New Zealand Triple Aim is a framework that Midland DHBs have embraced and seek to apply in service development initiatives (section 4.3). The Triple Aim means:

- » improved quality, safety and experience of care
- » improved health and equity for all populations

» better value for public health system resources.

Like any framework there are levels with its application. Midland DHBs have spent time developing initiatives to demonstrate an improvement through each of the triple aims. Ahead of the 2015/16 planning process Midland DHBs intend to adopt a regional planning methodology **that integrates the three aims to help answer the question, 'how is value better defined?'**

For 2014/15, the tables that follow outline the initiatives to be progressed by regional networks and action groups that have a primary impact to improve the quality of all regional services. Further detail is provided in appendix 4 and this includes initiatives that are expected to have indirect benefits as well.

National Initiatives	Milestone			
Midland Cancer Network Programme*	Q1	Q2	Q3	Q4
Primary - secondary pathway tools – prioritise pathway development & include equity reminders				
Faster Cancer Treatment service improvement initiatives				
Faster Cancer Treatment Health Target and wait time indicator and improvement plan				
Regional tumour standard reviews - regional DHB stocktake and gap analysis against national standards				
Improve Midland lung cancer services - Implement regional recommendations				
Improve Midland prostate cancer (level 2 priority)				
Improve Midland gynae-oncology services				
Improve Midland palliative care services (level 2 priority)				
Improve Midland PET-CT services (level 2 priority)				
Improve multidisciplinary meetings (MDM). Develop MDM databases				
Cardiac Services				
Ischaemic Heart Disease - Regionally agreed guidelines, protocols, processes and systems.				
Ischaemic Heart Disease - Angiograms and Percutaneous Revascularisation				
Strategic Midland Region Cardiac Regional Service Plan				
Regional Mental Health & Addiction Network				
Improve access to all age ranges				
Improve strategic alliances				
Eating Disorders Inpatient Care				
High and Complex Needs				
Forensic Inpatient Care				
Youth Forensic Implementation				
Perinatal / Maternal Mental Health & Addiction				
MH&A regional data management				
Regional Workforce Planning				
Mental Health and addiction strategic development				
Midland Regional Trauma System (MRTS)				
Governance				
Trauma Quality Improvement Programme (TQIP) – work plan development				
Risk Register				
Guidelines and Clinical Transfer Matrices				

*Midland Cancer Network Programme: Level 2 priority are initiatives that are subject to resource availability

Midland Stroke Network	Q1	Q2	Q3	Q4
Provide support for DHBs local work plans to implement the 2010 Stroke Guidelines				
Provide a conduit for information sharing and implementation of work programmes locally				
Ongoing implementation of education programmes for clinicians across the region				
Thrombolysis service in geographically remote areas of the Midland region.				
Discharge planning and post stroke care				
Māori Health				
Pacific Population Health				
Key audits and outcome measures are monitored by the Stroke Network				
Telestroke pilot				

Regional Initiatives	Milestone			
Child Health Action Group (CHAG)	Q1	Q2	Q3	Q4
A regional Service Plan & Implementation Plan				
A review of paediatric activity and / or admission rates				
Review of paediatric activity and/or admission rates– Acute – 0-4 years, asthma and gastroenteritis diagnoses				
Review of paediatric activity rates - First specialist assessments and follow up in the outpatient setting				
Ongoing monitoring of child and youth initiatives across the region and nationally				
Key outcome measures are monitored by the Child Health Action Group				
E-learning modules				
Information				
Map of Medicine				
Well Child/Tamariki Ora Quality Improvement Framework				
Midland Maternity Action Group (MMAG)				
Reduce the smoking and Midland SUDI rates and improve breastfeeding rates				
Improve access to pregnancy and parenting classes, particularly for rural and Māori pregnant women				
Improve Lead Maternity Carer (LMC) registration so that access to care is increased				
Inclusion of consumers in the MQ&SP governance boards at each Midland DHB to enable consumer informed decision-making				
Radiology				
National Radiology Service Improvement Project - to improve the effectiveness, efficiency and sustainability of radiology services				
Midland Smokefree Programme				
Improve the referral process and pathway for hospitalized Māori smokers to cessation services				
Maternity - establish a referral pathway to ensure that Māori pregnant women who smoke are identified early and supported to take up cessation advice and services				
Rangatahi - Confirm a comprehensive annual calendar of rangatahi (youth) events and provide support				

Objective 4: Build the workforce

Regional workforce and training development plan 2014/15

Workforce is identified as a key enabler both within the Ministry of Health's Guidance for DHB Annual Planning Priorities and the Regional Services Plan Guidelines for 2014/15. Within this Midland RSP we aim to develop the principles of culture, capability, capacity and change leadership. We recognised that there are long-standing gaps and weaknesses in our knowledge around the current workforce, particularly relating to capability and capacity. Critically evaluating the workforce as a number (headcount/FTE) does not provide sufficient evidence to enable clinical networks to develop new models of healthcare delivery.

Workforce planning is not an exact science. It requires us to predict potential future levels of demand for particular roles and predict likely future levels of supply so we can judge how many newly qualified health professionals will be required to deliver models of clinical care. Our workforce modelling will consider demand and supply variables and the current training volumes being delivered against the anticipated demand. During this year we will develop a workforce methodology that challenges the impacts described above and provides a reliable foundation on which to develop new workforce streams and subsequent training requirements.

This plan establishes, within the Midland region, the intent to re-establish a coordinated workforce and training approach to better determine our current need and potential future workforce needs. As part of this regional approach it will be important to determine that the region has the capacity to train staff in the right numbers and skills co-located to match population health care demand and need. A coordinated regional approach seeks to develop the capability of health workforces to become more flexible through multidisciplinary training that better matches population needs. Finally, it supports the principle to support delivery of care more focused to primary and community care, developing generalists. Recognising that specialists training within health careers will be limited to a few health care professionals located in particular centres.

General managers – human resources (GM-HR) provide a pivotal executive role in each of the Midland DHBs to plan and develop the future workforce. The regional director of training (RDoT) role working alongside GM-HRs provides the link between workforce and training. Better alignment of strategic planning between these two entities is essential to develop the workforce required within our region in the near future, whilst providing a long-term platform for developing a sustainable model of training and workforce development. The plan identifies that GM-HRs will work in tandem with RDoTs in workforce and training planning. Midland region is currently evaluating its training hub (Midland Region Training Network – MRTN) and is expected to raise the governance of this group to level III within regional leads for CEO, chief operating officers, GM-HR, directors of nursing and directors of allied health, with specific workstreams charged to execute and deliver the strategic plan herein.

This plan recognises the emerging national collaboration between District Health Board – Shared Services (DHB-SS) and Health Workforce New Zealand (HWNZ). This collaboration will support collection and collation of workforce intelligence and training data, thus enabling the Midland region to extract and critique credible and reliable data around its workforce (DHB-SS)

and funded training positions (HWNZ), and support development of health practitioner workforces to deliver new models of care.

Within this planning cycle closer engagement and subsequent alignment to the clinical networks has occurred. Recognising that workforce and training are enablers to support healthcare to our populations, strengthening the workforce capacity and capability in line with service delivery developed within the clinical networks. This is particularly reflected in the technical expertise from GM-HRs and the RDoT working alongside a newly developed position of workforce analyst, supporting the clinical and population need within the clinical networks. This new way of working within this RSP illustrates the shared vision to work collectively to develop solutions and delivery models of care for our vulnerable populations. The latter half of the 2013/14 RSP has seen greater alignment between the GM-HR group and the RDoT and this relationship has led to the successful development of a workforce intelligence and planning position within HealthShare Ltd. This role will provide intelligence and data to the GM-HR group and a database repository that will enable GM-HR/RDoT working with regional networks and action groups to consider new models of care and forecasting future workforce supply and demand.

The demography of our health workforce is aging and accordingly key strategies and activities have been developed within this plan to assert how our provider organisations will accommodate the unique circumstances that a more mature workforce brings to practice. Factors influencing demand include: changes in patterns of disease, development of technologies, introducing new professional or regulatory authority scopes of practice, financial constraints and workforce substitution. In conjunction with HWNZ and national DHB-SS, Midland DHBs are to explore the development of a data cube that provides a single point of reference for all workforces within the Midland region DHBs, populated by local DHB sources and national sources.

Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
Growing the health workforce through strengthening recruitment, retention and repatriation							
WF1	Retention and recruitment strategies for rural and primary care workforces	<p>Method to link sector together within a community and to recruit, orient and socialise new health professionals</p> <p>Enable each Midland DHB to lever off the successes and learnings of each other and to develop shared programmes where these are appropriate</p> <p>Clinical Training Centres</p> <p>Recruitment & Retention</p>	<ol style="list-style-type: none"> Investigate expansion of rural immersion programme (rip) at Whakatane to rural hospital at Waikato DHB General Practice: <ol style="list-style-type: none"> Develop training placements opportunities for GP trainees in vulnerable populations/hard to recruit centres. Develop placements for those GP II & III trainees seeking to experience another vocational scope as part of their training Determine training, provision and supervision models for GP practice across the Midland region. Map practices and GP educators Develop a strategy to actively recruit GP registrars with the intent of providing them placements for the <u>whole three years of their fellowship programme</u> 	<p>Implementation of a rip at a rural hospital in the Waikato.</p> <p>GP Registrars matched to vulnerable populations and areas of service need.</p> <p>Initial map completed.</p> <p>Developed business case, supported by DHBs/PHO's and HWNZ</p>	<p>Q4 (1)</p> <p>Q2 – ongoing (2)</p> <p>Q1 (2)</p> <p>Q 3-4 (2)</p> <p>Q4 (2)</p> <p>Q2 (2)</p>	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>	<p>(1) University of Auckland in partnership with primary care and Waikato DHB</p> <p>(2) HealthShare Ltd (MRTN) in partnership with primary care and Directors of Clinical Training</p>
WF2	Kia Ora Hauora Midland Region Programme – promotion of health as a career	<p>Young people gain exposure to health professionals in an interactive situation.</p> <p>Increased numbers of Māori young people pursue health careers</p> <p>The total population in the Midland region is 853,725 with 205,590 or 24% Māori compared with 17% Māori for</p>	<ol style="list-style-type: none"> Allocate DHB contact to assist Kia Ora Hauora coordinator to implement careers events in each Midland DHB in 2013/14 based on the patient journey through the emergency department into the hospital, and back to the community. Explore how the region may leverage off the Kia Ora Hauora health careers website and student tracking system for student events. 	<p>Ensure numbers of Māori continue to grow proportional to their DHB FTE</p>	<p>Q1-4</p> <p>Q4</p>	<p>✓</p>	<p>(1) GMsHR and Kia Ora Hauora in partnership with GMs Māori</p> <p>(2) HealthShare Ltd (MRTN)</p>

Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
	<p>NZ as a whole.</p> <p>This region would like to increase the numbers of Māori providing health care to Māori and non-Māori.</p> <p>Objective 1: Improve health outcomes for Māori</p>	<p>3. Develop protocol with Kia Ora Hauora to enable mentored trainees into DHB careers.</p>	<p>Annual targets are: Waikato: 2% BOP: 1% Lakes: 1% Taranaki:1% Tairāwhiti:1%</p>	Q4			
WF3	<p>Vulnerable, hard to recruit, New & emerging workforces</p>	<p>Midland DHBs will work with the identified workforces to gain: sustainable supply and retention good workforce utilisation increased service flexibility</p>	<p>1. Regulated workforces</p> <p>1.1 Sonographers: complete a regional stocktake on regional Sonographer workforce issues and work with HWNZ, RDoTs and GMSHR on the national work programme for Sonographers.</p> <p>1.2 Midwifery: with a regional microsite in place, assign a recruitment co-ordinator to oversee applicants to the midland region. Work with HWNZ to ensure all DHBs are eligible DHBs for midwife placements on the voluntary bonding scheme. Work with Directors of Nursing and Midwifery and the Maternity Clinical Network to assess attraction and retention issues – develop a work plan and implement it.</p> <p>1.3 Nursing: ensure all new RNs have access to a formal New Entry To Practice programme and that Enrolled Nurses are formally and appropriately orientated into DHB services. To do this we will review current numbers of internships, assess any current or future needs and provide for changes to the programme or increase in numbers as appropriate.</p> <p>DHBs will also ensure that their services are ready for Diabetes prescribers and consider other nursing specialties suited for prescriber status and</p>	<p>170 nursing graduates, (registered and enrolled nurses), have a formal orientation/new entry to practice programme in place</p>	<p>Q2 (1)</p> <p>Q2 (2)</p> <p>Q3 (1)</p> <p>Q1 (1)</p>	<p>✓</p> <p>✓</p>	<p>(1) HealthShare Ltd (MRTN) (2) GMSHR in partnership with RDoT, Clinical Networks, DONMs/CMAs/ HealthShare Ltd, relevant unions, Clinical training directors, RMO units and DHB services</p>

Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
		articulate these to and work with HWNZ to develop.					
	PGY I & II - Single Curriculum (MCNZ)	1.4 PGY I & II: supported implementation of MCNZ curriculum across the region. Development of a series of supervision workshops for Medical Supervisors	Earlier exposure to GP practice for a cohort of PGY II	Q3			
	Placement Map	1.5 Take a watching brief as this work is completed as part of MCNZ accreditation. Consider career mapping supported by this work.		Q3 (1)			
	Share Training Repositories	1.6 Development of centrally accessible repositories to support teaching and learning.		Q3 (1)			
	PGY I & II Outpatient and/or Community Attachment	1.7 Development of innovative placements across the region to support exposure to primary health care.		Q3 (1)			
	Rural Recruitment & Retention	1.8 Develop a strategy to actively recruit registrars with the intent of providing them placements for one of their fellowship programmes. Examine opportunities to deliberately recruit Registrars to be in hard to recruit locations.		Q3 (1) Q2-4 (2)			
	GP Dual Training	1.9 Need to identify hospital training needs and opportunities e.g. advanced ED experience, anaesthetic training etc.		Q2-4 (2)			
	Identify Hospital Training Needs & Opportunities	1.10 Also need to look at academic offerings for the trainees and how these can be best supported regionally e.g. emergency care offerings, ultrasound training etc.		Q2-4 (2)			

Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
	Academic Offerings for Trainees	<p>1.11 Resident Doctors: to support the medical pipeline work we will review the number of non-training positions and consider strategies to reduce non training positions- amongst other things, this may include replacement of non-training positions with training positions and discussing with non-trainees as to their career intentions to support them into vocational training. Target for reduction to be developed in 15/16.</p> <p>DHBs will engage with the NHB on the Medical pipeline work and consider appropriate vocational training opportunities for GPEP trainees in their years 2 and 3.</p> <p>1.12 Mental Health roles: work with the regional Mental Health Workforce Co-ordinator and the Mental Health and Addictions Clinical Network to develop recruitment strategies for mental health roles throughout the region – current hard to recruit roles include Nursing, allied health, addictions clinicians, Psychologists, service assessors, Psychiatrists in mental health for the older person.</p> <p>1.13 Endoscopy workforce: work with HWNZ on the programme to build the endoscopy workforce.</p> <p>1.14 Oncology workforce – work with the Midland Cancer Network on various projects related to: implementation of the Midland Oncology Service plan; improving Radiation Oncology Services; support of the midland Gynaecology model of care; the consultant and medical trainee workforce for palliative care and evaluation of the cancer nurse co-ordinator initiative.</p>		<p>Q2-4 (1 &2)</p> <p>Q2-4 (2)</p> <p>Q2-4 (2)</p> <p>Q1-4 (2)</p> <p>Q1-4 (2)</p>	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>	

Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
		<p>1.15 Senior Medical staff: to support the work on the medical pipeline we will review the number of NZ trainees in the workforce and develop strategies to support more NZ trainees through the medical pipeline and into SMO roles. Target for reduction to be developed in 15/16.</p> <p>1.16 Allied health: develop a range of multidisciplinary post graduate teaching and learning opportunities based around long term conditions and rehabilitation</p> <p>Seek to develop greater inclusion of Allied health new graduates to study alongside the conventional Nurse Entry to Practice programme.</p> <p>1.17 From time to time other specialist workforces will become hard to recruit, vulnerable or workforces with expanding or emerging scopes of practise. In general DHBs will be expected to develop their own plans if the issue is specific to their DHBs, but the regional recruitment team will monitor such issues and raise these to GMsHR if the issue impacts more than 2 DHBs. In these circumstances, GMsHR in consultation with relevant groups will consider the priority and resourcing needed to address immediate and/or urgent issues.</p>		<p>Q2 (1)</p> <p>Q2 (1)</p> <p>During the year (2)</p> <p>Q1-4 (2)</p>	✓	✓	

Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
		<p>2. Non-regulated workforces.</p> <p>Implement non-regulated workforce training business case – specifically :</p> <ol style="list-style-type: none"> 1. Health Care Assistants – Waikato DHB to complete initial training in April 2015. Lakes DHB and Taranaki DHB to adapt their programme from Waikato DHB. Tairāwhiti DHB to review proposal in 14/15. 2. Orderlies – Lakes DHB, BOP DHB, Taranaki DHB and Tairāwhiti to start in 14/15, subject to the approval process. Waikato DHB to commence in 15/16. 3. Allied Assistants – Waikato DHB training started in 13/14. Lakes DHB to adopt for allied in 15/16. Other DHBs to develop their proposals. <p>3. Pacifica Workforce</p> <ol style="list-style-type: none"> 1. Establish baseline workforce demographics for DHB Pacifica workforces. 2. Identify workforce needs, implement actions. Target for increasing the Pacifica workforce to be developed in 15/16. 		<p>Q1-4 (2)</p> <p>Q1-4 (2)</p> <p>Q2 onwards (2)</p>	<p>✓</p> <p>✓</p>	<p>✓</p> <p>✓</p>	

Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
<i>Shaping the future workforce through transformative change</i>							
WF4	Ageing workforce strategies	1. Understand the dynamics, an ageing workforce within the Midland Region and how best to utilise this workforce. Health sector grey pool of workers	1. Identify the potential capacity and capability of the ageing workforce and model how this cohort will continue to contribute to healthcare delivery within the Midland Region, e.g. physical expectations of the job such as flights and acute emergency care.	Q4 (1)	✓	✓	(1) Taranaki as the lead DHB to develop options (2) HR GMs
		2. DHBs workforce is ageing at a faster rate than the rest of the labour force. The DHBs need to be well positioned ahead of the time when the age of its workforce becomes material. There are many benefits to the proposed activities including:	2. <i>Flexible work arrangements</i> Develop options paper, pilot and assess feasibility	Q4 (1)	✓		
		<ul style="list-style-type: none"> • supporting succession and career planning and is research based • enabling employees with valuable skills and knowledge to plan their exit with support from the organisation • enabling DHBs to tap into the knowledge and skills of motivated retirees for service delivery, training and mentoring • reducing pressure on filling vacancies to maintain service delivery as potential additional available workforce 	Embed the Work Ability Index tool which allows the organisation to predict early retirement and put support in place for staff to reduce the likelihood leaving early. <i>Phased retirement options</i> Identify ways to ensure compliance with legislation, while allowing employees an opportunity to discuss and plan for their retirement and exit from the DHB. Support access to individual planning information and interim work arrangements	Q4 (2)	✓		
			<i>Third age (post retirement)</i> Support succession and career planning Identify key stakeholders within the Midland DHBs, and establish the feasibility and benefits of maintaining post retirement relationships Draft options paper for decision and implement			✓	

	Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
Strengthening health workforce intelligence								
WF5	Workforce Intelligence and modelling	Workforce planning: <ul style="list-style-type: none">Improves our understanding of current demographicsEnables us to model workforces for future needs	Provide demographic information and forecasting model for all workforces identified by the Clinical Networks and some base line intelligence outlined in workforce delivery WF3.		Q4 (1)	✓	✓	(1) HealthShare Ltd in partnership with GMsHR and HWNZ
Building and expanding the capability of the health workforce								
WF6	PGY I & II Training & Education Programmes	Current systems and processes are aligned to national standards	Implement the MCNZ PGY1 and II pre vocational medical curriculum and regional adoption. Examine national E portfolios and E career planning and if they can be adapted for the Midland Region	PGY1 and II pre vocational programmes are in place in the timeframe defined by MCNZ	Q4 (1)	✓	✓	(1) HealthShare Ltd in partnership with CMAs, Clinical Schools and Clinical Directors of Training.
WF7	Allied Health Post-graduate multi-disciplinary team first-year of practice programme	Develop a regional approach to support the allied health new graduate workforce in each DHB	1. Develop a pilot project plan, define benefits and objectives 2. Identify funding and cost-effective model for training (HWNZ) 3. Define project risks (HWNZ funding; allied health leadership in place to effect change; mandate to implement a regional model; define support and reporting requirements; sustainability; commitment by tertiary education provider) 4. Define project deliverables (post-graduate training through tertiary provider; competencies and training defined; contract / service level agreement) 5. Evaluation against defined objectives and benefits		Q1 Establish project board and finalise project plan Q2 Q3 Implement new-graduate training program. Q4 (1)	Q1 2015/2016 Evaluation		(1) HealthShare Ltd
	Unregulated staff training	Explore options for generic allied health assistant training programme for the support	6. Develop a pilot project plan, define benefits and objectives 7. Identify funding and cost-effective model for		Q1 Establish project board and finalise			(1) HealthShare Ltd

	Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
		workforce	training (DHBs/HWNZ) 8. Define project risks (funding; access to accredited assessor, allied health leadership in place to effect change; mandate to implement a regional model; define support and reporting requirements; sustainability) 9. Define project deliverables (competencies and training defined; applicability of learning materials for CareerForce modules; contract/service level agreement)		project plan Q2/3 Finalise project plan Q4 Implement project plan	Q4 2015/2016 Evaluation		
WF8	Nursing & Midwifery	E-Portfolios Regional NETP Midwifery RSP: Workforce E-Learning UG Recruitment Diabetes Nurse Prescribers	Develop infrastructure and process for nurses to develop interactive e-portfolios. Develop single NETP programme, incorporating primary and VLCA placements. Develop sustainable workforce. Build and deliver a series of e-learning modules i.e. CTG. Work with Wintec to deliberately recruit from high needs/difficult to recruit localities. Develop a workforce of Nursing Prescribers: BOP x Lake x Tairāwhiti x Taranaki x Waikato x		Q1 (1) Q3 (1) Q3 (1 & 2) Q3 (1)			(1) HealthShare Ltd (2) Clinical Networks

	Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
WF9	Skills and Simulation	Focus and activity is delivered without detracting from meeting local need. Expected area of growth – technology in learning and team based clinical training	Scope models of multi-disciplinary scenario training across region – using the existing Tairāwhiti model.		Q4 (1)	✓		(1) HealthShare Ltd in partnership with professional development units/Clinical Directors of Training/Clinical Schools
		Stocktake	Scope technology needs sub-regionally.		Q2 (1)			
		Skills & Simulation Strategy	Complete a comprehensive stocktake of all physical training resources and technical support staff.		Q4 (1)			
		Shared Training Repository	Develop a 3-5 year strategic plan to develop a sustainable skills and simulation methodology		Q4 (1)			
		Create Regular Network Around Meeting & Simulation Users	Develop a shared repository of teaching and learning resources (i.e. problem based scenarios, classroom bookings).		Q4 (1)			
WF10	Shared learning	Work towards a shared suite of learning resources across the region	1. Develop a business case that proposes the future model of the Managed Virtual Learning environment (MVLE) Advance E Portfolios and E career planning across nursing workforces 2. Complete the development of regional E Training – the current priority list is below: <ul style="list-style-type: none"> • Restraint Minimisation and Safe Practice • Hand Hygiene • Nursing Code of Conduct • Fire Training • Health and Safety Responsibilities • IV Medicine Management • Consumer Rights • Emergency Management • Electrical Safety 		Q1 (1)			(1) HealthShare Ltd in partnership with GMsHR, Regional Training Network and Wintec
					Q4 (1)			
					Q2-Q3 (1)	✓	✓	(2) E Learning team in partnership with the Health of the Older Peoples Clinical Network
						✓		

Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
		<p>3. Complete shared learning resources in conjunction with the following clinical networks:</p> <ul style="list-style-type: none"> a) Health of Older People – develop shared regional education and training resources for dementia and delirium pathways. b) Cardiac Network – develop health literacy education. c) Māori Health – ensure appropriate cultural competency training is available and develop regional on line recording ethnicity training. d) Midland Stroke Network – Make available the Auckland Thrombolysis learning tool on the regional E learning network e) Midland Trauma Network – consider offering Moodle as an online education and policy document network 		<p>Q2-Q3 (1 & 2)</p> <p>Q2-Q3 (1 & 2)</p> <p>Q2-Q3 (1 & 2)</p> <p>Q2-Q3 (1 & 2)</p> <p>Q2-Q3 (1 & 2)</p>			
	Long-Term Sustainability Business Case	<ul style="list-style-type: none"> • Business Case development for GMsHR post July 2015 • Computer literacy for virtual learning • Research and evaluation • Alliances (national and international and other regions, private providers, tertiary providers). 		Q1 (1)			
	Advanced Care Planning	<p>Moodle link to Midland Region Training Network site:</p> <ul style="list-style-type: none"> • Level I – access to staff • Level II – (GMsHR Lead) 		Q2 (1)			

Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
WF11	Alignment of training funding to 70/20/10	<p>Funding matches contracted volumes and funding criteria</p> <p>Identify service needs and map to funded training positions across all zones.</p> <p>Identify and report where DHBs need to maintain HO FTE to meet service needs where positions are funded via HWNZ and where budget to be redistributed.</p> <p>Develop service and funding plans as required for approval. Focussed funding matched to developing workforce with difficulty to recruit too.</p> <p>Establish protocols for cross DHB training (if required).</p> <p>Examine potential to develop innovative clinical placements across primary/secondary interface and across traditional DHB boundaries</p> <p>Establish a series of Primary Care placements for those PGYII seeking to experience primary care as part of the new NZMC curriculum. Promoting primary care careers earlier in their post graduate training.</p>	<p>Compliance with funding criteria is achieved by 1 July 2015</p>	<p>Q1-4</p> <p>Q1-4</p> <p>Q4</p> <p>Q4</p> <p>Q4</p>	✓		<p>(1) HealthShare Ltd RDoT in partnership Directors of Clinical Training, RMO units, COOs, GMsHR and CMAs</p>
Strengthening health workforce planning – determine need and expectations of Clinical Networks whilst developing workforce intelligence across the whole of service to support robust planning guidance							
WF12	Future workforce planning for <u>Renal Maternity, Radiology and Cardiac services</u>	<p>Utility of existing workforce model critiqued against workforce forecasting [Q2 – Renal, Radiology; Q4 – Maternity, Cardiac]</p> <p>Develop a robust understanding of Cardiac SMO workforce issues and identify future workforce needs including training programmes</p> <p>Explore options for innovative workforce models</p>	<p>Q2 & Q4 (1 & 2)</p> <p>Q2 (1 & 2)</p> <p>Q4 (2,3, 4)</p>	✓			<p>(1) HSL RDoT & Workforce Analyst Role.</p> <p>(2) Regional Clinical Networks</p> <p>(3) Midland DHBs</p> <p>(4) HSL</p>

	Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
		Future workforce requirements are identified and plans developed to ensure appropriate care provision continues.	Develop a concept paper which explores alternative models and use of workforce to future proof service delivery Trial new collaborative models and evaluate specific models as agreed	Q4 (2,3, 4) Q4 (2,3, 4)		✓		
	Workforce planning and forecasting for <u>Maternity medical staff</u>	O&G placements in identified areas planned for with RANZCOG.	Quantification of percentage of consultant time spent in obstetrics to ascertain level of obstetric workforce need Quantification benchmarked across other three regions by RDOTs Strategic plan for sustainable obstetric physician service provision inclusive of obstetric anaesthetists, SMOs, RMO training, and placements is developed Increase PGY1 and PGY2 numbers doing RMO runs Explore feasibility of separate obstetrics and Gynae. work for tertiary facilities Complete position paper identifying different global models of obstetric care delivery and make available for analysis Develop a consistent regional approach to PGY1 and 2 O&G runs Develop a sustainable model of RMO training and mentorship across the region which match anticipated SMO vacancy models	Q2 (2) Q2 (1 & 2) Q4 (5) Q2 (2, 3,4) Q4 (2 & 5) Q4 (2 & 5) Q2 (2, 3,4) Q2 (2, 3,4)	 ✓ ✓ ✓ ✓ ✓	 ✓ ✓		(1) HSL RDoT & Workforce Analyst Role. (2) Regional Clinical Networks (3) Midland DHBs (4) HSL (5) GM-HR

Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
Workforce planning for <u>Elective services</u>	Future workforce requirements are identified and plans developed to ensure appropriate care provision continues.	<p>A system in place for capturing up-to-date specialist capacity for each DHB and the region as a whole</p> <p>Regional planning to capture workforce constraints and shortages, with the view of sharing resources where practicable</p> <p>Implement a regional production planning model that identifies the capacity of DHBs to deliver elective services at sub-specialty level, in order to match capacity and demand across the region</p> <p>Forward planning for regional service delivery including investigating regional appointments</p>	<p>Q1 ongoing (2)</p> <p>Q1 ongoing (2)</p>	✓			<p>(1) HSL RDoT & Workforce Analyst Role.</p> <p>(2) Regional Clinical Networks</p> <p>(3) Midland DHBs</p> <p>(4) HSL</p>
Workforce planning for <u>Mental Health services</u>	<p>Future workforce requirements are identified and plans developed to ensure appropriate care provision continues.</p> <p>Workforce initiatives aligned to national drivers.</p>	<p>Undertake a regional workforce stocktake and needs analysis</p> <p>Implement and support recommendations</p> <p>Establish workforce priorities annually</p> <p>Identify opportunities to build Midland' capacity in Trauma Informed Care</p> <p>Trauma informed Care workshops are delivered across Midland</p>	<p>Q1 start 2016</p> <p>Complete (2)</p> <p>✓</p> <p>✓</p>	<p>✓</p> <p>✓</p> <p>✓</p> <p>✓</p>	<p>✓</p> <p>✓</p> <p>✓</p>		<p>(1) HSL RDoT & Workforce Analyst Role.</p> <p>(2) Regional Mental Health Network</p> <p>(3) Midland DHBs</p> <p>(4) HSL</p>
Workforce planning for <u>Trauma services</u>	Trauma clinicians in the Midland region maintain competency and skill aligned to current best practice through the development of a tool for staff working in the area of trauma (e.g. nursing, Trauma Oriented Consultants (TOC), core staff)	<p>Determine orientation and training requirements for staff specialising in and/or providing trauma care</p> <p>Develop a professional development pathway for staff involved in trauma patient care</p> <p>Review opportunities for regional support of training and professional development</p>	<p>Q4 (2, 3)</p> <p>Q4 (2, 3)</p> <p>Q4 (2, 3)</p>	✓		✓	<p>(1) HSL RDoT & Workforce Analyst Role.</p> <p>(2) Regional Clinical Networks</p> <p>(3) Midland DHBs</p> <p>(4) HSL</p>

Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
Workforce planning for Child Health Services	Workforce - Plan for a sustainable generalist and specialist paediatric workforce <ul style="list-style-type: none"> Identify child health workforce across the primary, community and secondary sectors (head count and FTE) Identify current workforce shortages or vulnerable services If possible identify volume of patient contacts per FTE/occupational role 		Q4 (1 & 2)				(1) HSL RDoT & Workforce Analyst Role. (2) Regional Clinical Networks (3) Midland DHBs (4) HSL

The table below outlines regional initiatives to be progressed by regional networks and action groups that have a primary impact to build workforce. Further detail is provided in appendix 4 and this includes initiatives that are expected to have indirect benefits as well.

National Initiatives	Milestone			
Midland Cancer Network Programme	Q1	Q2	Q3	Q4
Improve medical oncology services - continue to implement Midland Medical Oncology Service Plan – medical oncologists and cancer nursing workforce; Bay of Plenty DHB recruit to haematologist vacancy; Bay of Plenty/Waikato service change; Lakes/Waikato service change				
Improve radiation oncology services – medical physicists				
Improve the functionality and coverage of multidisciplinary meetings (MDM)				
Support the cancer nurse coordinator initiative (CNCI) – support national evaluation of programme				
Midland gynae-oncology model of service – gynae-oncology surgeons and supporting workforce				
Improve colonoscopy services – support national workforce initiatives that focus on enabling DHBs to meet colonoscopy demand				
Midland palliative care – specialist palliative care workforce – SMOs and Advanced Trainees				
Continue to facilitate Midland Māori Health Providers in the Kia Ora – E te iwi programme				
Cardiac Services				
Strategic Midland Region Cardiac Regional Service Plan – Workforce				
Elective Services				
Development of a Regional Chronic Pain education program				
Development of a Regional collaboration between external Chronic Pain agencies e.g. QE Health, ACC and regional network				
Improved ability for clinicians to cover patients around the region when required				
Create sustainable workforce development plans for regional roles implemented as part of regional work				

National Initiatives	Milestone			
Elective Services (continued)	Q1	Q2	Q3	Q4
Regional appointment process for clinical personal in at risk areas				
Develop a standard regional process for appointing and monitoring nurses to deliver Avastin treatments				
Improved ability for Ophthalmology clinicians to access educational resources				
Regional Mental Health & Addiction Network				
Improve access to all age ranges				
Improve strategic alliances				
Eating Disorders Inpatient Care				
High and Complex Needs				
Forensic Inpatient Care				
Youth Forensic Implementation				
Perinatal / Maternal Mental Health & Addiction				
MH&A regional data management				
Regional Workforce Planning				
Mental Health and addiction strategic development				
Midland Regional Trauma System (MRTS)	Q1	Q2	Q3	Q4
Community of Research/Learning				
Midland Conference				
Trauma Specialist Workforce				
Midland Stroke Network				
Telestroke pilot				

Regional Initiatives	Milestone			
Child Health Action Group (CHAG)	Q1	Q2	Q3	Q4
A regional Service Plan & Implementation Plan				
Review of paediatric admission rates - Understand the capacity of the paediatric services				
Workforce - Plan for a sustainable generalist and specialist paediatric workforce				
E-learning modules				
Midland Maternity Action Group (MMAG)				
Workforce – plan a sustainable maternity workforce				
Strengthen consistency of practices through shared educational activities and shared resources				
Midland Smokefree Programme				
Improve the referral process and pathway for hospitalized Māori smokers to cessation services				
Maternity - establish a referral pathway to ensure that Māori pregnant women who smoke are identified early and supported to take up cessation advice and services				
Engage Kohanga Reo / Kura - Support to adopt the Tupeka Kore (tobacco free) philosophy as tikanga.				
Rangatahi - Confirm a comprehensive annual calendar of rangatahi (youth) events and provide support				

Midland DHBs trainee numbers for 2013-2014

Figure 12: Midland DHB Trainee Numbers for 2013-2014

		BAY OF PLENTY		LAKES		TARANAK		TAIRAWHITI		WAIKATO	
PU CODE	TRAINING PROGRAMME	CONTRACTED 12/13	CONTRACTED 2014	CONTRACTED 12/13	CONTRACTED 2014	CONTRACTED 12/13	CONTRACTED 2014	CONTRACTED 12/13	CONTRACTED 2014	CONTRACTED 12/13	CONTRACTED 2014
PRE VOCATIONAL TRAINING											
CTM20	Year 1 House Surgeons	20	24	11	12.5	12	13	7	9	28	25
CTM30	PGY2	12	20	7	10	8	8	6	5	13	13
CTM32	Diploma in Paediatrics	2	2	5	1	1	1	2	3	1	2
CTM55	Diploma in Obstetrics and Gynaecology		2				2				2
REGISTRAR TRAINING											
CTM51A	Anaesthesia - Pre Part 1	6	5	2	2	2	3			11	11
CTM51B	Anaesthesia - Post Part 1									13.5	13.5
CTM52A	Emergency Medicine - Pre Part 1			1.5						6.5	6.5
CTM52B	Emergency Medicine - Post Part 1									6	6
CTM54A	Physician Training - Adult Medicine (Basic)	3	5	5	4.25	2	3			21	21
CTM54B	Physician Training - Adult Medicine (Advanced)	2	2							14.5	14.5
CTM54D	Physician Training - Diabetic Medicine									1	1
CTM54E	Physician Training - Endocrinology									1	1
CTM54G	Physician Training - Gastroenterology		1								1
CTM54L	Palliative Care Medicine									1	1
CTM54LH	Palliative Care - Hospice Rotation									2	2
CTM54S	Physician Training - Sexual Health									1	1
CTM54PA	Physician Training - Paediatrics (Basic)		2	5	2	1	1			6	6
CTM54PB	Physician Training - Paediatrics (Advanced)	2	1	2	1	1	1	0.7		1	1
CTM55A	Obstetrics and Gynaecology - Pre MRNZCOG	2	2	1	1	1	1			3	3
CTM55B	Obstetrics and Gynaecology - Post MRNZCOG		1	1	1					4	4
CTM56A	Ophthalmology - Pre Part 1	1	1	1	1					1	1
CTM56B	Ophthalmology - Post Part 1									2	2
CTM57A	Pathology - Pre Part 1									1	1
CTM58B1	Psychiatry - Basic Year 1	2		1		1	0.5			1	4
CTM58B23	Psychiatry - Year 2/3	2	2							6	6
CTM58A	Psychiatry - Advanced	1								6	3
CTM60A	Radiology - Pre Part 1	2	3	1						4	4
CTM60B	Radiology - Post Part 1	1	1		1					3	3
CTM60RA	Radiation Oncology - Pre Part 1									2	2
CTM60RB	Radiation Oncology - Post Part 1									2	2
CTM61AD	Dermatology									1	1
CTM61S	SET Surgery Training										
CTM61S	Cardiothoracic Surgery									1	1
CTM61S	General Surgery	3	4	3	2	3	3			7	6
CTM61S	Orthopaedic Surgery	3	3			3	3			4	4
CTM61S	Otolaryngology Surgery										
CTM61S	Plastic Surgery										1
CTM61S	Urology	1	1							1	1
CTM61S	Vascular Surgery									2	2
CTM62RM	Rural Hospital Medicine			3.5	1	1	1.5	1.5	1	2	2
CTM70TA	Medical Physics - Therapy Part 1										
CTM70TB	Medical Physics - Therapy Part 2										1
ALLIED HEALTH											
CTT20	Anaesthetic Technician	1	1					1	1	5	8
CTT50	Physiology Technician								1		
CTMRT30	Ultrasonography	1	2		1			1	4	4	4
CTMRT4N	Radiotherapy - New Graduate - Non Supernumerary									3	3
CTMRT4S	Radiotherapy - New Graduate - Supernumerary										1
CTPC	Programme Co-ordination										
IRP001W	Additional PGY1		2		2		2				

Regional workforce planning and development

Workforce demographics: Overall, the national health workforce is made up of 66,692 workers, including both full and part-time staff, but excluding temporary and contracted staff. The Midland region accounts for 12,544, or 19 percent of this total workforce. In comparison, the Northern region makes up 36 percent of the total national health workforce. The following demographics are taken from data provided by HWIP: Health Workforce Information Programme, and is current as at September 2013.

Age Demographics: Nationally, the health workforce has an average age of 45.5 years. The Midland region, in comparison, has an average age of 46.2 years. The Counties-Manukau region's average age of 43.5 years is the lowest of all DHBs nationally.

Within the Midland DHBs, Bay of Plenty DHB has the highest average age of 47.5 years, full 2-years above the national average. Waikato DHB has the lowest average age, equalling the national average.

Occupationally, the biggest difference between national and Midland average age was seen in the area of Nursing, with the national average being 43 years, whilst the average Midland age was over 3 years higher than this, at 46.2 years.

Figure 13: Mean Age by Midland DHB for 2013-2014

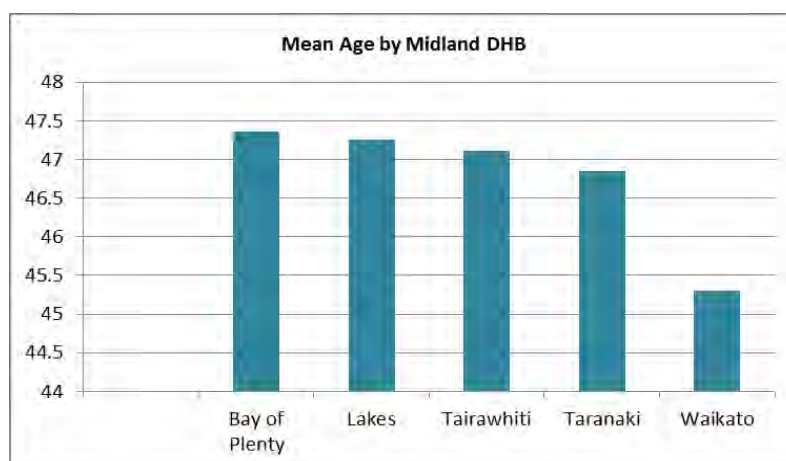
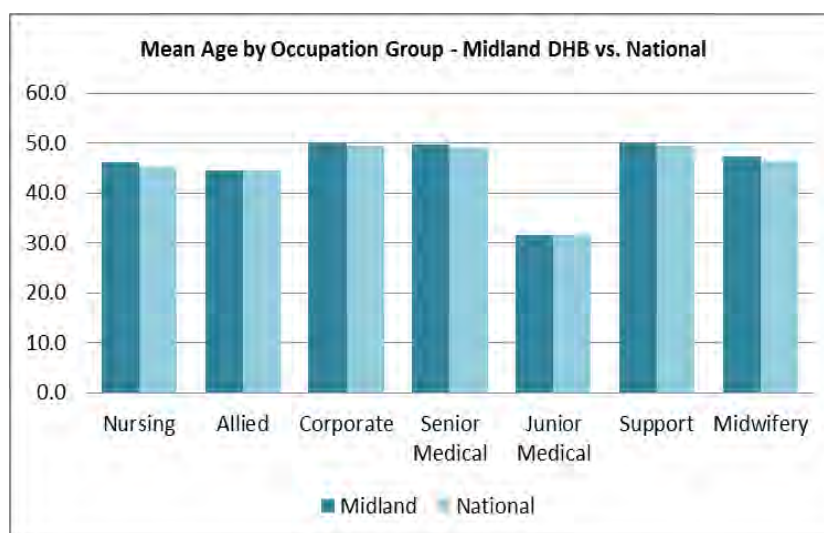


Figure 14: Mean Age by Occupation Group – Midland DHB vs. National for 2013-2014



Gender: At a national level, women make up 79 percent of the health workforce, whilst male workers are 21 percent. This represents a 2 percent decrease in the proportion of male workers from 2012 data. Consistent with this finding, the percentage of male workers across the Midland region fell by 1 percent on last year. The biggest disparity was in Tairāwhiti DHB, which recorded an 82 percent female workforce, and just 18 percent male. The lowest difference was at Waikato DHB, which had a 77 percent/23 percent split.

Generally, the Midland gender split is replicated at the occupation group level, although the exception to this is in the medical classification, whereby the proportion of males is significantly higher than the total workforce representation, and higher than the proportion of female workers. Taranaki DHB had the highest proportion of female SMOs at 29.6 percent, whilst Lakes DHB had the highest proportion of female RMOs, and at 58.8 percent the only Midland DHB to have over 50 percent female RMOs. In nursing, Waikato DHB had the highest number of male nurses at 11.6 percent.

Figure 15: Gender Proportion – Midland DHB Health Workforce for 2013-201

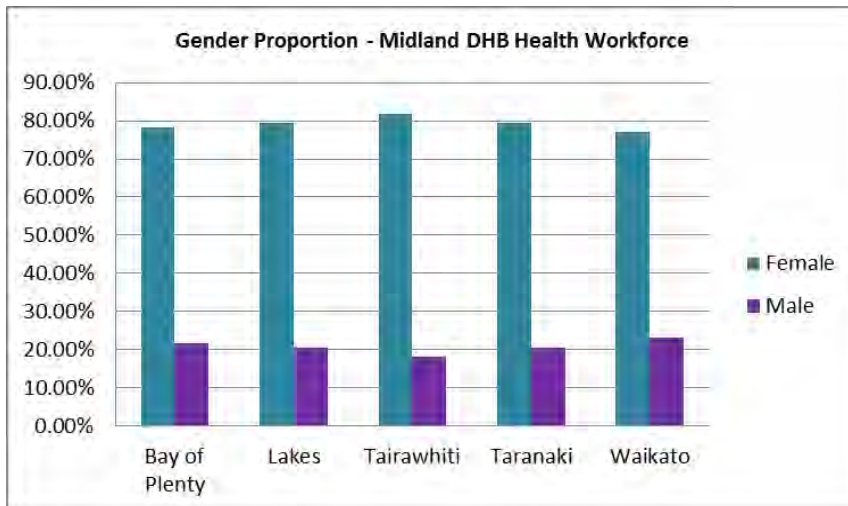
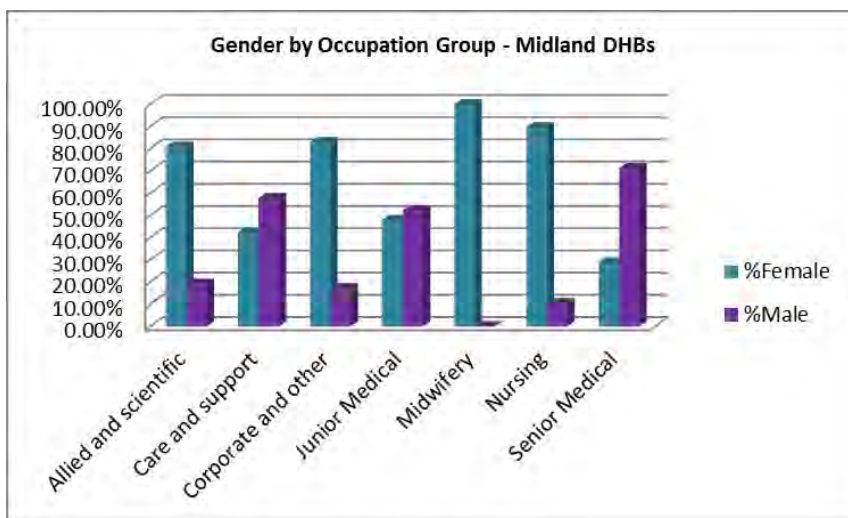


Figure 16: Gender by Occupation Group – Midland DHBs for 2013-2014



Ethnicity: There was little change in the overall ethnicity proportion of the health workforce nationally from last year. Nationally, the lowest proportion of **Māori** workers was seen at South Canterbury DHB, with 1.6 percent. Counties Manukau reported 9.5 percent Pacific workers, compared to the national average of 3 percent.

The Midland region had the highest proportion of **Māori workers** with 10 percent, far above the national average of 6 percent, although still well under the national **Māori** population of 14 percent (2013 Census). Across the Midland area, there was a slight decrease in the proportion of **Māori** workers from last year, and a corresponding increase in the Asian grouping.

Across the Midland region, the DHBs differed significantly in their demographic makeup. Taranaki saw the highest proportion of European workers with 83 percent, whilst Tairawhiti reported 23.8 percent **Māori staff**. Further, Waikato DHB included 16 percent of workers identifying as Asian ethnicity, contrasting with Taranaki and Tairawhiti who recorded under 5 percent Asian workers.

Figure 17: Ethnicity – National for 2013-2014

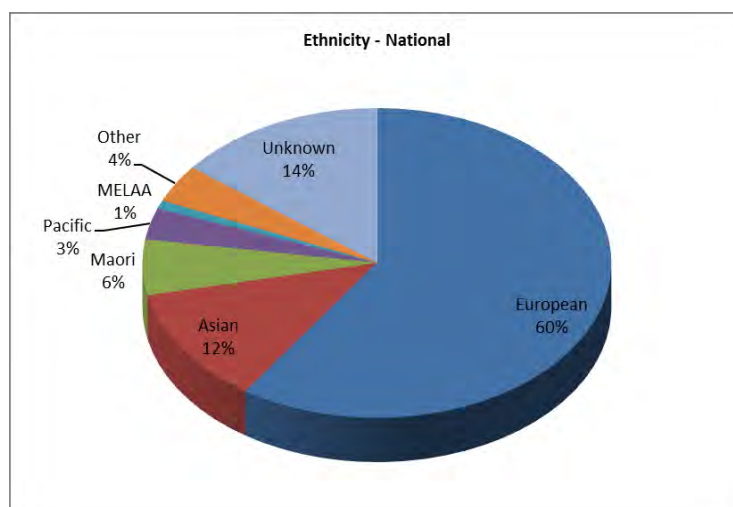


Figure 18: Ethnicity – Midland DHBs for 2013-2014

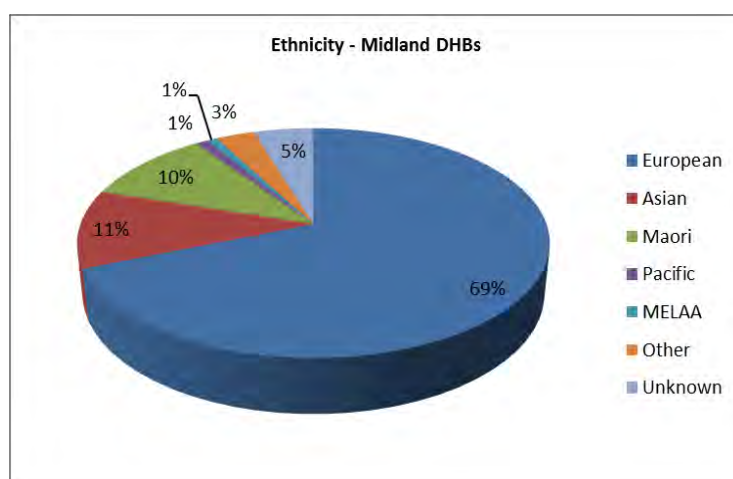
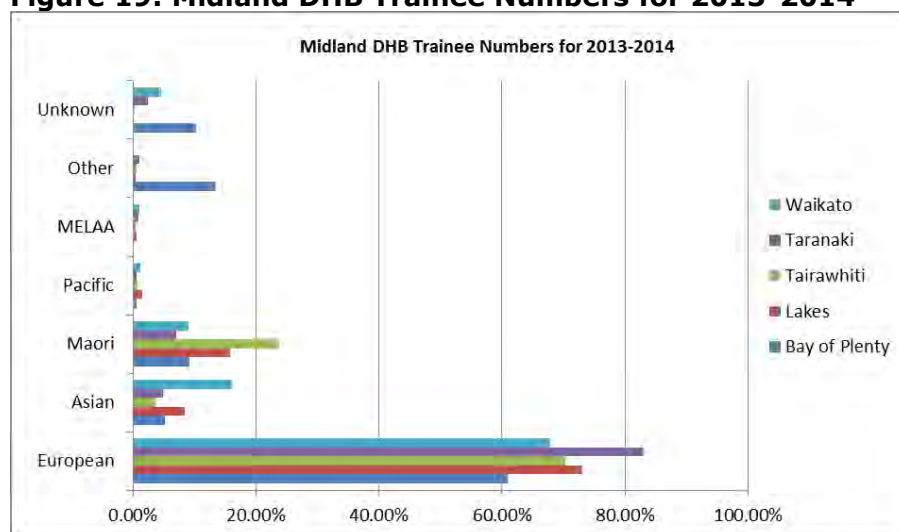


Figure 19: Midland DHB Trainee Numbers for 2013-2014



Objective 5: Improve clinical information systems

The strategic drivers for regional clinical IS investments are:

- » integrated care focused on the patient
- » effective and efficient clinical practice
- » effective business change
- » strategically aligned, agile IS environment.

The Midland Regional IS Service will implement the Midland Region Information Services Plan (MRISP); advance National Health IT Board (NHITB) priorities, specifically the critical priorities for FY14-15, and support the delivery of the IS enablers required to implement this Regional Services Plan (RSP). Clinical IS enablers are being delivered under a regional eSPACE programme.

The process of prioritising all IS investment and work effort is done via the IS Executive Group which is comprised of clinical leaders and business leaders from each of the Midland DHBs. This group reviews on a quarterly basis the programmes of work underway and the portfolio of planned IS investments across Midland DHBs, and provides recommendations to DHBs on the IS funding decisions required to support local, regional and national priorities. All recommendations are made within the context of the affordability envelope of the Midland DHBs. The current 3 year IS Portfolio and a summary of the NHITB critical priorities is included in appendix 5.

The current focus for clinical IS delivery is on the regional deployment of:

- » The ePharmacy hospital dispensing application which is due to go live across the Midland region at each DHB by the end of 2014. This will support hospital pharmacy processes regionally as well as providing a foundation for regional deployment of further medication management capability, specifically medicines reconciliation and electronic prescribing. A national pilot of the integrated medication management solutions has been undertaken at Taranaki DHB and will provide a reference implementation for regional roll-out.
- » Clinical workstation functionality utilising solutions from Orion, Sysmex and other suppliers is a foundation IS enabler across all clinical specialities. The first Midland DHB (Waikato) will be implemented on the solution in the 2013/14 financial year with Lakes DHB deployment in the 2014/15 financial year. Deployment of the remaining Midland DHBs and delivery of enhanced functionality will be undertaken in line with the regional IS portfolio and the eSPACE work programme.
- » A regional clinical data repository as a foundation IS enabler across all clinical specialities. The Sysmex CDR is being established as a component of the clinical workstation solution to support access to clinical information across organisational boundaries.
- » Electronic referral management as a key enabler for improved clinical (and business) practice. Primary care electronic referrals have been implemented across the region with the focus now on supporting end to end referral management through implementing referral management workflow within the DHB and supporting intra- and inter-DHB referrals.
- » Further expansion of clinical pathway tools to support improved clinical practice.

- » The Midland Regional Telehealth Strategy through development and implementation of a work programme and supporting IT road map. Core videoconferencing capability is being established in the 2013/14 financial year.
- » The delivery of these initiatives requires ongoing prioritisation of current activities at both a local and regional level to enable appropriate resources to be made available.

As regional IS structures and capability mature, opportunities to leverage the foundation infrastructure building blocks such as the regional network (Midland Connected Health) and the regional hosting platform (Midland Regional Platform) are being identified. For example, consideration is being given to regional IS solutions such as endoscopy and risk management.

The major risks to the ICT enablement of the RSP are:

- » The near and long-term affordability of the ICT program with several Midland DHBs under considerable financial pressure.
- » The volume of competing demand for local, regional and national IS delivery far exceeds capacity, and requires ongoing, rigorous efforts directed at visibility and prioritisation to manage conflicts.

The table below outlines regional initiatives to be progressed by regional networks and action groups that have a primary impact to improve clinical information systems. Further detail is provided in appendix 4 and this includes initiatives that are expected to have indirect benefits as well.

National Initiatives	Milestone			
	Q1	Q2	Q3	Q4
Cardiac Services				
Integrated Care Management - Regional Cardiac e-referral mechanisms – Primary/ Secondary / Tertiary services				
Ischaemic Heart Disease - Revascularisation - Cardiac Surgery				
Elective Services				
Complete a regional GP survey around areas of improvement for Ophthalmology and Chronic Pain.				
Regional Mental Health & Addiction Network				
Improve access to all age ranges				
Improve strategic alliances				
Eating Disorders Inpatient Care				
High and Complex Needs				
Forensic Inpatient Care				
Youth Forensic Implementation				
Perinatal / Maternal Mental Health & Addiction				
MH&A regional data management				
Midland Regional Trauma System (MRTS)				
Registry				
Trauma Quality Improvement Programme (TQIP) - IT platform				
IS Support for MRTS				
Midland Stroke Network				
Key audits and outcome measures are monitored by the Stroke Network				
Telestroke pilot				

Regional Initiatives	Milestone			
Child Health Action Group (CHAG)	Q1	Q2	Q3	Q4
A regional Service Plan & Implementation Plan				
National Child Health Information Programme (NCHIP)				

Objective 6: Efficiently allocate public health system resources

The role of Midland DHBs is to fund the provision of the majority of the public health and disability services in the region through the contracts that the five DHBs have with providers. Midland DHBs are working together to deliver a health system that is clinically and financially **sustainable, where safe and effective services are provided as close to people's homes as possible.**

Efficiently allocating public health system resources can occur in a variety of ways. For highly specialised clinical services, Midland DHBs work together to ensure that patients are transported in a timely manner to the hospital that performs complex services sufficiently frequently to provide safe and effective services. The historical referral pathway for Tokoroa residents to receive non-urgent orthopaedic surgery was for them to be referred to Waikato Hospital. After a review and discussion with GPs in Tokoroa, it was agreed that these residents may now be referred to Rotorua Hospital to receive non-urgent orthopaedic surgery. This has provided these residents with closer access to this surgery and means that Waikato Hospital can focus on performing more complex orthopaedic surgery.

Determining value and efficiency

Measuring efficiency savings may be difficult and can take time. This can apply to a number of the initiatives being undertaken by the regional networks and action groups. As indicated in objective 3, ahead of the 2015/16 planning process Midland DHBs intend to adopt a regional planning methodology that integrates the three aims of the New Zealand Triple Aim to help **answer the question, 'how is value defined better?'** This is likely to start with investment logic mapping methodology and apply quality, equity and outcomes lenses. Training is likely to be provided to the regional networks and action groups in August or September of 2014.

For the 2014/15 RSP, Midland DHB CEOs have reviewed the activities of the regional groups – both clinical and non-clinical. They have agreed that the initiatives contained in the 2014/15 RSP represent value.

Capital investment planning

Midland DHBs have recently drafted their first Midland Region Capital Investment Plan (MRCIP). The MRCIP provides an overview of capital intentions planned in the Midland region over the next ten years and is aligned with the strategic direction and objectives outlined in the 2014/15 RSP. The MRCIP represents a regional amalgam of the detailed capital expenditure plans that each DHB has completed according to local, regional and national objectives after taking account of affordability. Opportunities for more efficiently allocating resources for capital have yet to be determined.

National agencies

Midland DHBs are working with Health Benefits Ltd, a national agency that is standardising non-clinical services such as food services, laundry, procurement and the implementation of a financial information system. HBL is tasked with saving \$700 million over seven years.

The National Health Committee (NHC) is another national agency that Midland DHBs are working with to more efficiently introduce new technology or the expansion of existing technology in health.

HealthShare Limited

HealthShare Limited (HSL), established in 2001, is a regional Shared Services Agency jointly owned by Waikato, Bay of Plenty, Lakes, Taranaki, and Tairāwhiti District Health Boards. HealthShare employ staff to perform tasks on behalf of the Midland DHBs that would otherwise require each DHB to employ their own staff and develop this expertise. From August 2011 HSL has taken on an expanded role as a regional provider of non-clinical services and now provides operational support in a number of areas identified as benefiting from a regional solution.

The Midland DHBs determine the services that HSL will provide and the level of these services on an annual basis. These determinations are made through the RSP and regional business case processes. Categories of possible regional service delivery include:

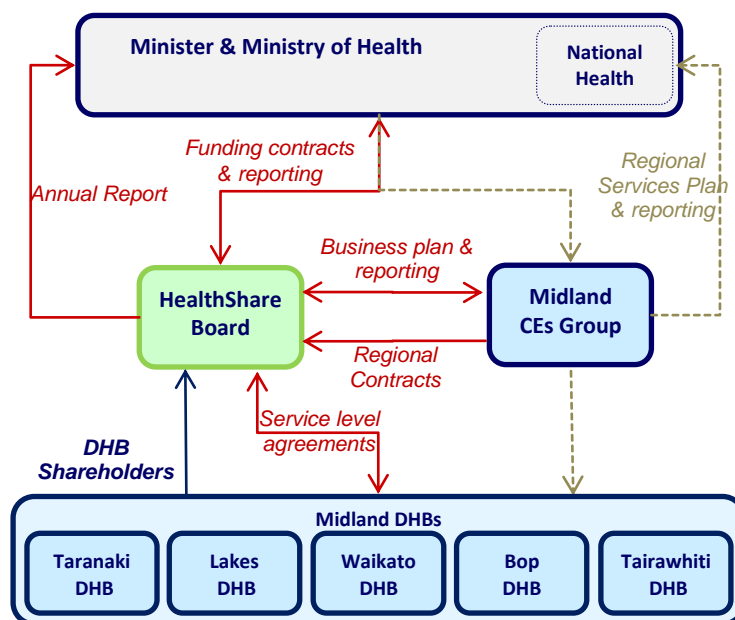
- » Activities that support future regional direction and change through the development of regional plans.
- » Facilitating the development of clinical service initiatives undertaken by regional clinical networks and regional action groups that support clinical service change.
- » Key functions that support and enable change through the ongoing development of the **region's workforce and information systems**.
- » Back office service provision that can drive efficiencies at a regional level, alongside new national back office shared services.

The annually agreed regional services form the basis for HSL's Business Plan which specifies the **company's performance framework, the services to be provided**, and the associated performance measures. **HealthShare's Business Plan also details, at a service level, the activities that have been purchased by the shareholding DHBs.**

HSL has multiple planning and reporting relationships within the Midland region and to national agencies as depicted in the following diagram.



Serving the Midland DHBs through network coordination and support excellence



The following regional services are expected to be provided from HSL in 2014/15:

- » Regional planning and reporting facilitation
- » Regional service networks: Midland Cancer Network, Midland Mental Health and Addictions
- » Regional clinical networks and regional action groups including: Cardiac Network, Child Health Action Group, Elective Services Action Group, Health of Older People Action Group, Midland Maternity Action Group, Midland Region Trauma System, Radiology Network, Stroke Network, Regional Emergency Departments Services*, Renal Action Group*, Rheumatic Fever Action Group *
- » Midland region training network
- » Workforce development and intelligence support
- » Regional information services
- » Regional shared service delivery including:
 - Third party provider audit and assurance service
 - Regional internal audit service (Waikato, Lakes, Taranaki, Tairāwhiti)
 - Midland recruitment and selection service
 - Midland Smokefree programme.

* These areas are not included in the 2014/15 RSP.

The table below outlines regional initiatives to be progressed by regional networks and action groups that have a primary impact to efficiently allocate public health system resources. Further detail is provided in appendix 4 and this includes initiatives that are expected to have indirect benefits as well.

National Initiatives	Milestone			
Midland Cancer Network Programme	Q1	Q2	Q3	Q4
National Lung Cancer Work Programme				
Regional DHBs review against national tumour standards				
Improve radiation oncology and medical oncology services				
Faster Cancer Treatment health target and wait time indicator				
Improve colonoscopy services				
Improve multidisciplinary meetings				
Cardiac Services				
Integrated Care Management - Primary Risk Factor Management				
Integrated Care Management - Secondary Risk Factor Management				
Elective Services				
Clarity of clinical conditions that are not be treated within the region and streamlining of pathways to providers				
Agree standard intervention rates overseen by the regional Ophthalmology Clinical Network				
Develop a regional RetCam service				
Continuation and development of additional regional sharing of patients to non-tertiary care facilities outside of their domiciled DHB				
Reduction in appropriate low complexity acute cases being transferred to Waikato DHB from around the region.				
Expansion of sub-regional arrangements allowing sharing of lower complexity patient regionally across appropriate specialties				
Regional Mental Health & Addiction Network				
Improve access to all age ranges				
Improve strategic alliances				
Eating Disorders Inpatient Care				
High and Complex Needs				
Forensic Inpatient Care				
Youth Forensic Implementation				
Perinatal / Maternal Mental Health & Addiction				
Regional Workforce Planning				
Mental Health and addiction strategic development				
Midland Regional Trauma System (MRTS)				
Registry				
Trauma Quality Improvement Programme (TQIP) – work plan development				
Research Centre				
Structure				
Midland Stroke Network				
Support the NZ Stroke Foundation to develop a primary stroke prevention education resource kit				
Key audits and outcome measures are monitored by the Stroke Network				
Telestroke pilot				

Regional Initiatives	Milestone			
Child Health Action Group (CHAG)	Q1	Q2	Q3	Q4
A regional Service Plan & Implementation Plan				
Review of paediatric activity and/or admission rates– Acute – 0-4 years, asthma and gastroenteritis diagnoses				
Review of paediatric activity rates - First specialist assessments and follow up in the outpatient setting				
Review of paediatric admission rates - Understand the capacity of the paediatric services				
Well Child/Tamariki Ora Quality Improvement Framework				
Midland Maternity Action Group (MMAG)	Q1	Q2	Q3	Q4
Improve patient care, quality and safety through establishing a robust maternity/neonatal transfer system				
Strengthen consistency of practices through shared educational activities and shared resources				
Radiology				
National Radiology Service Improvement Project - to improve the effectiveness, efficiency and sustainability of radiology services				
Scope and Implementation of regional e-referral and e-orders				
Completion of Primary Access Criteria				
Investigate funding options for radiology services				
Regional Benchmarking – staffing and service delivery models				

APPENDICES



Appendix 1: Regional governance

Each DHB has a chief executive with governance provided by a Board comprising appointed 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 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 responsibility is to develop plans and policy that are consistent with Government objectives and improve health outcomes for the local populations, 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 Midland Region Clinical Services Plan document refreshing earlier work that framed the basis for initial cooperation.

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 DHBs may have other historical arrangements.⁵
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.
7. Equity of access to regional services.

⁵ 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.

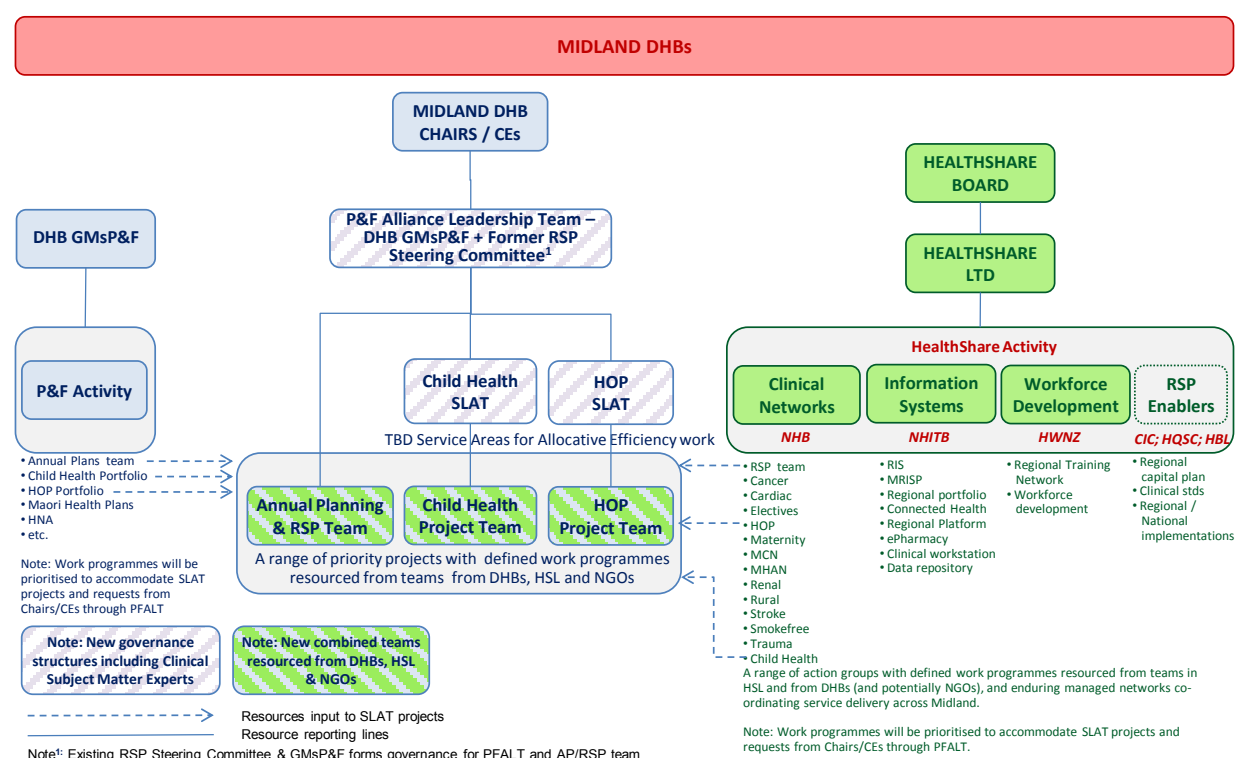
8. Secondary and tertiary care is acknowledged as episodic in response to short term higher health needs. Primary and community care provides ongoing care in response to change in **health needs over the course of an individual's lifetime.**
9. All DHBs will have input into the development of Regional Service Plans.
10. Funding prioritisation for local services remains a local DHB responsibility⁶.
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 an Alliance **Leadership Team facilitated 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 bi-monthly progress reporting is provided to the Chief Executives Group.

The Planning and Funding Alliance Leadership Team will focus on identifying priority areas for regional action, there may be some reallocation of current resource as priorities are clarified.

The diagram below illustrates the overarching regional reporting and accountability arrangements for Midland DHBs. This includes those for HealthShare Ltd and for various regional projects and workstreams.



⁶ Further discussion needs to be had on what remains a local service and what becomes a regional service

Regional elective services governance

Midland DHBs have a specific governance group overseeing regional elective services. Key functions of Project Governance Group include:

- Provides leadership for developing regional elective services
- Is accountable for the outcomes of the project
- Identifies and steers elective services where a regional approach is required
- Approves project changes (if required)
- Provides project oversight and guidance
- Provides knowledge and recommendations
- Commits DHB resources
- Helps identify and remove project barriers
- Identifies risks and issues and assists with mitigation

Membership Project Governance Group:

1. Midland CE representative (Ron Dunham)
2. Midland COO representative (Jan Adams)
3. Action group chair (Dale Oliff)
4. Planning and Funding General Manager representative (Brett Paradine)
5. Senior HealthShare representative (Andrew Boyd)
6. Senior clinical representative (Martin Thomas)
7. Taranaki representative (Rosemary Clements)
8. Tairāwhiti representative (Lynsey Bartlett)

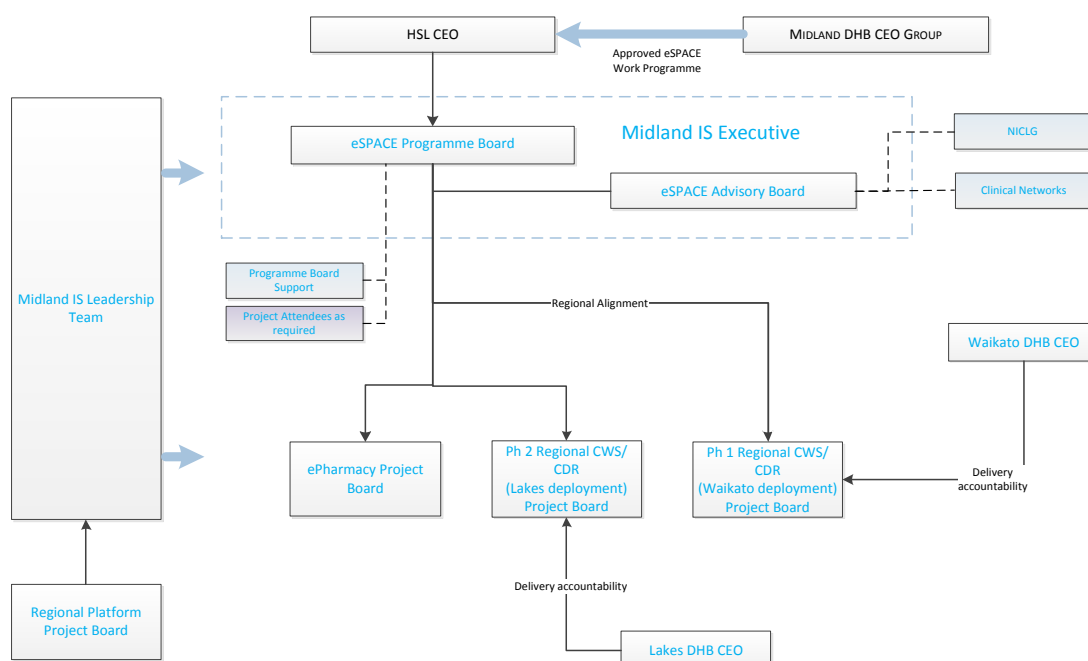
Information services

Regional IS governance

Integrated, multi-disciplinary, executive level governance and leadership is critical to support the delivery of the Midland Regional Information Services Plan (MRISP) and other regional IS initiatives.

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

With this in mind, a delineation of the governance applied to MRISP work programmes has been applied 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 regional IS governance structure is shown below.



The purpose of the IS executive group is to provide overarching guidance to all regional IS activities to ensure that the Midland IS programme of work is executed across the Midland DHBs in line with Midland and national clinical and business directions.

The **Midland IS Executive** provides overarching guidance to the regional IS portfolio including all MRISP work streams and regional IS priorities. This group and its role are delivered by the combination of the eSPACE Programme Board and eSPACE Advisory Board. The IS Executive is chaired by the Midland CIO Lead and reports to the HSL CEO.

The **Midland eSPACE Programme Board** provides the overall governance in relation to delivery of the agreed eSPACE Work Programme, and its constituent parts. The group is chaired by the Regional COO Representative.

Regional engagement and input is critical to implementation of the eSPACE Programme. The role of the **eSPACE Advisory Group** is to provide feedback on key aspects of the programme to support and enhance the decision making processes of the eSPACE Programme Board. The group has strong linkages into the regional clinical networks and Regional Service Plan governance groups. The eSPACE Advisory Group is chaired by the HSL Chief Medical Information Officer (CMIO). It includes 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.

Regional IS portfolio

All capital IS investment in Midland region is prioritised through the IS Executive Group. 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 ongoing investment and projects frequently cross multiple years. Investments must therefore be planned on a four 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.

Appendix 2: Future trends on Midland region populations and health services

Future trends overview

The following table describes some of the trends in healthcare that will impact upon Midland DHBs, with a brief overview of the likely impact of each trend on the continuum of health care services – from prevention promotion to rehabilitation and palliative care. This table does not describe our intended response to each trend.

Table 1: Future trends affecting Midland region populations

Type of Change	Prevention & health promotion	Primary care & early intervention	Secondary care - elective and acute	Rehabilitation, home support & palliative care
Demography The populations are ageing, and the proportion of Māori is increasing in each of the DHBs. The prevalence of long term conditions (LTCs) such as diabetes, cancer, age related disability and cardiovascular disease will increase.	There will be greater emphasis on strategies to reduce the incidence of conditions such as diabetes and heart disease via lifestyle modification (e.g. healthy pregnancy, smoking cessation, HEHA), public policy and urban design. Falls prevention approaches are likely to expand. Intersectoral approaches to improving Child Health will be important to resolve this problem.	Increased prevalence of chronic conditions, age related conditions, and co-morbidities result in increased demand for primary care services. Demand for disability services will also increase. The higher proportion of Māori will result in calls for more Māori owned and managed health services. Focus on achieving a healthy pregnancy and delivery is critical to long term well being	Demand for both elective services (e.g. hip replacements) and acute services (ED attendances and acute medical admissions) will increase. Older patients and Māori are more likely to have co-morbidities, requiring more complex care.	A review of Australian aged care services found that 86% of people aged 85 years plus require assistance with everyday activities, although only about 13% use residential care services. More services for the elderly such as aged residential care, restorative home care and dementia services will be required. Greater focus on refining care for those “in the last year of life” will identify a need for more comprehensive palliative care services.
Social Changes <ul style="list-style-type: none"> Increasing rates of obesity Changing consumer expectations Lifestyle changes 	Sedentary lifestyles and poor eating habits are resulting in increased obesity related diseases in New Zealand. Smoking rates are reducing – but at a slower pace among Māori.	The baby boomer generation is more likely to be assertive in requesting health services and to be informed of rights and options. Patients are becoming better informed about their own healthcare (e.g. through the internet), meaning they are better placed to take a more active role in management of their own health.	Increasing patient and clinician expectations will increase pressure for secondary services to provide the newest treatments, and purchase the latest equipment, in turn increasing costs. Bariatric surgery demand will increase, as will the use of appearance medicine (at least in private hospitals).	Most people will demand home based care options rather than residential services.

Table 2: Future trends affecting healthcare provision

Type of Change	Prevention & health promotion	Primary care & early intervention	Secondary care- elective and acute	Rehabilitation, home support & palliative care
Technology Technological advances in fields such as: <ul style="list-style-type: none"> • Genomics • Imaging • Diagnostics • Pharmaceuticals • Medical devices • Nanotechnology • Telehealth & IT 	Preventative technologies, for example, new vaccines, such as Gardasil (HPV vaccine) will reduce demand for some services (such as cancer and screening services), while increasing demand for other services (such as vaccine services). Screening programmes to identify genetic predispositions to common conditions (e.g. heart disease, diabetes) may be introduced.	Screening and early detection initiatives, for example, for bowel cancer screening programmes, may reduce demand for treatment services, while improvements in clinical imaging technologies will result in increased provision of those services. The use of near patient testing is likely to increase. Genomics will require additional knowledge of a new set of tests and will introduce ethical complications about predictive testing. Information systems will allow easy access to health records from home and consumers will expect email/videoconference options to contact their primary care provider.	Expanding treatment options are likely to result in the provision of more complex and expensive treatments and procedures. An Australian report calculates that technology changes have accounted for a third of the increase in real health expenditure in Australia over the last decade. Average length of stay declined more than 50% between 1989 and 2006, and while improving treatments will continue to reduce ALOS, the older age of patients will work to counteract this trend. Minimally invasive surgery will result in more use of day case surgery.	Improvements in tele-health and improvements in remote access to health records may assist health professionals in managing the expected increases in those requiring care at home. Technological advances together with reduced cardiac and accident mortality mean that people with incurable diseases are likely to survive for longer, resulting in increased demand for palliative care services.
Models of care Changing models of care incl: <ul style="list-style-type: none"> • Integrated family health centres • Clarification of roles/functions of small rural hospitals • Strengthening of secondary services with increasing nursing specialization • Use of specialty centres • Greater integration of Māori models of care 	Health promotion and prevention services may be integrated to a greater extent in primary care settings in future.	Future trends in changing models of care include using the workforce more efficiently, ensuring that GPs and nurses only see patients when necessary. For example, healthcare assistants providing health education for patients with long-term conditions. Improved coordination and potential shifts of secondary care services to primary care setting will result in GPs having better access to diagnostics, and undertaking more simple procedures such as minor surgery.	New practitioner roles may emerge – nurse endoscopist, physician assistant, nurse anaesthetist, etc. resulting in more multidisciplinary service provision. Volume – outcome relationships will drive greater aggregation of volumes in larger centres. However, changes in location of activity are unlikely to have a major impact on demand for specialist services overall, although potential shifts of secondary services to primary care may free up specialist time for more complex work.	Encouraging people to remain living in their homes for as long as possible and self-managing healthcare, with support from allied health and primary care professionals, is preferred model of care for the elderly, aimed at improving quality of life. Home care and rehabilitation services are becoming more integrated with primary care, to provide patients with seamless care. Increased communication between primary care and workers within the community is key to this change.
Workforce changes <ul style="list-style-type: none"> • Ageing & retiring workforce • Reduced willingness to work antisocial hours • More part time employees • Increased subspecialisation • Changing workforce roles 	Providing lifestyle advice and improving health literacy may become a greater part of most clinical roles.	Willingness to provide after-hours services may continue to decline. Ability to support rural towns and rural hospital services may also decline. Services may retrench to urban areas.	Increased specialisation may erode the ability of small hospitals to provide 24/7 surgical services, unless generalist approach can be strengthened. Workforce shortages likely to be supplemented with international recruitment, but increasing awareness of importance of 'grow your own' recruitment programmes will counterbalance this.	Workforce shortages are likely to be plugged with international recruitment.

Appendix 3: Health services – now and in the future

This section provides an overview of clinical services available currently within the Midland region. It explores trends and pressures and how they impact on services at an overview level. We then provide a more detailed breakdown by major service grouping, providing a picture of services provided currently and an indication of key pressure points for the future on those services specifically.

High level service overview

The DHBs provide a comprehensive range of emergency, acute and elective secondary services, to a varying degree (associated primarily with the size of the district). Waikato DHB serves as the hub for provision of very highly specialised services within the region. The majority of out of region referrals are to Auckland region DHBs, but DHBs also refer to other centres. Table 3 provides an overview of highly specialised referral flows by different DHBs within the region.

Table 3 illustrates a general characteristic of the region – the tight 3 (Waikato, Bay of Plenty & Lakes) which work more consistently as a region, and the loose two (Taranaki and Tairāwhiti) which sit on the margins of the region and have more variable referral patterns, and looser clinical relationships based on geographical/ access and historical provision grounds. One driver of the variability has been the difficult patient transport (especially non-emergency) from new Plymouth or Gisborne to Hamilton. Even emergency transfers are frequently lengthy and occasionally disrupted by weather.

Table 3: Current tertiary flows from Midland DHBs

Speciality	Bay of Plenty	Lakes	Tairāwhiti	Taranaki	Waikato
Medical & ICU	Waikato	Waikato	Waikato	Waikato except elective renal (CMDHB)	Waikato
Cancer treatment	Waikato until 1/10/14	Waikato	Waikato	MidCentral DHB	Waikato
Surgery	Waikato	Waikato	Waikato	CCDHB, Waikato	Waikato
Paediatrics	Auckland except paed surgery (Waikato)	Auckland except paed surgery (Waikato)	Auckland except paed surgery (Waikato)	Auckland	Auckland except paed surgery (Waikato)
Obstetrics & Neonatal	Waikato	Waikato	Waikato	Waikato	Waikato
Mental health	Waikato	Waikato	Capital & Coast	Waikato	Waikato

Major Service groupings – now and in the future

3.1 Major Hospital Surgical services

Current service availability

A full range of surgical services is available in the Midland region, with the exception of quaternary services (including transplant services) which are provided from Auckland, or in a few cases from Wellington. Each DHB provides 24/7 acute surgical services covering the major specialties: general surgery, orthopaedics, gynaecology and obstetrics. Bay of Plenty provides 24/7 acute surgical services at two sites: Tauranga and Whakatane. In other DHBs the smaller rural hospitals either provide no surgical services or low complexity elective surgery (especially Thames and Taupo) only. Most very highly specialised surgical services, including very highly specialised sub-specialties (such as cardiac surgery, neurosurgery) and higher risk or more complex surgery is provided from Waikato Hospital. These very highly specialised services are generally provided 24/7.

Elective surgery

The Midland elective services plan describes intended actions to increase to elective surgery, including by regional capacity planning where this can achieve greater gains. An option that clinical networks may wish to pursue in the future is for provincial centres to do more routine elective surgery to help maintain critical mass, while the major centres take on more of the acute and complex work. However, planning will need to be cognisant of studies of the relationship between volumes and outcomes, which generally suggest that outcomes are better in larger volume centres. This may lead to the development of centres specialising in particular procedures in the region. It is also understood that a reemphasis on training general surgeons to function as generalists will maintain services in the provinces.

Future trends

The future trends can be expected to affect the future provision of surgical services in Midland in the following ways:

- Population ageing can be expected to increase the demand for orthopaedics, general surgery, ophthalmology and services with greater utilisation at higher ages;
- Population growth in the Bay of Plenty may result in the ability to provide more complex interventions locally;
- Subspecialisation (e.g. from general surgery to upper and lower Gastro intestinal), combined with reduced willingness to work frequent call rosters will make it more difficult to maintain 24/7 acute surgery in Gisborne and Whakatane. Support from neighbouring hospitals will assist in managing this pressure. DHBs and the sector need to explicitly address the consequences of sub-specialisation and the reality that the marginal reduction in risk achieved may be at the expense of increased risk to the (increased) populations at a distance from services. The theoretical increased risk of generalised services may actually be less for such populations.
- Nurse endoscopy roles might reduce the extent to which general surgeons provide screening endoscopy services;
- More services might be provided at a distance using tele-health supports; and
- Larger primary care centres may take on some diagnostic work and minor surgery.

Likely changes in future levels of surgical services over the next two decades are set out below.

Table 4: Expected future summary surgical services levels

DHB	Comment
Bay of Plenty	Population growth will lead to increased subspecialty presence at Tauranga.
Lakes	Current levels of subspecialty should be sustainable with regional support.
Tairāwhiti	Current levels of acute surgical services will continue to require regional support.
Taranaki	Current levels of surgery at Taranaki should be sustainable with regional support.
Waikato	Assumes no change to future allocation of tertiary services (and higher levels) nationally – Auckland is unlikely to be able to accommodate Midland growth.

3.2 Major Hospital Medical and Emergency Department services

Current service availability

Midland DHBs provide 24/7 access to ED and acute medical service at both main hospitals, and in many DHBs, also in rural health centres.

Immunology and infectious disease subspecialties are not well established in the region and are mainly provided from Auckland. Other very highly specialised services are provided by Waikato DHB for the region, including interventional cardiology, neurology, respiratory and gastroenterology. Renal services are provided by Waikato for the region except Taranaki, which obtains some services from Counties Manukau. Waikato works with Bay of Plenty DHB, Tairāwhiti and Taranaki DHBs to delivery renal dialysis therapy across the region.

An issue for the region is the number of SMOs working in a subspecialty in a team of less than three staff.

Outside of Waikato most ED medical staff does not have FACEM qualifications and are staffed primarily with medical officers. As FACEM trainee numbers grow the larger provincial centres are attracting some established FACEMS to provide relevant resource.

ED attendances have been growing regionally (and internationally) for a complex set of reasons including:

- Population ageing;
- Difficulty in obtaining timely primary care appointments;
- The cost differential with primary care; and
- Perceptions of quality and convenience.

Future trends

The trends can be expected to affect the future provision of medical and emergency services in Midland in the following ways:

- Population ageing will significantly increase the demand for medical services;

- Population growth in the Bay of Plenty may result in the ability to provide more complex interventions (e.g. interventional cardiology) locally;
- More tertiary consultation liaison or virtual FSA services might be provided at a distance using tele-health technology; and
- Larger primary care centres (once adequately equipped) may expect more visiting outpatient services locally (e.g. cardiology, respiratory, neurology) in accordance with the Better Sooner More convenient Strategy.

Better management of medical conditions at an early stage constitutes one of the greatest potential opportunities to improve life expectancy, and reduce hospital admissions.

Table 5 shows the expected future summary levels of medical and emergency services at each DHB's major hospital. Little change is expected in the overall configuration of medical services at the base hospitals in the region, with substantial increases in volumes counteracting any trends to subspecialisation.

Table 5: Expected future medical services levels

DHB	Comment
Bay of Plenty	Population growth will lead to increased subspecialty presence (e.g. interventional cardiology) at Tauranga – these roles could be shared with Waikato to increase critical mass. Likely major pressure on medical beds at Tauranga with significant predicted growth in CWDs.
Lakes	Some volumes currently provided at Taupo may flow to Rotorua as rural hospital inpatient viability is challenged.
Tairāwhiti	General medical services are the most sustainable of the clinical services provided at Tairāwhiti.
Taranaki	Current levels of subspecialty practice in generalist roles at Taranaki may be difficult to maintain in the absence of defined clinical networks supporting local practice.
Waikato	Assumes no change to future allocation of tertiary services nationally. Auckland unlikely to be able to pick up current Midland volumes.

3.3 Cancer treatment services

Current services

Midland DHBs are split between 2 regional cancer networks: Midland Cancer Network for Bay of Plenty, Lakes, Tairāwhiti and Waikato DHBs. Taranaki is a member of the Central Cancer Network. The four Midland members of the Midland cancer network have developed and are implementing a strong action plan aimed at reducing inequalities and improving the patient journey.

Service flows are relatively complex in comparison to services in other regions, though clinical mapping suggests that outcomes are best when services are provided in one centre.

- All Midland Cancer Network DHBs refer to Hamilton Radiology for PET-CT (Waikato DHB), except Tairāwhiti has the option to also refer to Pacific Radiology, Wellington.
- All Midland Cancer Network DHBs refer to Waikato DHB for regional endobronchial ultrasound (EBUS) service.
- All DHBs refer paediatric oncology patients to Auckland DHB – though some paediatric surgery for cancer is undertaken in the region.
- Palliative care is provided by all DHBs – mainly through contracts with Hospice services.

Table 6: Cancer related services in Midland DHBs

DHB	Service	Provided by
Bay of Plenty	Treatment planning, highly specialised surgery	Waikato DHB
	Medical oncology, haematology, radiation oncology (from 1/10/14)	Bay of Plenty DHB (local)
	Chemotherapy	Bay of Plenty DHB (local)
Lakes	Highly specialised surgery, medical oncology and radiation oncology	Waikato DHB
	Chemotherapy	Lakes DHB (local)
Tairāwhiti	Mammography screening	Hawke's Bay DHB
	Radiation oncology, medical oncology, haematology	Waikato DHB
	Chemotherapy	Tairāwhiti DHB (local)
	Highly specialised surgery	Waikato and Auckland DHBs
	Mammography screening symptomatic	Tairāwhiti DHB (local)
Taranaki	Radiation oncology, medical oncology and complex chemotherapy	MidCentral DHB
	Highly specialised surgery (excluding gynae-oncology)	Waikato DHB
	Gynae-oncology tertiary surgery	Capital and Coast DHB
	Chemotherapy	Taranaki DHB (local)
Waikato	Medical oncology and radiation oncology Chemotherapy	Waikato DHB (local)
	Haematology	Waikato DHB (local)

Future Trends

Volumes of cancer services rise sharply with age; hence total volumes are expected to increase significantly with the ageing population. Since cancer services are a mainly outpatient and day service specialty, the impact on future bed days and CWDs is limited. However, the total service requirement will increase by a similar percentage to that foreseen in medical services – some 60 percent by 2026 – and the rise in associated costs is likely to be even greater.

3.4 Women's and children's health services

Current service availability

The Midland region currently provides 24/7 access to general obstetric, neonatal care and paediatric services at each of the major DHB hospitals. Waikato provides the majority of very highly specialised paediatric and obstetric care, with sub-specialty very highly specialised back-up provided by Auckland DHBs. Local provision for paediatric subspecialties generally consists of local paediatricians supported by visiting paediatric subspecialists.

It is of particular interest that maternity/neonatal services have clearly evolved to achieve high level services to at risk populations. This is a clear reflection of response to community needs.

Significant numbers of Midland babies are born in the smaller rural health centres or primary birthing centres. The Midland region is well served by small rural hospitals providing birthing services. However, small facilities have tended to have difficulty maintaining financial and clinical viability. Lead Maternity Carers (LMCs), usually midwives, are required to have a backup LMC (another midwife, and/or an obstetrician or GP) at each birth – requiring two people to be on 24 hour call in each area. This requirement can make it difficult to provide birthing services in rural areas.

Future trends

Both maternity and paediatric CWDs and bed days are projected to decline for non-Māori over the next 15 years – particularly in Taranaki, Tairāwhiti and Lakes. Māori CWDs and bed days are expected to increase. These trends may mean that in order to sustain the service revised service delivery and funding models are designed to maintain those services that it is important to retain.

Maternity and paediatric services are critical services for populations: the RDM suggests that they, along with diagnostic support, develop in advance of other services. The rationale is clear: obstetric services are a core service which remains difficult to regionalise without adverse outcomes. Many DHB services in smaller places, e.g. Gisborne, develop 'outward' from critical provision: there must be obstetric, which means paediatric support, which means anaesthetic support. The provision of ED requires support and so the infrastructure for secondary services is built around essential

3.5 Rehabilitation and elder care services

Current service availability

All Midland DHBs provide specialist assessment treatment and rehabilitation services, including both community ATR and specialist inpatient units.

DHBs also provide access to aged residential care services and home based support including household management, personal care, and restorative care.

Future trends

Status quo forecasts based solely on demographic change indicate a major investment in ATR and aged residential care services will be needed to maintain current service access levels.

Based on current service models, a more than 60 percent increase in geriatricians, allied health, and rest home nursing staff will be needed to meet future demands. Alternatively, significant investments in restorative and home-based care will be necessary to divert clients who will otherwise move into residential care.

Opportunities for changes to models of care include:

Use of InterRAI as a needs assessment and care planning tool to identify risks and monitor KPIs;

Prevention programmes including fall prevention and cvd risk management;

Greater use of restorative home based care involving registered staff directing the work of home care workers;

Investing in a more highly skilled home care workforce; and

Better coordination between community health services and primary care.

Clinical support services – now and future

Clinical support services include anaesthesia, radiology, pharmacy, pathology and Critical care/intensive care and clinical genetics.

Current services

The core clinical support services are available at each DHB's major hospital, and to a lesser extent in the smaller rural health centres. Of interest, Taranaki DHB contracts with private entities for radiology and anaesthesia services. Clinical genetics is available on a visiting basis from Auckland to Waikato and to Taranaki and Tairāwhiti from Wellington.

Diagnostic services have clearly evolved as a response to a commitment to the practice of modern medicine and the use of up to date technology across the region. Access to diagnostic Imaging particularly is indicative of this.

Future trends

Future advances in technology are likely to result in increased use of tele-health services – particularly in radiology, where the advent of PACs means that one radiologist might be able to cover the entire region over night. Pathology is also greatly impacted by technology, with much biochemistry now automated, and advances in near patient testing likely to change models of care in the future by supporting home and primary care based testing for many conditions.

In relation to genomics, the number and range of potential tests for genetic susceptibilities are increasing at a rapid pace. Currently access to genomics is highly constrained in the Midland region.

The ageing population will place considerable strain on the available intensive care beds. Access to these beds and repatriation from then already creates some tensions between DHB clinical staff. This contrasts with the access to neonatal intensive care, which, while also constrained, was given as an example of a networked service with clear and equitable access criteria.

Primary and community services

Current services

Primary care services are available in all areas. Community nursing and allied health services are provided in all districts, by both NGO provisions and DHB provider arm provision of services in the community.

After-hours access to services differs by DHB and locality. In Hamilton and surrounding areas Anglesea Medical provides a 24/7 A&M service that most practices divert to afterhours. At the smaller DHBs access to services after 10pm is usually the local Emergency Department, with A&M or large primary care centres open until 10pm in Taranaki and to 8pm in Gisborne.

Data supplied on GPs per practice, show that the average number of GPs (excluding locums) per practice is 3.2. However, the median number is 2.0 – indicating that most practices consist of one or two GPs only.

Primary Health Organisations (PHOs) are non-profit organisations contracted to DHBs to provide a comprehensive set of preventative and treatment services for their enrolled population (Table 7). Of note, nearly half the Midland population are members of one large PHO – the Midland Health Network PHO. A number of PHOs that have merged build critical mass and reduce overheads. The new organisational structures increase capacity, decrease overheads, are a platform for devolution and provide better patient access and coordination across the region.

There has been a great deal of innovation by DHBs and PHOs across the region resulting in locally targeted projects that focus on perceived areas of greatest need (e.g. diabetes, cardiovascular risk management, asthma, sexual health, youth health, mental health, refugee and migrant health and immunisations services).

For example a number of outreach services provided by primary health multi-disciplinary teams (including doctors, nurses and community health workers) have found real success in taking services to communities that would otherwise not engage with mainstream services (e.g. immunisation, breast and cervical screening, cardiac rehabilitation and respiratory services). Kaupapa Māori services have had a key role to play here. Considerable benefits have also been gained by working across and with other sectors (e.g. local City Councils, Work and Income New Zealand, Ministry of Social Development, Housing New Zealand and Accident Compensation Corporation).

Table 7: PHO enrolled populations

PHO	Enrolled populations in January 2014
Eastern Bay of Plenty Primary Health Alliance	45,754
Nga Mataapuna Oranga PHO	11,141
Western Bay of Plenty PHO	146,631
Rotorua Area Primary Health Service	72,683
Ngāti Porou Hauora Inc	8,980
Hauraki PHO	80,280
Midland Health Network (MHN) PHO - Total	422,301
made up of:	
• MHN Lakes	33,861
• MHN Tairāwhiti	25,936
• MHN Taranaki	104,238
• MHN Waikato	258,266

Appendix 4: Work programmes of regional networks and action groups

The work programmes of regional networks and action groups are set out in this appendix. They are grouped as initiatives originating under national or regional direction and are aligned against the region's six strategic objectives. This is to show how initiatives contribute to the region's strategic outcomes and vision.

It needs to be noted however that the six strategic objectives, while helpful to provide a clear line of sight for the region, they are simply a construct for a purpose. Aligning initiatives against these strategic objectives can create some difficulty for regional networks and action groups. This is due to initiatives in individual work programmes being interdependent on other initiatives and being developed as an integrated 'whole' for that service or area. Rearranging these initiatives to fit a regional construct may not fit neatly.

Regional strategic objectives

- 1: Improve Māori health outcomes
- 2: Integrate across continuums of care
- 3: Improve quality across all regional services
- 4: Build the workforce
- 5: Improve clinical information systems
- 6: Efficiently allocate public health system resources

For Milestones, where these are ongoing more than one box is shaded.

Similarly where there are actions that sit beneath initiatives with multiple milestones then more than one box is shaded

	Actions are specifically aimed at achieving this objective
	Actions will achieve this objective but as an indirect consequence

National Initiatives	Milestone			
Midland Cancer Network Programme	Q1	Q2	Q3	Q4
Midland Māori cancer improvement plan				
Primary - secondary pathway tools – prioritise pathway development & include equity reminders				
Faster Cancer Treatment – using data / information to identify and address inequity & improve services				
Shorter waits for cancer treatment - sustain performance targets for radiotherapy and chemotherapy				
Improve medical oncology services - continue to implement Midland Medical Oncology Service Plan				
Improve radiation oncology services – Waikato/Bay of Plenty service change transition project				
Faster Cancer Treatment Health Target and wait time indicator				
Regional tumour standard reviews - regional DHB stocktake and gap analysis against national standards				
Improve Midland lung cancer services - Implement regional recommendations				
Improve Midland prostate cancer (level 2 priority)				
Improve Midland gynae-oncology services				
Improve Midland palliative care services (level 2 priority)				
Improve Midland PET-CT services (level 2 priority)				
Improve the functionality and coverage of multidisciplinary meetings (MDM). Develop MDM databases				
Improve waiting times and quality of endoscopy/colonoscopy services				
Support the cancer nurse coordinator initiative (CNCI)				
National lung cancer work programme				

*level 2 priority are initiatives that are subject to resource availability

[illegible]

National Initiatives	Milestone			
Health of Older People	Q1	Q2	Q3	Q4
Improving services for people with dementia				
Delirium service development				
Wrap around services (rapid response and discharge management)				
Improving services between hospital specialist services and aged residential care				

Regional Mental Health & Addiction Network	Q1	Q2	Q3	Q4
Improve access to all age ranges				
Improve strategic alliances				
Eating Disorders Inpatient Care				
High and Complex Needs				
Forensic Inpatient Care				
Youth Forensic Implementation				
Perinatal / Maternal Mental Health & Addiction				
MH&A regional data management				
Regional Workforce Planning				
Mental Health and addiction strategic development				

Midland Regional Trauma System (MRTS)	Q1	Q2	Q3	Q4
Governance				
Registry				
Trauma Quality Improvement Programme (TQIP) – work plan development				
Trauma Quality Improvement Programme (TQIP) - IT platform				
Risk Register				
Guidelines and Clinical Transfer Matrices				
Midland Immediate Medical Response Service (project is currently on hold)				
Community of Research/Learning				
Midland Conference				
Research Centre				
Trauma Specialist Workforce				
IS Support for MRTS				
Structure				

Midland Stroke Network	Q1	Q2	Q3	Q4
Provide support for DHBs local work plans to implement the 2010 Stroke Guidelines				
Provide a conduit for information sharing and implementation of work programmes locally				
Support the NZ Stroke Foundation to develop a primary stroke prevention education resource kit				
Ongoing implementation of education programmes for clinicians across the region				
Thrombolysis service in geographically remote areas of the Midland region.				
Discharge planning and post stroke care				
Māori Health				
Pacific Population Health				
Key audits and outcome measures are monitored by the Stroke Network				
Telestroke pilot				

Appendix 4.1: National priorities

4.1.1 Midland Cancer Network Work Programme

Clinical Director: Dr Humphrey Pullon

Programme Manager: Jan Smith

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. The Midland Cancer Network, HealthShare Ltd encompasses all Midland organisations involved in the cancer continuum in the Bay of Plenty, Lakes, Tairāwhiti and Waikato districts, with an open invitation to Taranaki (with the Waikato DHB as the lead). Most New Zealanders will have experience of cancer, either personally or through a relative or friend.

Key drivers for cancer control action are:

- cancer is the country's leading cause of death (29.8 percent)
- cancer is a major cause of hospitalisation and a significant driver of cancer cost
- while the overall 'risk' of developing cancer in New Zealand is decreasing, the number of people developing cancer is increasing mainly because of population growth and ageing. The number of cancer registrations is projected to increase annually by 2.6 percent from 2006-2016
- cancer continues to have inequalities with higher Māori incidence (20 percent greater), higher Māori mortality (80% higher) and Māori are more likely than non-Māori to have their cancer detected at a later stage of disease spread
- there are wide variations in survival rates between DHBs in New Zealand. Although both Māori and non-Māori showed an increase in survival over time (1994-2009), only the non-Māori change was statistically significant. For Māori the only tumour site to show a significant improvement in survival was cancer of the breast
- residents of more socioeconomically deprived areas are more likely to develop cancer, less likely to have their cancer detected early, and have poorer survival than residents of less deprived areas
- once people are diagnosed with cancer they are now less likely to die from it. This means that people are surviving longer, and being treated for longer periods of time, with different treatments.

Using 2007, 2008 and 2009 data Bay of Plenty age-standardised registration rate was significantly higher than the national mean (Ministry of Health, 2009) and so was Lakes (2006-2008 data). The other Midland DHBs were not significantly different to the national registration rate.

Table 8: Midland DHB cancer registrations volumes 1999-2011 (source: Ministry CancerMart updated Dec.2013)

DHB	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Grand Total
Bay of Plenty	828	823	1,016	1,003	1,014	1,018	1,125	1,173	1,168	1,248	1,255	1,198	1,299	14,168
Lakes	385	383	440	436	470	416	452	468	503	510	475	506	563	6,007
Tairāwhiti	226	201	202	191	222	228	227	206	204	211	261	223	200	2,802
Waikato	1,371	1,376	1,428	1,378	1,579	1,602	1,577	1,660	1,711	1,647	1,676	1,774	1,821	20,600
Midland Total	2,810	2,783	3,086	3,008	3,285	3,264	3,381	3,507	3,586	3,616	3,667	3,701	3,883	43,577

Waikato, Lakes, Bay of Plenty and Tairāwhiti all have significantly higher age-standardised cancer death rates compared to the national rate (Ministry of Health, 2011). There is DHB variation in registration and mortality rates between DHBs (Table 9).

Table 9: Midland DHBs with significant difference for registration and mortality age-standardisation rates compared to national rate 2006-2008.

Tumour site	Midland DHBs with significantly different registration rates	Midland DHBs with significantly different mortality rate
Lung	Lakes and Tairāwhiti significantly higher	Waikato, Lakes & Tairāwhiti significantly higher
Colorectal	Tairāwhiti significantly lower	Waikato significantly higher
Prostate	Not significantly different	Not significantly different
Breast	Not significantly different	Not significantly different

Linkages

The 2014–2015 Midland Cancer Network work plan aligns with:

National Cancer Programme Work Programme
 National Radiation Oncology Plan (due 2014)
 National Medical Oncology Models of Care Implementation Plan 2013-14
 National Guidance for Cancer Multidisciplinary Meetings
 Other national cancer/palliative care plans and/or guidance
 Midland Palliative Care Service Plans
 Midland Radiation Oncology Demand and Capacity Modelling Report

Midland Regional Services Plan
 HealthShare Ltd SOI and Business Plan
 Midland District Health Board (DHB) Annual Plans
 Midland Cancer Network Strategic Plan 2009-2014
 Hei Pā Harakeke Action Plan 2012-2014
 Midland Medical Oncology Service Plan 2013-2018
 FCT Indicators and Business Rules and Data Definitions (March 2014)

National Cancer Programme

The National Cancer Programme is an integrated national programme that covers the Ministry of Health, DHBs' and regional cancer networks activity across the cancer continuum. The regional plan is informed by initiatives identified in the National Cancer Programme Work Plan.

The national cancer Better, Sooner, More Convenient Health Care:

Vision: We want all people to easily access the best services, in a timely way to improve overall cancer outcomes

Measures: Success will be measured by five year survival rates, cancer incidence and cancer mortality data.

A health system that functions well for all people is one that focuses on:

- wait times: all people get timely access to services across the whole cancer pathway (screening, detection, diagnosis, treatment and management, palliative care⁷);
- access: all people have access to services that maintain good health and independence;
- quality: all people receive excellent services wherever they are;
- financial sustainability: all services make the best use of available resources.

Midland Cancer Network

Cancer control planning and service improvement is complex involving multiple organisations, services and stakeholders. The Midland Cancer Network is a managed service network working alongside Midland DHBs and other constituent organisations will support the implementation of the prioritised national work programme and identified regional initiatives.

The Midland Cancer Network aims are to:

- reduce the incidence and impact of cancer
- reduce inequalities with respect to cancer and;
- improve the experience and outcomes for people with cancer.

The strategic directions outlined in the Midland Cancer Network Strategic Plan 2009-2014 are:

- 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

The infrastructure to support the work programme is a Midland Cancer Network Executive Group that provides leadership and oversees the work programme. Working alongside the work programme is a Midland Cancer Network Consumer/Carer Work Group and the Midland Hei Pā Harakeke (Māori Cancer Work Group). There are links to the other Midland groups i.e. Midland CEOs, COOs, GMs Planning and Funding, Midland IS Executive Group.

The majority of the network's resource is dedicated to supporting regional tumour and service improvement work groups. There are local DHB sub groups linked into the regional work programme. Clinical leadership is seen as a key enabler of the work programme. The groups are chaired by a clinician or person outside of the network management team, and the focus is on clinical frameworks/pathways, service planning and quality improvement. Regional work groups include:

- Tumour work groups: lung, bowel and breast.
- Service work groups: adolescent and young adult, palliative care, CNS/care coordination, medical oncology, radiation oncology (includes PET variance committee), research and audit.
- In addition the network hosts the National Lung Cancer Working Group with an agreed work plan for 2013-15.

Midland Cancer Network Executive Group supports the national cancer work programme which is significant, has prioritised regional initiatives. There is limited resource and if prioritisation is required the Midland Cancer Network Executive Group prioritised the following for 2014/15:

From National Cancer Programme

Radiotherapy and chemotherapy health target
Faster Tests and Cancer Treatment health target/wait time indicators
Regional review against national tumour standards
Multidisciplinary meetings improvements
Colonoscopy wait time indicators

Regional priorities

Regional support- BOP/Waikato radiation oncology service change
Regional support-BOP/Waikato/Lakes medical oncology service change
Midland Medical Oncology Models of Care Service Plan
Midland Palliative Care Service Plans
Addressing regional Māori inequalities with respect to cancer

Line of sight - Cancer

Regional cancer priorities and objectives

Implementing the priorities of the National Cancer Programme remains the focus for regional service planning.

A significant change is the shorter waits for cancer treatment Health Target will move to a Policy Priority indicator 1 October 2014.

The new Faster Cancer Treatment Health Target – the proportion of patients referred urgently with high suspicion of cancer and who need to be seen within two weeks who receive their first cancer treatment (or other management) within 62 days, will be effective from 1 October 2014, with achievement rate of 85% by July 2016.

The Faster Cancer Treatment 31 day wait time indicator will become a Policy Priority indicator.

Colonoscopy wait time targets have increased from 2013/14.

National priorities in particular aim to:

- improve access to cancer services;
- timeliness of services across the whole cancer pathway; and
- the quality of cancer services delivered.

⁷ Midland palliative care services include both malignant and non-malignant conditions.

Common regional objective: 1. Improve Māori health outcomes (note: all cancer focus areas have an aspect that contribute to improving Māori health outcomes)

Cancer focus area 1: reduce the impact and inequalities of cancer on Midland Māori		
Measure: long term – improved five year survival rates, cancer incidence and mortality rates between Māori and non- Māori. Report on inequities in access to, timeliness and quality of, and outcomes from, cancer services between Māori and non- Māori. All Midland cancer measures will include data related to Māori and non- Māori.		
Key Action	Milestone	Responsibility
Māori cancer improvement plan <ul style="list-style-type: none"> Continue to facilitate Midland Māori Health Providers in the Kia ora - E te iwi Increase the number of DHB whānau ora contract agreements, that include a cancer component Continue to support Midland breast screening initiatives to increase Māori participation. 	Midland builds capacity and capability to run local Māori health provider Kia ora - E te iwi programme	Midland Cancer Network lead facilitation with Māori health provider and DHB Māori health services Waikato DHB Planning and Funding BreastScreen Midland
Primary - secondary pathway tools Map of Medicine (MoM) integration with patient management system and current e-referral processes (primary-secondary). <ul style="list-style-type: none"> Apply prioritisation tool which will consider inequity when planning order of pathway development Once developed include locally specific equity reminders for clinicians and support services information for high need populations. 		Midlands Health Network
Key Action	Milestone	Responsibility
Faster Cancer Treatment <ul style="list-style-type: none"> From FCT wait time data information and/or from regional tumour standards identify any equity issues and implement improvement strategies. 		All

Common regional objective: 2. Integrate across continuum of care

Cancer focus area 2: Maintain timeliness of access to radiotherapy or chemotherapy		
Measure: shorter waits for cancer treatment Health Target/policy priority indicator – all patients, ready-for-treatment, wait less than 4 weeks for radiotherapy or chemotherapy		
Key Action	Milestone	Responsibility
Shorter waits for cancer treatment Sustain performance against the radiotherapy and chemotherapy wait time targets by more efficient use of existing resources and investing in workforce and capacity as required. Regional initiatives to support are:	DHB cancer centres report cancer treatment target monthly	Radiation therapy – Waikato and BOP DHBs (note BOP start date 1 October 2014) Chemotherapy – all DHBs
Improve medical oncology services Scope regional requirements to implement the National Medical Oncology Implementation Plan 2013/14 priority project recommendations within available resources, i.e. SMO review project, oncology nursing knowledge and skills framework. Implement the priority areas identified in the National Medical Oncology Models of Care Implementation Plan 2014/15 (to be developed)		Midland Cancer Network leads facilitation with all DHBs via Midland Medical Oncology Working Group
Continue to implement Midland Medical Oncology Service Plan 2013-18 annual work plan priorities: <ul style="list-style-type: none"> BOP/Waikato medical oncology service change is implemented with some BOP FSAs and follow-ups to transition from Waikato services to Tauranga Hospital. 	Service change effective 1 July 2014	Midland Cancer Network leads facilitation with BOP and Waikato DHBs
<ul style="list-style-type: none"> Midland SMO capacity increase by 0.5 FTE. SMO will become part of the Tauranga Cancer Centre hub. 	Increase in SMO resource effective 14 July 2014	BOP DHB provider arm
<ul style="list-style-type: none"> Scope feasibility of Tauranga Hospital developing an inpatient service that will support medical oncology, radiation oncology and haematology services (priority level 2) 	Plan developed with feasibility options on service configuration and implications by 30 June 2015	Midland Cancer Network leads facilitation with BOP and Waikato DHBs via Midland Medical Oncology Working Group and the Midland Radiation Oncology Transition Work Group
<ul style="list-style-type: none"> Scope feasibility to align medical oncologist SMO resource requirement with Lakes population demand for ambulatory medical oncology services (priority level 2). 	Updated model of service and service agreement between Lakes and Waikato by 30 June 2015 (tbc)	Midland Cancer Network leads facilitation with Lakes and Waikato DHBs
<ul style="list-style-type: none"> Implement and strengthen lead physician concept (as per Tairāwhiti model of service) for DHBs that have visiting specialist services i.e. Lakes and Thames (priority level 2). 	All DHBs with visiting clinics have lead physician in place by December 2014	Midland Cancer Network leads facilitation with Lakes and Waikato DHBs
Improve radiation oncology services Implement recommendations from the Waikato Radiation Oncology Service Plan 2010 and Midland Radiation Oncology Demand and Capacity Report 2012-2020 <ul style="list-style-type: none"> Support any national workforce training initiatives that support the region in recruitment and retention of workforce such as medical physicists. 		Midland Cancer Network leads facilitation with Bay of Plenty and Waikato DHBs via the Midland Radiation Oncology Transition Work Group
<ul style="list-style-type: none"> Midland Cancer Network continues to work with DHBs on a regional service change transition project, and regional governance structure to support the establishment of a local radiation oncology service at BOP 	Regional governance and service plan support vision for 'one regional service – two providers' Bay of Plenty radiation oncology	Midland Cancer Network leads facilitation with Bay of Plenty and Waikato DHBs via the Midland Radiation Oncology Transition Work

<ul style="list-style-type: none"> Facilitate post implementation review to evaluate the service change and transition of patient care with the establishment of Bay of Plenty radiation oncology service at Tauranga Hospital 	service commences 1/10/14 Evaluation report completed by June 2015 (tbc)	Group
<ul style="list-style-type: none"> Waikato Regional Cancer Centre completes technology upgrade to three linacs. Waikato Regional Cancer Centre develops business case for replacement linac (green) due 2015/16. 		Waikato DHB – Regional Cancer Centre

Common regional objective 3: Improve quality across all regional services

Cancer focus area 3: Improve timeliness and quality of cancer patient pathway from the time the patients are referred into the DHB through treatment to follow-up/palliative care		
Measure: Faster Cancer Treatment (FCT) Health Target and Policy Priority 30 <ul style="list-style-type: none"> The new Faster Cancer Treatment Health Target – the proportion of patients referred urgently with high suspicion of cancer and who need to be seen within two weeks who receive their first cancer treatment (or other management) within 62 days, will be effective from 1 October 2014, with achievement rate of 85% by July 2016. PP30 31 day indicator - proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days of decision-to-treat. 		
Key Action	Milestone	Responsibility
FCT Health Target and wait time indicator Midland Faster Cancer Treatment Implementation Plan (2014) recommendations continue to be implemented. Update 2014 plan. Monitor non-compliance with updated national FCT data definitions (published 7/3/14). Agree methodology to link identified risks into DHB quality and risk services.	Monthly FCT health target and PP reporting Improvements in the performance against the PP30 FCT wait time indicators.	Midland DHBs Midland Cancer Network report to Midland DHB and Executive Group quarterly % meeting wait times (by DHB, ethnicity and by tumour type)
Primary - secondary pathway tools Map of Medicine (MoM) integration with patient management system and current e-referral processes (primary-secondary). <ul style="list-style-type: none"> Colorectal MoM pathway published Jul/Aug 2014 Breast MoM pathway Aug/Sept 2014 Scope feasibility using MoM A-Z site for regional clinical guidelines. 	In development phase – encourage clinicians to review the cancer pathway prior to making referral.	Midlands Health Network, Bay Navigator and Health Waikato PMO
Regional tumour standard reviews Undertake regional DHB stocktake of bowel cancer services and service gap analysis against national bowel cancer standards <ul style="list-style-type: none"> DHB self-assessment and data analysis completed by August 2014 MCN Bowel Cancer Working Group reviews findings and develops report by September 2015. 	Bowel cancer review completed with regional service improvement report developed by 28 October 2014.	Midland Cancer Network leads facilitation with all DHBs and other relevant organisations
Undertake regional DHB stocktake of gynae-oncology services and service gap analysis against national gynae-oncology standards <ul style="list-style-type: none"> One-off work group established and DHB self-assessment and data analysis completed by October 2014 Regional gynae-oncology cancer working group reviews findings and develops regional report by November 2014. 	Gynaecological cancer review completed with regional service improvement report developed by 28 February 2015.	Midland Cancer Network leads facilitation with all DHBs and other relevant organisations
Undertake regional DHB stocktake of breast cancer services and service gap analysis against national breast cancer standards <ul style="list-style-type: none"> DHB self-assessment and data analysis completed by February 2015 MCN Breast Cancer Work Group reviews findings and develops report by Mar 2015. 	Breast cancer review completed with regional service improvement report developed by 30 June 2015.	Midland Cancer Network leads facilitation with all DHBs and other relevant organisations
Cancer Services Improvement Fund (Round 1 - March 2014 RFP) Implementing service improvement activities to improve FCT wait times and/or implementation of tumour standards as per agreement with Ministry (tbc) <ul style="list-style-type: none"> Midland supportive care initiatives Midland Inter-DHB referral process 		All Midland DHBs Midland Cancer Network
<ul style="list-style-type: none"> Improve Midland gynae-oncology services Scope and develop Midland gynae-oncology model of service and improvement plan, informed by recommendations from the National Gynaecological Oncology Service Provision Models (draft 28/11/13) and regional review against national standards. Scope opportunities to improve MDM and links with Auckland MDM and implement recommended surgical flow model	Midland gynae-oncology model of service scoped by 30 June 2015	Midland Cancer Network leads facilitation with all DHBs and other relevant organisations such as Auckland DHB and Northern Cancer Network
Improve Midland prostate cancer Review recommendations from the Midlands Prostate Cancer Study Research and Midland Advanced Prostate Cancer Research and commence service improvement initiatives (priority level 2). Assist Clinical School with launch of research findings in 2014.		Midland Cancer Network lead facilitation with all DHBs and other relevant organisations
Improve Midland palliative care services Implement National Specialist Palliative Care Service Specifications (not yet finalised) Implement Midland Palliative Care Service Plan recommendations (priority 2): <ul style="list-style-type: none"> support recruitment and retention of SMOs 	National Specialist Palliative Care Service Specifications implemented (timeframe tbc)	Midland Cancer Network leads facilitation with all DHBs and hospices

<ul style="list-style-type: none"> continue end of life care planning and supporting education continue primary palliative care education implement new Midland advanced palliative care medical training model service by January 2015 continue to review and standardise clinical guidelines for the region. 		
Key Action	Milestone	Responsibility
Improve Midland lung cancer services <ul style="list-style-type: none"> Implement regional recommendations following 2013/14 review against national lung cancer tumour standards (tbc) improve timeliness to thoracic surgery maintain timeliness to regional EBUS improve the number of patients that have chest CT prior to bronchoscopy (priority 2) scope Midland access to CT biopsy (priority 2) 		All Midland DHBs and Midland Lung Cancer Working Group
Cancer focus area 5: Improve the functionality and coverage of multidisciplinary meetings (MDM)		
Measure: Monitor through policy priority (PP24) improving waiting times – cancer multidisciplinary meetings		
Key Action	Milestone	Responsibility
Continue implementation of the Midland MDM Plan (2014) that works towards compliance with the National MDM guidance and improve the functionality and coverage of MDMs across the region	Midland DHBs report PP24 – progress delivering improved cancer MDMs based on the regional actions agreed using the funding for MDMs including variance in expenditure against allocated DHB MDM funds	Midland DHBs
Cancer focus area 6: Improve waiting times and quality of endoscopy/colonoscopy services		
Measures: waiting times for diagnostic and surveillance/follow-up colonoscopy policy priority (PP29)		
<ul style="list-style-type: none"> Diagnostic colonoscopy: 75% people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days) Diagnostic colonoscopy: 60% people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days) Surveillance/follow-up colonoscopy: 60% people waiting for a surveillance/follow-up colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date. 		
Key Action	Milestone	Responsibility
Continue supporting implementation of the national Endoscopy Quality Improvement (EQI) programme. <ul style="list-style-type: none"> DHBs continue to work with the national EQI team on development of the Global Rating Scale (GRS). DHBs continue to identify and implement improvements to colonoscopy services. 	PP29 monthly reporting	All Midland DHBs BOP DHB is the lead DHB and the operational base for the national EQI team and programme

Common regional objective: 4. Build the workforce (note: all cancer focus areas have an aspect that contribute Building the workforce)

Cancer focus area 7: Support the cancer nurse coordinator initiative (CNCI)		
Measure: Monitor through six monthly crown funding agreement variation – appoint cancer nurse coordinators reporting		
Key Action	Milestone	Responsibility
<ul style="list-style-type: none"> DHBs support the continued development of DHB cancer nurse CNS/coordinator roles including participation in the national CNCI evaluation process Enable and support cancer nurse coordinators attendance at national and regional training and mentoring forums. 	Six monthly CFA reporting	All Midland DHBs

Common regional objective: 6. Efficiently allocate public health system resources

The regional cancer network adds value by taking a population based approach across organisational boundaries to engage and partner with stakeholders to influence and support decision making to enable health gain attainments beyond what stakeholders could achieve alone. This approach reduces duplication of effort. Functions include leading regional service planning, facilitate regional service change, facilitate continuous quality service improvement, facilitate stocktake of services and gap analysis against national standards, support monitoring and evaluation, development of regional standardised clinical pathways and clinical guidelines aiming for clinical and financially sustainable cancer services. There are 'best value resource' aspects to all of the cancer focus areas.		
Cancer focus area 8: National lung cancer work programme		
Measure: monitor through six monthly regional cancer network agreement reporting for the National Lung Cancer Working Group		
Key Action	Milestone	Responsibility
Lead and facilitate the National Lung Cancer Working Group and work programme: <ul style="list-style-type: none"> Develop lung cancer specific MDM prioritisation criteria Develop concept paper on early detection of lung cancer provided to Ministry of Health Complete the development of a national lung cancer core dataset, data definitions and business rules Undertake review and update national Standards of Service Provision for Lung Cancer Patients in New Zealand (2011). 	Facilitate two national meetings per annum. National lung cancer specific MDM prioritisation criteria and early detection of lung cancer submitted to Ministry of Health by 30 June 2014. National lung cancer core dataset and business rules submitted to Ministry of Health 31 March 2015 (approximate date). Final version of Standards of Service Provision for Lung Cancer Patients in New Zealand submitted to Ministry of Health 29 May 2015 (approximate date).	Midland Cancer Network National Lung Cancer Working Group

Other cancer focus areas:		
Improve Midland PET-CT services Implement requirements of updated nationally agreed PET-CT clinical indicators Review and update Midland PET-CT Agreement by 31 May 2015	Midland agreement renewed by 31 May 2015.	Midland DHBs Midland Cancer Network leads facilitation
Endoscopy Reporting System DHBs prepare capital business case for implementation of an endoscopy reporting system (ProVation) and on approval support implementation. Work in partnership with regional IS on regional component as well as local interface and actions as required.		Midland DHBs that have prioritised capital HealthShare IS as required

4.1.2 Cardiac Services

Chair: Dr Gerald Devlin

Project Manager: Philippa Edwards

Context and vision:

Cardiovascular diseases are a leading cause of death in New Zealand and are responsible for 27.4 percent of all deaths annually. Within the set of cardiovascular diseases, ischaemic heart disease (IHD) is the second biggest killer (second only to cancer as a single cause of death) and is responsible for 18.8 percent of all deaths. The burden of heart disease is greatest amongst Māori, where ischaemic heart disease is a major cause of all deaths and the rate of hospital admissions for heart failure is nearly four times that of Europeans/non-Māori. Males have a consistently higher age-standardised mortality rate from ischaemic heart disease than females with the 2010 male age-standardised rate being 85.3 percent higher than the female rate⁸.

Although age-adjusted death rates have declined steadily over the past few decades the total number of cardiovascular events is projected to rise due to our aging population and increasing prevalence of cardiovascular risk factors such as diabetes and obesity. Many deaths are premature (accounting for 33 percent of lives lost between 45 and 64 years of age) and potentially preventable. It is estimated that 80 percent of the population have three or more of the risk factors, such as smoking, physical inactivity, poor diet and being overweight. It is conceivable that within a few decades the elderly will outlive their middle-aged children who will die as a result of cardiovascular disease.

In general poor health outcomes occur amongst Māori, Pacific and Asian people, those people living in socioeconomically deprived environments and people from communities located at a distance from their base hospital. In the past two years the Midland region has successfully turned around from having the lowest access markers of cardiovascular care measured nationally, which include angiography, angioplasty and cardiovascular surgery intervention rates. This has been achieved with strong collaboration between secondary and tertiary service providers inside Midland region. The Midland Regions tertiary centre, Waikato Hospital, has successfully implemented an Acute Coronary Syndrome (ACS) Project, which is now embedded and working as part of business as usual functions.

How we will progress our key objectives:

The Midland Cardiac Clinical Network (MCCN) is a programme of work led by a Dr Gerard Devlin (Clinical Unit Leader Cardiology, Cardiothoracic Surgery and Vascular Surgery Interventional Cardiologist, WDHB.) The network has a strong history of engaging clinical leaders in service improvement and works closely with the National Cardiac Network. The MCCN has representation from all Midland DHBs comprising of senior clinical leads (Doctors, Nursing and Allied Health professionals), primary care, public health, St John, Māori Health, senior DHB management and planning and funding.

Service delivery will be addressed through three key priorities for the Network:

1. Integrated Care Management across the Continuum (ICM)
2. Ischaemic Heart Disease Management (IHD)
3. Development of a Cardiac Clinical Regional Services Plan (CCRSP)

How we will measure our success:

The measures for cardiovascular services across Midland Region will be in the achievement, or variance explanation to national indicators. Measures will be monitored for the Māori population comparative to the non-Māori population.

MOH Measures:

Secondary Services

- Standardised intervention rates:
- Cardiac surgery: 6.5 per 10,000 of population
- Percutaneous revascularisation: 12.5 per 10,000 of population
- Coronary angiography: 34.7 per 10,000 of population
- Proportion of patients scored using the national cardiac surgery Clinical Priority Access Criteria (CPAC) tool, and proportion of patients treated within assigned urgency timeframe.
- The waiting list for cardiac surgery remains between 5 percent and 7.5 percent of planned annual cardiac throughput, and does not exceed 10 percent of annual throughput.
- No patient waits longer than five months for cardiac surgery during 2014 and waiting times are reduced to a maximum of four months by the end of December 2014.

Acute Coronary Syndrome

- Report quarterly on regional activity that supports Accelerated Chest Pain Pathway development and implementation
- Each region will have established measures of ACS risk stratification and timeliness for patients to receive appropriate intervention
- 70 percent of high risk patients will receive and angiogram within 3 days of admission
- Over 95 percent of patients presenting with ACS who undergo coronary angiography will have completion of ANZACS-QI ACS and CATH/PCI registry data collection within 30 days

Note from MOH: A national definition for the counting of high risk will be made available as soon as it is agreed.

⁸ Ministry of Health: Mortality and Demographic Data (2010) <http://www.health.govt.nz/publication/mortality-and-demographic-data-2010>

Key network linkages:

National	<ul style="list-style-type: none"> The New Zealand Cardiac Network Other regional cardiac clinical networks
DHB Public Health Unit Plans	<ul style="list-style-type: none"> Population Health: nutrition, physical activity and healthy weight and thus reduce the incidence of diabetes and cardiovascular disease Breakfast eaters and Feeding our Families; National Heart Foundation programmes
DHB Māori Health Plans	<ul style="list-style-type: none"> Measures will be monitored for the Māori population comparative to the non-Māori population.
DHB Annual Plans	<ul style="list-style-type: none"> Improved access to Electives (MoH targets) More Heart and Diabetes Checks ACS Project Cardiac – secondary services CVD risk assessment and ACCPs Workforce Capital IS

2014/15 Cardiac Network Work Programme:

Priority 1: Integrated Care Management of CVD across the Health Continuum (ICM)

Initiative ICM - 1	CVD Pathway development <ul style="list-style-type: none"> Integrated Primary/Secondary Cardiac Care pathways are developed across the continuum via alignment with current local pathway development initiatives (Map of Medicine and Bay Navigator). 				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Actions	Develop and action a phased plan for the development of the primary/secondary pathways				
Milestone	Quarterly				
Measurable	Track phased development of the primary/secondary pathways Uptake of the pathways once live				
Enablers	Network members, DHBs and MOM PM				

Initiative ICM - 2	Primary Risk Factor Management <ul style="list-style-type: none"> Risk Factor Testing, Intervention and Management Identify rate of CV testing per PHO and introduce management KPIs for high risk patients in the midland region with Aspirin and Statins Improved partnership around primary/secondary care A priority of MāoriHealth 				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Actions	Māori Health holding Excellence Seminars Primary Care membership on network strengthened				
Milestone	Quarterly				
Measurable	By Ethnicity and per DHB: <ol style="list-style-type: none"> More Heart and Diabetes - Checks 90 percent of the eligible population with have their CVD risk assessed in the last five years Monitor uptake of Statins and Aspirins by localities across the Midland Region 				
Enablers	Network strategic planning to support primary care access and performance				

Initiative ICM - 3	Secondary Risk Factor Management <p>Development and implementation of Accelerated Chest Pain Pathways (ACPPs) in Midland Region Emergency Departments Ascertain number of discharged patients receiving guideline based cardiac risk modification care by:</p> <ol style="list-style-type: none"> Discharge Medications (Aspirin and Statins) Risk modification plan IP education - care education available to cardiac patients and care workers Cardiac rehab referral & attendance 				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Actions	Develop and action a phased plan for the development of the regional Accelerated Chest Pain Pathways (ACPPs)				
Milestone	Implement plan – Q4, 2014/15 Review and monitor – Q4, 2015/16				
Measurable	Use ANZACS-QI to monitor Discharge Medications (Aspirin and Statins) Potential to reduce utilisation of secondary services – monitor admission rates and LOS Track phased progress of the regional ACPPs				
Enablers	ANZACS-QI, NMDS				

Initiative ICM - 4	Regional Cardiac e-referral mechanisms across Primary- Secondary-Tertiary services <ul style="list-style-type: none"> E-referrals and regional IP tracking IT solutions (Prim-Sec, Sec-Tert) 				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Actions	Explore potential in regional Clinical Work Station (CWS) implementation to develop e ordering from secondary to tertiary				
Milestone	Quarterly				
Measurable	Track progress on CWS and development on internal ordering				
Inputs & Resources	Costs attributed to BPAC referral development – costs undefined. Costs should be shared across region.				
Enablers	MRIS – for integration into DHB Clinical Workstations BPAC for referral development, MCCN, Primary Representation				

Initiative ICM - 5	Heart Failure <ul style="list-style-type: none"> Understand and assess the health burden of Heart Failure (HF) in the Midland region Assess the current models of care delivered across the Midland region 				
	15/14 - Implement strategy to decrease Heart Failure numbers in the region.				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Actions	Collect data and information to form a regional situational analysis of heart failure				
Milestone	14/15 – Seek data and scope for future initiatives 15/16 – Implement change initiatives to improve HF rates				
Measurable	By Ethnicity and per DHB benchmark and work towards a decline in numbers 1. Rate of IP acute admission with HF per 10,000 pp 2. LOS of patients with primary diagnosis of HF Investigate sources of mortality data for HF patients.				
Enablers	Regional heart failure data across the continuum				
DHB Contribution	Provision of data. Support development and implementation of initiatives to improve heart failure detection and management				

Initiative ICM - 6	Cardiac Rehabilitation <ul style="list-style-type: none"> Assess the current level of access and service models available across the Midland region 				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integration across continuums of care		3: Improve quality across all regional services
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources
Actions	Collect data and information to form a regional situational analysis of cardiac rehabilitation				
Milestone	14/15 – Seek data and scope for future initiatives				
Measurable	Progress monitored quarterly against phased plan				
Enablers	Regional rehabilitation data across the continuum				
DHB Contribution	Provision of data				

Priority 2: Ischaemic Heart Disease (IHD)

Initiative IHD - 1	Regionally agreed guidelines, protocols, processes and systems. To continue to develop, implement and review processes to ensure: <ul style="list-style-type: none"> A consistent approach to decision making, prioritisation and management to ensure equity of access to diagnosis and intervention. Local risk stratification of suspected ACS patients with nationally agreed scoring tools to support decision making The transfer of high risk patients to a centre delivering angiography and revascularisation Quality initiatives and work programme are developed to address any regional inequity of access and outcomes. Monitoring and audit via ANZACS_QI to maintain sustainability, future validity and compliance 				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Milestone	Quarterly review				
Actions	Develop a register of all regional guidelines, protocols, processes and systems to append to the CCRSP				
Measurable	Reporting via ANZACS-QI: 1. Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days 2. Implement systems for prompt transfer of high risk patients to tertiary centres for the appropriate interventions.				
Inputs & Resources	No additional costs ANZACS-QI data entry by each DHB				
Enablers	Regional data provided by each DHB. Regional analysis. DHB service engagement.				
DHB Contribution	Lead CEO sponsorship. DHB support for network members to attend quarterly meetings.				

Initiative IHD - 2	Angiograms and Percutaneous Revascularisation					
	<ul style="list-style-type: none"> Review National Performance compliance and implement corrective actions 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Actions	Review production planning methodology with a view to quantifying capacity required and resourcing to achieve target Review prioritisation and booking processes to ensure equitable access and delivery of service					
Milestone	Quarterly review					
Measurable	Standardised intervention rates by Ethnicity and per DHB: <ol style="list-style-type: none"> ACS risk stratification primary and secondary care targets Coronary angiography: Rate of 34.7 per 10,000 of population 70% of acute high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') 90% of elective accepted referrals for coronary angiograms will receive their angiogram within 3 months (90 days) and no patient will wait longer than 5 months, moving to 4 months from Jan 2015. Percutaneous revascularisation: 12.5 per 10,000 of population 					
Inputs & Resources	Cardiology Service Management and Clinicians					
Enablers	Regional visibility and operational planning/management. DHB service engagement.					
DHB Contribution	Lead CEO sponsorship. DHB support and engagement in regional operational planning.					

Initiative IHD - 3	Revascularisation - Cardiac Surgery					
	<ul style="list-style-type: none"> Review and ensure that cardiac surgery services are aligned with the regional population needs Improve equity of access to and delivery of cardiac surgery All cardiac surgery patients are prioritised, and treated in accordance with assigned priority and urgency timeframes 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Actions	Review production planning methodology with a view to quantifying capacity required and resourcing to achieve target Review prioritisation and booking processes to ensure equitable access and delivery of service					
Milestone	Quarterly reporting					
Measurable	<ol style="list-style-type: none"> Proportion of patients scored using the national cardiac surgery Clinical Priority Access Criteria (CPAC) tool, and proportion of patients treated within assigned urgency timeframe The waiting list for cardiac surgery remains between 5% and 7.5% of planned annual cardiac throughput, and does not exceed 10% of annual throughput No patient wait longer than five months for cardiac surgery during 2014, and waiting times are reduced to a maximum for four months by the end of December 2014 Cardiac surgery By Ethnicity and per DHB: 6.5 per 10,000 of population (CABG) 					
Inputs & Resources	Requirement: dependent on the implementation of the National Surgery Data Base at WDHB in 13/14. Cost to WDHB – approx. \$60,000 plus annual fee \$10,600					
Enablers	Regional service planning. Midland Regional Information Systems (MRIS) and WDHB I.T department					
DHB Contribution	WDHB - If the National Surgery (Dendrite) data base was not implemented in the 13/14 period, then costs of approximately \$60,000, plus on going annual fee of \$10,600					

Priority 3: Strategic Midland Region Cardiac Clinical Regional Service Plan (CCRSP)

Initiative CCRSP - 1	Cardiac Services Plan for the Midland Region					
	<ul style="list-style-type: none"> Development of a Strategic Cardiac Clinical Regional Services Plan (CCRSP) supporting cardiovascular care to be overseen by the Midland Cardiac Clinical Network (MCCN). Changes and impacts to current/planned/future service delivery models that may impact regional cardiac services will be reviewed by the MCCN group to ensure alignment with strategic regional planning. The strategic plan will ensure service delivery is tailored to the needs of high risk population groups (such as: Māori), and that any changes in service delivery provision do not impact other regional cardiac services without prior agreement from the impacted DHBs. Address the national cardiac mission statement: "To stop New Zealanders dying prematurely from heart disease" Mechanism for review: Continuous local and regional review via quality programmes (such as ANZACS-QI) and implement new quality initiatives across the region. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Actions	Phased development and delivery of the RCCSP. This document will respond to cardiovascular disease in the Midland region, outline service demand with recommendations for improved and integrated service delivery. Looking forward to the next 3-5 years the goal clinical outcomes are: <ul style="list-style-type: none"> More people receive access to cardiac services which supports New Zealanders to live longer, healthier and more independent lives Equality of access to cardiac services in the Midland region Timelier access to cardiac services reduced admission rates Reduced mortality rates Regional Cardiac services demand – capacity mapping and production planning methodologies employed					
Milestone	Quarterly					
Measurable	Track phased development of the CCRSP					

Inputs & Resources	ANZACS-QI: data entry compliance by all DHBs
Enablers	Yet to be defined
DHB Contribution	CEO Sponsor. DHB Cardiac Service engagement and support for strategic regional planning

Initiative CCRSP - 2	Health Literacy <ul style="list-style-type: none"> To work with a coordinated approach across the Midland region clinical networks to Health literacy, public awareness and education with an emphasis for Māori 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Action	Use Localities mapping to identify communities who are not accessing primary cardiac services and who present in advanced stages of IHD Investigate and leverage methodologies and opportunities to increase cardiac health literacy					
Milestone	Quarterly					
Measurable	Constant, concise and standardised, care education available to cardiac patients and care workers					
Inputs & Resources	Gaining regional efficiencies by combining and consolidating training packages					
Enablers	Community networks, Māori Health, Primary and Secondary Care and Public Health stakeholders. Consumer Liaisons Liaison with the National Cardiac Network, The NZ Heart Foundation and other regional DHB groups					

Initiative CCRSP - 3	Workforce					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Action	Support recently appointed Midland Workforce Advisor to map the current workforce hours and special interests per discipline (Doctors, Nurses, Allied Health, Diagnostic's) available within the region, and ideal within the region as a future planning and recruitment tool for the region					
Milestone	Regional Cardiac HR map developed					
Measurable	Regional Cardiac HR map fully populated and agreed as correct by all Midland DHBs					
Inputs & Resources	GMs HR, MHTN					
Enablers	MHTN					
DHB Contribution	GMS HR support and involvement					

Initiative CCRSP - 4	Cultural Competency e-learning programme <ul style="list-style-type: none"> Implement an e-learning cultural competency programme (with a cardiac care focus) designed to be utilised in primary and secondary health care arenas 					
	Initiative was developed as part of the 13/14 RSP work programme					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Action	Develop or modify an existing e- competency program to be informative on cardiac care, and that can be made available across the continuum					
Milestone	Secondary Services – Q4, 2014/15 Primary health Care Professionals – Q4, 2015/16					
Measurable	Constant training opportunities across Primary and secondary arenas which support cultural competency Reduce inequalities in health outcomes for Māori					
Enablers	Midland Regional Training Network.					

4.1.3 Elective Services

CEO Lead: Ron Dunham

Clinical Lead: Chief Medical Officer - Dr Martin Thomas

COO Lead: Dale Oliff

Project Manager: Samuel Mackenzie

Key overarching focus:

Key objectives common across the networks include:

- Reduce inequalities and improve quality using evidence-based best practice models of care
- Recommend regional solutions to meet service care needs in the primary, community, secondary and tertiary sectors and implement solutions which maximize current capacity and/or better utilize resources.
- Promote organized systems of care
- Develop clinical leadership
- Support continuing work on technological developments which support services

How we will progress these outcomes:

- Understand population health needs
- Understand intervention rates and equity of access across the region.
- Facilitate initiatives that enhance the delivery to services with a focus on regional benefits
- Explore ways to better utilize clinical and staff resources across the region
- Explore ways to better integrate care between primary, secondary and tertiary services
- Achieve specific strategic priorities identified by each clinical network
- Identify regional strategic leadership opportunities for new clinical networks

Measures to show success annually:

- Increased number of procedures and 'first specialist assessments' (FSA)
- Reduced waiting times
- Lower rates of returned referrals
- Reduced 'did not attend' (DNA) rates
- Variation in scoring thresholds are reducing
- Increased number of Map of Medicine pathways across work streams and increased use of those pathways
- Improved management of elective volumes within regional capacity (Increased numbers of patients being transferred between DHBs for non-tertiary care)
- Demonstrate improvement in feedback received GP questionnaires.

Measures to show success over the next three years:

- Clinicians have access to a regional appointment process for services deemed appropriate
- Clinicians have greater ease moving between regional hospitals
- Clinicians are providing more treatments using technological solutions (telemedicine etc.)
- Clinicians agree that data quality has improved
- Clinicians agree that system changes to follow best practice are quicker and approaches to make changes are widely known
- Regional clinical networks can influence how funding is spent within their specialty areas
- A process for regional equipment purchasing is available
- Regional policies are stored at a location accessible at all DHB sites
- Additional regional policies have been developed and agreed
- Additional regional staff positions have been created and natural progression into these roles has been defined
- A minimum level of staff regionally for Chronic Pain is understood
- Data relating to patients being treated by regional services is better understood as are regional pathways that are available to clinicians
- Pain management group education sessions are provided at three regional DHBs locations
- Regional clinical networks have sub-groups available for allied health and other clinicians to also share their own learning's with their fellow colleagues.

Electives workstream – Clinical networks and overarching focus:

Over the next three years the elective services workstream plans to develop the following areas across the Midland region:

- Chronic Pain
- Ophthalmology
- Ear Nose and Throat

The focus of the above Clinical Networks will be to:

1. Maintain and develop strong clinical network leadership to advise and advance regional outcomes.
2. Develop staff mobility to allow regional DHBs to support each other if/when required.
3. Reduce inequalities using evidence-based best practice models of care while informed by demographic analysis. The impacts and outcomes of developments will be monitored.
4. Identify and develop ways of using technological advancements to improve health outcomes and efficiencies.
5. Develop and implement additional pathways of care.
6. Improve data quality and regional consistency/standardization. This provides the ability to discuss volumes and compare clinical information regionally.
7. Develop regional models which allow for additional clinical support and regional activities not currently available within single DHBs.
8. Share resources around the region to maximize capacity where available.

1. Chronic Pain	Ophthalmology	Ear Nose and Throat (Otolaryngology)
Overarching focus on seamless patient journey with more patients having access and attaining non-specialist regional support, reduction in DNAs and clinical support available for an at risk service <u>Key work</u> <ul style="list-style-type: none"> Clinical leadership development Implement evidence-based best practice models of care Maximize outcomes through primary, community, secondary and tertiary integration 	Overarching focus on development around regional business changes supported by clinical evidence and leadership, integration between multiple clinical networks and reciprocal discussions with numerous regional departments. <u>Key work</u> <ul style="list-style-type: none"> Clinical leadership development Implement evidence-based best practice models of care Maximize outcomes through primary, community, secondary and tertiary integration Improved utilization of technological solutions to support clinical care Process for appointing, supporting and maintaining regional approved new clinical staff roles Best value for public health systems resources and regional equity of purchasing 	Overarching focus will be on the development of the network for the first year. This will lead into focuses around improved workforce and improved pathways of care for ENT patients regionally. <u>Key work</u> <ul style="list-style-type: none"> Clinical leadership development Implement evidence-based best practice models of care Maximize outcomes through primary, community, secondary and tertiary integration Process for appointing, supporting and maintaining regional ENT staff Best value for public health systems resources

Three groups will no longer continue to be part of the RSP process. They will however continue to meet regionally and will report through to the Regional Electives Governance Group on a six monthly basis; they are:

- Orthopedics - focus will be clinical collaboration and connections in relation to regional patient movement, hand work (plastics), and ERAS
- Plastics - focus areas planned will be skin lesions (next 6 months), breast, then hand
- Vascular - focus will be regional appointments and clinical collaborations

The focus of the above areas will be to:

- Develop a workplan for sign off by the Regional Electives Governance Group
- Maintain and continue to develop regional clinical networks able to advise and advance regional outcomes.
- Continue to develop regional pathways of care

1.0 Chronic Pain

Clinical Objective	Implementing evidence-based best practice models of care					
Initiative P1.1	Produce Maps of Medicine for Chronic Pain – one per annum					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Measurable	Clinical network: <ol style="list-style-type: none"> Approved pathways to be built into Map of Medicine software to be accessible across the region. Reduction in variation of scoring tools used regionally for conditions with regional pathways Reduced trend in variation of waiting times for conditions with regional pathways Lower rates of returned referrals in focused areas identified at the beginning of each year or less than 5% Reduced 'did not attend' (DNA) rates for conditions with regional pathways 					Milestone
						Quarterly reporting Quarterly reporting Quarterly reporting Quarterly reporting Quarterly reporting
Inputs & Resources	Clinical Chair and appropriate clinicians to be freed to attend meetings on an as needed basis to progress regionally agreed work. Map of Medicine administration support					
Responsibilities	Accountable roles: Chair of the Chronic Pain Network and HealthShare Project Manager.					
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities					
DHB Contribution	Clinical time freed to attend meetings (4 half day meetings/Per Annum) and non-clinical time prioritised to pursue regional objectives (as approved by the electives regional action/governance group) Support from Waikato DHB Map of Medicine team					

Clinical Objective	Implement evidence-based best practice models of care					
Initiative P1.2	Complete demand analysis to inform Chronic Pain Map of Medicine pathways					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Measurable	Information collection: <ol style="list-style-type: none"> Understand population health needs and variation by ethnicity for conditions agreed by the regional Chronic Pain network Understand intervention rates and equity of access across the region for conditions agreed by the regional Chronic Pain network Clinicians agree that data/information used to inform Map of Medicine clinical pathways for Chronic Pain are comparable across all regional DHBs 					Milestone
						Dec 2014 and Quarterly reporting Dec 2014 and Quarterly reporting Quarterly reporting
Inputs & Resources	Clinical FTE as noted in initiative 1.1 Data analyst FTE from DHBs to inform discussions					
Responsibilities	Accountable roles: Clinical network Chair, Elective Services Action Group and HealthShare Project Manager					
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities					
DHB Contribution	Non-clinical time made available to pursue regional objectives (as noted in initiative 1). DHB Analytical support and advise on local data relevant to the above outcomes (0.1FTE).					

Clinical Objective	<i>Implementing evidence-based best practice models of care</i>					
Initiative P1.3	Regional Opioid policy is approved					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Measurable	1. Regional Opioid policy has been created and approved 2. Benefits have begun to be identified: <ul style="list-style-type: none"> ○ Reduced variation in treatment regionally by condition ○ Reduced variation in treatment regionally by specialty ○ Reduced amount of opioids prescribed 					Milestone 1. Dec 2014 2. Jun 2015
Inputs & Resources	Clinical FTE as noted in initiative 1 Additional clinician attendance made available to pursue regional objectives (as noted in initiative 1) Additional clinician attendance made available from other relevant specialty fields (Palliative care, Mental Health etc.) As requested by the Electives Regional Action Group					
Responsibilities	Accountable roles: Clinical network Chair, HealthShare Project Manager.					
Enablers	GoToMeeting Facilities and travel arrangements as appropriate					
DHB Contribution	Non-clinical time made available to pursue regional objectives (as noted in initiative 1). Additional clinician attendance made available from other relevant specialty fields (Palliative care, Mental Health etc.) (?0.05FTE total) Management and additional resources as requested by the regional Action group					

Clinical Objective	<i>Recommend regional solutions to meet service care needs in the primary, community, secondary and tertiary sectors and implement solutions which maximize current capacity and/or better utilize resources.</i>					
Initiative P2.1	Development of a Regional Chronic Pain education program					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Measurable	1. Agree regional education program structure and three DHBs where programs will be run. 2. All three DHBs to have provided at least one regional education program to patients 3. Increased number of patients attending regional Chronic Pain education programs and tracked numbers of patients being invited to education programs 4. Reduced patient DNA rate to clinics					Milestone Dec 2014 Jun 2015 Jun 2015 Jun 2015
Inputs & Resources	Clinical FTE as noted in initiative 1.1					
Responsibilities	Accountable roles: Clinical network Chairs and HealthShare Project Manager.					
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities					
DHB Contribution	Non-clinical time made available to pursue regional objectives (as noted in initiative 1).					

Clinical Objective	<i>Recommend regional solutions to meet service care needs in the primary, community, secondary and tertiary sectors and implement solutions which maximize current capacity and/or better utilize resources.</i>					
Initiative P2.2	Development of a Regional collaboration between external Chronic Pain agencies e.g. QE Health, ACC etc. and the Chronic pain network					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Measurable	1. Additional and clearer options available for Regional Chronic Pain patients through Map of Medicine pathways e.g. direct referral criteria for attending external providers TARPS Including ACC pain providers 2. Reduced time required by clinicians to complete administrative tasks e.g. streamlined ACC documentation 3. Clinicians report increase appropriateness of referral information					Milestone Quarterly reporting Jun 2015 Jun 2015
Inputs & Resources	Clinical FTE as noted in initiative 1.1					
Responsibilities	Accountable roles: Clinical network Chair, ACC and HealthShare Project Manager.					
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities					
DHB Contribution	Non-clinical time made available to pursue regional objectives (as noted in initiative 1.1).					

Clinical Objective	Recommend regional solutions to meet service care needs in the primary, community, secondary and tertiary sectors and implement solutions which maximize current capacity and/or better utilize resources.					
Initiative P2.3	Improved ability for clinicians to cover patients around the region when required					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Measurable	1. <i>Chronic Pain SMOs are able attend regional sites/work remotely for the purposes of clinical collaboration/education e.g. regional swipe card/computer access so complex patients can be discussed with both clinicians having access to appropriate patient information</i> 2. <i>Ability to do regional locum arrangements to allow cover of areas who do not have a Chronic pain SMO e.g. Gisborne.</i>					Milestone Dec 2014 Jun 2015
Inputs & Resources	Clinical FTE as noted in initiative 1.1 IS support					
Responsibilities	Accountable roles: Clinical network chair, Regional IS and HealthShare Project manager.					
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities, IS support.					
DHB Contribution	Non-clinical time made available to pursue regional objectives (as noted in initiative 1.1). HR advice made available around regional movement					

Clinical Objective	Recommend regional solutions to meet service care needs in the primary, community, secondary and tertiary sectors and implement solutions which maximize current capacity and/or better utilize resources.					
Initiative P2.4	Clarity of clinical conditions that will not be treated within the Midland region and streamlining of pathways to locations where treatment will be provided					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Measurable	1. <i>Chronic Pain clinical network have identified areas where the Midland region will generally not provide services and clear regional pathways for direct transfers are agreed</i> 2. <i>External providers report receiving all relevant information for cases transferred under new pathways</i>					Milestone Jun 2015 Jun 2015
Inputs & Resources	Clinical FTE as noted in initiative 1.1 Data analyst support as approved by the regional action group					
Responsibilities	Accountable roles: Clinical network chair and HealthShare Project manager.					
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities, support from national DHBs whom receive complex patients					
DHB Contribution	Non-clinical time made available to pursue regional objectives (as noted in initiative 1.1).					

2.0 Ophthalmology

Clinical objective	Process for appointing, supporting and maintaining regional approved new clinical staff roles					
Initiative O1.1	Create sustainable workforce development plans for regional roles implemented as part of regional work					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Measurable	1. Work with clinical networks to inform regional workforce of changing positions and identify ways to create sustainable workforce for newly developed positions as part of regional initiatives: <ul style="list-style-type: none"> Staff progression is available for newly developed clinical roles as part of project work <i>The key focus is to reduce the risk of initiatives requiring return to old processes as newly skilled staff cannot be replaced.</i>					Milestone <i>Quarterly reporting</i>
Inputs & Resources	Clinical FTE as noted in initiative 1 Additional clinician attendance made available to pursue regional objectives (as noted in initiative 1) DHB and regional HR to complete and advise on information to inform hospital and regional process matters (?0.1FTE)					
Responsibilities	Accountable roles: Regional Workforce, Clinical network chairs, HealthShare Project manager.					
Enablers	GoToMeeting Facilities and travel arrangements as appropriate.					
DHB Contribution	Non-clinical time made available to pursue regional objectives (as noted in initiative 1). DHB and Regional HR as approved by the regional Action Group/Regional HR					

Clinical objective	<i>Implement evidence-based best practice models of care</i>				
Initiative O1.2	Attain demand analysis to inform Ophthalmology Map of Medicine pathways				
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Measurable	Demand analysis: 1. Understand population health needs and variation by ethnicity for conditions agreed by the regional Ophthalmology clinical network 2. Understand intervention rates and equity of access across the region for conditions agreed by the regional Ophthalmology clinical network 3. Clinicians agree that data/information used to inform Map of Medicine clinical pathways for Ophthalmology clinical network are comparable across all regional DHBs				Milestone Jun 2015 Dec 2014 Jun 2015
Inputs & Resources	Clinical FTE as noted in initiative 1.1 Data analyst FTE from regional DHBs to inform discussions				
Responsibilities	Accountable roles: Clinical network chair, Elective services Action Group and HealthShare Project manager				
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities				
DHB Contribution	Non-clinical time made available to pursue regional objectives (as noted in initiative 1). DHB Analytical support and advice on local data relevant to the above outcomes (0.1FTE).				

Clinical objective	Recommend regional solutions to meet service care needs in the primary, community, secondary and tertiary sectors and implement solutions which maximize current capacity and/or better utilize resources.				
Initiative O2.1	Regional appointment process for clinical personal in at risk areas				
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Measurable	1. A process allowing for utilization of regional specialists has been provided by the regional ophthalmology group and agreed by the regional General Managers HR 2. <i>Regional General Managers HR has utilized the regional appointments process for a clinical appointment.</i> 3. Provide documentation around process and learning's of what worked and what didn't to MoH to distribute. 4. Provide feedback on process and possible improvements following first appointment. 5. Regionalise process to a minimum of two additional clinical areas				Milestone Dec 2014 Dec 2020 Following appointment Following appointment 6 months following appointment
Inputs & Resources	Clinical FTE as noted in initiative 1.1 HR input into process for creating policy				
Responsibilities	Accountable roles: Clinical network Chair, Regional HR and HealthShare Project Manager.				
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities				
DHB Contribution	Non-clinical time made available to pursue regional objectives (as noted in initiative 1.1). HR staff advise as approved by the regional action group chair				

Clinical objective	Recommend regional solutions to meet service care needs in the primary, community, secondary and tertiary sectors and implement solutions which maximize current capacity and/or better utilize resources.				
Initiative O2.2	Complete a regional GP survey around areas of improvement for Ophthalmology and Chronic Pain.				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Measurable	Demonstrate improvement in feedback received GP questionnaires from following years				Milestone Annual reporting
Inputs & Resources	Advise provided from Bay of Plenty on their GP survey and learning's DHB staff from Quality and Risk provided to aid in development of a regional GP survey				
Responsibilities	Accountable roles: Clinical network chairs and HealthShare Project managers.				
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities				
DHB Contribution	Non-clinical time made available to pursue regional objectives (as noted in initiative 1). Contribution of time from Human resources to discuss workforce information (0.05FTE) DHB Analytical support and advice on local data relevant to the above outcomes (as noted in initiative 2). Advise provided from Bay of Plenty on their GP survey and learning's (?5days) DHB staff from Quality and Risk provided to aid in development of a regional GP survey (0.2FTE)				

Clinical objective	Recommend regional solutions to meet service care needs in the primary, community, secondary and tertiary sectors and implement solutions which maximize current capacity and/or better utilize resources.				
Initiative O2.3	Agree standard intervention rates overseen by the regional Ophthalmology Clinical Network scoped, documented and provided to the elective services governance group for discussion				
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Measurable	<ol style="list-style-type: none"> 1. Regional intervention rates and issues around standardization regionally discussed with regional Planning and Funding departments, Provider arms and all departments that would be impacted 2. Regional intervention rates collected and discrepancies clarified 3. Benefits from regional intervention rates identified, documented and provided to the regional elective services action group. <p>Expected benefits</p> <ul style="list-style-type: none"> o Improved regional equity of access o Improved regional understanding of clinical subspecialties needed o Improved clarity and standardization around regional clinical processes o Reduced variation in access thresholds o Increased numbers of patients transferred between DHBs for non-tertiary care o Increase FSAs and treatments provided 				Milestone Dec 2014 Jun 2015 Jun 2015
Inputs & Resources	Clinical FTE as noted in initiative 1.1 Additional clinician attendance made available to pursue regional objectives (as noted in initiative 1) Staff from DHBs to support process as required by the Action/Governance groups				
Responsibilities	Accountable roles: Clinical network chair, Regional IS and HealthShare Project manager.				
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities				
DHB Contribution	Planning and Funding support (≈0.1FTE from each DHB) Staff from DHBs to support process as required by the Action/Governance groups				

Clinical objective	Process for appointing, supporting and maintaining regional approved new clinical staff roles				
Initiative O3.1	Develop a standard regional process for appointing and monitoring non-SMO staff to deliver Avastin treatments				
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Measurable	<ol style="list-style-type: none"> 1. Process for training nurses to administer Avastin regionally agreed by regional clinical network and regional HR 2. Process for supporting nurses who may fill roles outside DHB agreed by regional clinical networks and regional HR 3. Learning from process creation provided to inform further regional positions which require advanced scopes of practice. 4. Expected benefits to be reported back <ol style="list-style-type: none"> a. Increase in FSAs b. Increase in nurses providing Avastin treatments c. Replicable clinical pathway and learning's that can be provided to external DHBs <p>NB: Legal issues around legislation limitation and collage requirements are likely to delay timeframes – however the Auckland Trial provides an understanding that the change is possible and would show positive results</p>				Milestone Jun 2015 Jun 2015 Jun 2015 Jun 2015
Inputs & Resources	DHB and regional HR to support and advise on hospital and regional process matters (0.1FTE)				
Responsibilities	Clinical network chairs and HealthShare Project manager, Regional HR				
Enablers	DHB and regional HR support, possible legal advise				
DHB Contribution	Non-clinical time made available to pursue regional objectives (as noted in initiative 1). DHB HR support to advise on hospital access matters (≈0.05FTE)				

Clinical objective	Improved utilization of technological solutions to support clinical care				
Initiative O4.1	Develop a regional RetCam service (This is a regional business case that the ophthalmology group would like to trial and is an opportunity to work on a child health population problem with one of our leading networks)				
Initiative aligns with Midland objectives::	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Measurable	<ol style="list-style-type: none"> 1. Business case completed and provided to regional electives Action/Governance groups for approval 2. Process documented for future regional clinical business cases <p><i>Retcam benefits the population by reducing rental problems that can lead to blindness in neonatal and paediatric patients. Details of population benefits would be provided as part of the business case.</i></p>				Milestone Jun 2015 Jun 2015
Inputs & Resources	Clinical FTE as noted in initiative 1 Additional clinician attendance made available to pursue regional objectives (as noted in initiative 1) Staff from DHBs to support process as required by the Action/Governance groups				
Responsibilities	Accountable roles: Ophthalmology and Child Health Clinical Network chairs and HealthShare Project Managers				
Enablers	Access to additional staff from DHBs to support process as required by the Action/Governance groups, Regional Child Health Network support				
DHB Contribution	Access to additional staff from DHBs to support process as required by the Action/Governance groups (≈0.2FTE)				

Clinical objective	Improved utilization of technological solutions to support clinical care				
Initiative O4.2	Improved ability for Ophthalmology clinicians to access educational resources				
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Measurable	1. <i>Regional Ophthalmology staff have access to facilities that allow for videoconferencing into clinical education sessions.</i> 2. <i>Increase number of patient seen in clinics due to additional clinical time freed up from travel.</i>				Milestone Dec 2014 Jun 2015
Inputs & Resources	IS support				
Responsibilities	Accountable roles: Clinical network chair, Regional IS and HealthShare Project manager.				
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities, IS support.				
DHB Contribution	IS support				

3.0 Ear Nose and Throat

Clinical Objective	<i>Implementing evidence-based best practice models of care</i>				
E1.1	<i>Produce Maps of Medicine for ENT – one per annum</i>				
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Measurable	Clinical network: 1. Approved pathways to be built into Map of Medicine software to be accessible across the region. 2. Reduction in variation of scoring tools used regionally for conditions with regional pathways 3. Reduced trend in variation of waiting times for conditions with regional pathways 4. Lower rates of returned referrals in focused areas identified at the beginning of each year or less than 5% 5. Reduced 'did not attend' (DNA) rates for conditions with regional pathways				Milestone Quarterly reporting Quarterly reporting Quarterly reporting Quarterly reporting Quarterly reporting
Inputs & Resources	Clinical Chair and appropriate clinicians to be freed to attend meetings on an as needed basis to progress regionally agreed work. Map of Medicine administration support				
Responsibilities	Accountable roles: Chair of the Chronic Pain Network and HealthShare Project Manager.				
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities				
DHB Contribution	Clinical time freed to attend meetings (4 half day meetings/Per Annum) and non-clinical time prioritised to pursue regional objectives (as approved by the electives regional action/governance group) Support from Waikato DHB Map of Medicine team				

Clinical Objective	Clinical leadership development				
E2.1	<i>Develop network for ENT services</i>				
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Measurable	1. Clinical network has had first meeting and appointed a regional Chair 2. Clinical network has developed a work program and had it signed off by the regional elective services action group and governance group 3. ENT network report quarterly on progress to the regional elective services action group and governance group and MoH				Milestone Dec 2014 June 2015 Quarterly reporting
Inputs & Resources	Clinical Chair and appropriate clinicians to be freed to attend meetings on an as needed basis to progress regionally agreed work. Map of Medicine administration support				
Responsibilities	Accountable roles: Chair of the Chronic Pain Network and HealthShare Project Manager.				
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities				
DHB Contribution	Clinical time freed to attend meetings (4 half day meetings/Per Annum) and non-clinical time prioritised to pursue regional objectives (as approved by the electives regional action/governance group) Support from Waikato DHB Map of Medicine team				

4.0 General

Clinical Objective	<i>Implementing evidence-based best practice models of care</i>				
G2.1	<i>Continuation and development of additional regional sharing of patients to non-tertiary care facilities outside of their domiciled DHB</i>				
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Measurable	1. Increased number of appropriate patients moving between regional DHBs for secondary level care 2. Number of patients transferred regularly reported				Milestone Quarterly reporting Quarterly reporting
Inputs & Resources	Clinical Chair and appropriate clinicians to be freed to attend meetings on an as needed basis to progress regionally agreed work. Map of Medicine administration support				
Responsibilities	Accountable roles: Chair of the Chronic Pain Network and HealthShare Project Manager.				

Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities
DHB Contribution	Clinical time freed to attend meetings (4 half day meetings/Per Annum) and non-clinical time prioritised to pursue regional objectives (as approved by the electives regional action/governance group) Support from Waikato DHB Map of Medicine team

Clinical Objective	<i>Implementing evidence-based best practice models of care</i>					
G2.2	<i>Reduction in appropriate low complexity acute cases being transferred to Waikato DHB from around the region.</i>					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Measurable	Pressure areas for lower complexity acute cases understood Reduction in lower complexity acute cases being transferred to Waikato					Milestone Oct 2014 Quarterly reporting
Inputs & Resources	Clinical Chair and appropriate clinicians to be freed to attend meetings on an as needed basis to progress regionally agreed work. Map of Medicine administration support					
Responsibilities	Accountable roles: Chair of the Chronic Pain Network and HealthShare Project Manager.					
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities					
DHB Contribution	Clinical time freed to attend meetings (4 half day meetings/Per Annum) and non-clinical time prioritised to pursue regional objectives (as approved by the electives regional action/governance group) Support from Waikato DHB Map of Medicine team					

Clinical Objective	<i>Implementing evidence-based best practice models of care</i>					
G2.3	<i>Expansion of sub-regional arrangements allowing sharing of lower complexity patient regionally across appropriate specialties</i>					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Measurable	1. Increased number of appropriate patients moving between regional DHBs for secondary level care 2. Numbers of patients being transferred regularly reported					Milestone Quarterly reporting Quarterly reporting
Inputs & Resources	Clinical Chair and appropriate clinicians to be freed to attend meetings on an as needed basis to progress regionally agreed work. Map of Medicine administration support					
Responsibilities	Accountable roles: Chair of the Chronic Pain Network and HealthShare Project Manager.					
Enablers	GoToMeeting facilities, Meeting rooms, Videoconference and Teleconference facilities					
DHB Contribution	Clinical time freed to attend meetings (4 half day meetings/Per Annum) and non-clinical time prioritised to pursue regional objectives (as approved by the electives regional action/governance group) Support from Waikato DHB Map of Medicine team					

4.1.4 Health of Older People

Chair: Dr Phil Wood, Geriatrician

Vision: To conduct regional activity on behalf of the Midland DHBs that improves services for older people in order to facilitate 'ageing in place'. This means that older people will be assisted and encouraged to remain in their own homes, by having access to services that are coordinated and responsive to their varied and changing needs, and services that promote and maintain independence.

Key objectives:

1. Keeping older people well and independent
2. Reducing hospital admissions and rates of long-term residential care
3. Providing timely and coordinated services for people with complex needs living in the community
4. Reducing inequalities in health outcomes for Māori

Context:

New Zealand, like many countries, has an ageing population, with an increasing proportion of people in the older age groups. The population aged 65 years and over has increased from 11 per cent of the total population in 1991 and is expected to reach 21 per cent by 2031. The number of people aged 65 years and over is projected to increase from around 550,000 in 2009 to 1 million in the late 2020s, when they will outnumber children.

The ageing of the New Zealand population reflects the combined impact of lower fertility (achieved through access to effective birth control); increasing longevity (thanks to advances in medical technology and increased survival rates from life-threatening diseases); and the movement of the large number of people born during the 1950s to early 1970s into the older ages.

The tables below show numbers and proportions of people that make up the population in the Midland region. The first table shows the population at 2014, based on projections from 2006 census data (2013 census data is not currently available in age bands). The table shows the total number of people in each DHB and the region as a whole, the number of people 65 years and older, and the percentages of people 65 years and over.

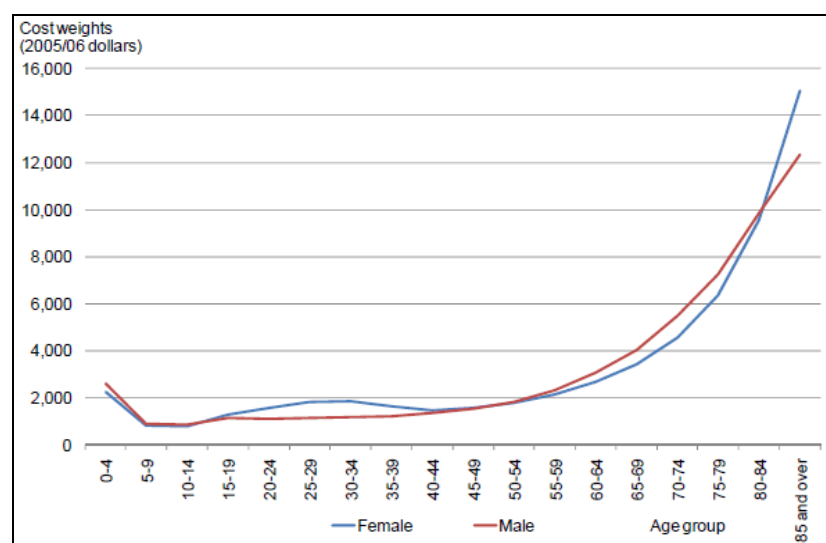
The second table shows the projection for 2025. It can be seen that the number of people over 65 in the Midland area is expected to rise from 137,650 people in 2014 (16.2 percent of the total population), to 191,965 people over 65 in 2025, 22.6 percent of the total population.

Midland Population in 2014	Waikato	BOP	Taranaki	Lakes	Tairāwhiti	Midland
Total Population	374,550	215,610	110,350	103,250	46,795	850,555
Number of people 65 years and older	56,360	40,220	19,285	15,330	6,455	137,650
Percentage of population 65 years and older	15.0%	18.7%	17.5%	14.8%	13.8%	16.2%

Midland Population in 2025	Waikato	BOP	Taranaki	Lakes	Tairāwhiti	Midland
Total Population	403,840	238,230	111,495	104,970	47,525	906,060
Number of people 65 years and older	79,160	56,200	25,670	21,560	9,375	191,965
Percentage of population 65 years and older	21.1%	26.1%	23.3%	20.9%	20.0%	22.6%

The increase in the number of people over the age of 65 years is considered important because population ageing affects health spending, as older people tend to require more health care, this can be seen in the graph below

Health cost weights, by age group



Source: Ministry of Health

Therefore, the Ministry of Health, District Health Boards and other healthcare providers develop and implement strategies aimed at keeping older people as well and independent as possible, and fully involved in decisions about their health and well-being.

Initiative 1	Improving services for people with dementia As New Zealand's older population grows there will also be an increase in the number of people with dementia. In 2011, just over 48,000 New Zealanders had dementia. By 2026, it is estimated that over 78,000 New Zealanders will have dementia. An increase of over 60 percent ⁹ . In 2013/14, two dementia pathways were developed and published on the Map of Medicine. These pathways were for the assessment of dementia, and the management of dementia. The 2014/15 year will focus on the implementation of the pathways, updating them as required and monitoring their use.					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Key actions Undertake road shows and other communications with primary health care regarding dementia pathways Develop dementia awareness and education resources Recruit dementia pathway educators across the region Complete regional implementation of the Midland dementia pathways; dementia assessment, and dementia management					by 31 Aug 2014 30 Sept 2014 31 Dec 2014 30 June 2015
Measurable	Dementia education/awareness resources developed Dementia educators recruited Map of Medicine provided statistics, such as GPs using the maps, pages viewed Increase in appropriate referrals to specialist services, where the patient journey had followed the maps					
Inputs & Resources	Education/awareness resources Dementia services educator role in each DHB Access to CT scans – primary referred The Midland DHBs are committed to identifying an appropriate representative for national discussions on dementia					
Responsibilities	Health of Older People Action Group Primary Healthcare Organisations (PHO) Non-Government Organisations (NGO)					
Enablers	IT system integration with primary care, allowing auto population of patient data to e-referrals from Map of Medicine					

Initiative 2	Delirium service development Delirium increases the risk of adverse outcomes, including length of stay, complications, cognitive and functional decline, residential care admission and mortality. For example, patients with delirium have a length of stay twice as long as those without delirium; delirium trebles the rate of cognitive decline in people with dementia; and rates of falls, incontinence and pressure sores more than trebled in hospital patients with delirium, and mortality increases markedly. ¹⁰ In 2013/14, a stock-take of the delirium services and resources that were available across the region was conducted. In the 2014/15, further actions are planned to identify service development opportunities and share resources and learning across the Midland region					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Key actions Complete a report summarizing the information from the stock-take to include examples of good practice, a gap analysis and recommendations for service development Operationalise the sharing of resources (human and other resources) across the region where practicable Work with DHBs and MOH to improve data collection and information relating to delirium					by 31 July 2014 30 Sept 2014 30 June 2015
Measurable	Report complete Report examples of the sharing of delirium resources across the region Relevant data / information available					
Inputs & Resources	Optional – some DHBs may want to implement delirium resources, based on the work from another Midland DHB Optional – there may be opportunities for DHBs to share human resources, such as clinical nurse specialists for education sessions that may require funding					
Responsibilities	Health of Older People Action Group					
Enablers	Optional – workforce development					

⁹ Ministry of Health *New Zealand Framework for Dementia Care* 2013

¹⁰ Australia and New Zealand Society for Geriatric Medicine *Position Statement 13 – Delirium in Older People* (Revised 2012)

Initiative 3	Wrap around services (rapid response and discharge management) In 2013/14 District Health Boards reviewed rapid response and discharge management services (wrap around services) in each DHB, and a regional stock-take was undertaken. In the 2014/15 year, DHBs will implement findings from their reviews and lessons learned from CREST in Canterbury and START in Waikato. The regional work plan for 2014/15 includes noting work underway and opportunities for shared learning. This may take the form of regional presentations, documenting examples of good practice, providing benchmarking data, and other steps as determined by Health of Older People Action Group					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Key actions Provide a summary document of the regional stock-take Communicate with DHBs to find out what work is underway with regard to DHB implementation of the findings from their reviews Provide opportunities to share learning and resources Determine relevant benchmarking data, including InterRAI data, and share on a regular basis					
	by 31 July 2014 Ongoing Ongoing Ongoing					
Measurable	Stock-take document complete Report examples of shared learning and shared resources Provide quarterly data/benchmarking reports					
Inputs & Resources	DHB Implementation of findings from their reviews of wrap around services Data analysis					
Responsibilities	DHBs Health of Older People Action Group					
Enablers	InterRAI information system analytics					

Initiative 4	Improving services between hospital specialist services and aged residential care People in aged residential care have been identified as people with high or very high needs that are indefinite, and are unable to be supported in the community ¹¹ Due to the high and often complex needs of people in aged residential care, the relationship and liaison between specialist services for older people and aged residential care, should be as seamless as possible to improve the care of the older person					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Key actions Document the initiatives for service integration that may currently exist in each DHB area Communicate with specialist services for older people, and age residential care facilities to find out where perceived gaps and opportunities exist Provide opportunities to share learning and resources Other actions as determined by the Health of Older People Action Group					
	by Dec 2014 Jan 2015 Ongoing Ongoing					
Measurable	Service integration initiatives documented Data report showing measures that relate to service integration for people in residential care, such as admissions to hospital, emergency department presentations and length of stay					
Inputs & Resources	None identified					
Responsibilities	Health of Older People Action Group					
Enablers	Data measures and collection					

¹¹ Ministry of Health Residential Care Eligibility

4.1.5 Regional Mental Health & Addiction Network Work Programme 2014-2015

Clinical Chair: Professor Graham Mellsop
Regional Director: Eseta Nonu-Reid

Vision: *“Living well with supportive systems”* underpinned by:

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

Key Objectives:

1. Leading regional mental health and addiction planning
2. Leading regional service improvement
3. Supporting the achievement of health targets and policy priorities
4. Linking to national and regional governance structures and processes
5. Leading and/or supporting the development of nationally consistent approaches to mental health and addiction
6. Reducing inequalities in mental health and addiction outcomes
7. Efficiency and effectiveness to determine and inform funding prioritisation decisions

This plan is inclusive of primary, secondary, and the tertiary mental health and addiction sectors and should be read in conjunction with the local District Annual Plan.

Mental Health & Addiction Context¹²

Since the 1990s the mental health and addiction sector has been through significant growth and rapid change, not only in relation to the range of services available, the way they are provided and the strong emphasis on a culture of recovery, but also in terms of the expectations of people who use services, their families and whānau, and communities. The service changes have only been possible through the efforts of an innovative and energetic sector that is willing to make continual improvements and never stand still. Despite all the improvements over recent years, service quality and the level of access to services remain variable for people with mental health and addiction issues. It is essential we continue to make changes, with a renewed focus on earlier and more effective responses, improved outcomes, better system integration and performance, increased access to services, effective use of resources and stronger whole-of-government partnerships.

Māori continue to more frequently experience mental health and addiction issues (Oakley Browne et al 2006), inpatient admission, seclusion and compulsory treatment (Ministry of Health 2012a) than other groups. We also continue to have:

- one of the highest rates of youth suicide in the developed world
- high rates of the use of seclusion, with variation between district health boards (DHBs)
- high rates of the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992, with variation between DHBs
- variation in access to services especially for children and youth
- variable waiting times for access to mental health and addiction services
- variable alignment and integration between services provided by DHBs and those provided by NGOs
- variable integration between specialist services and primary care
- limited and variable primary mental health responses for people experiencing common but debilitating mental health and addiction issues and no ability to measure access to these primary mental health responses
- gaps in responses for people with co-existing mental health and addiction problems, and those with co-existing mental health issues and disabilities
- variability in the quality of specialist inpatient facilities.

To tackle these challenges, significant changes are needed to better meet the needs of those in our communities who use our services. We must take the time to consider cutting-edge practice and this plan allows the region to take incremental steps towards achieving these goals.

¹² Ministry of Health, 2012: Mental Health & Addiction Service Development Plan; *Rising to the Challenge*

Governance					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
	Initiative	Description	Timeframe	Deliverable	Gains
G1	Improve access to all age ranges MoH	Monitor efficiency and effectiveness of service delivery to improve waiting times Māori Mental Health & Addiction is improved	Ongoing June 2015	Waiting times are reduced HONOS compliance is improved Seclusion and restraint rates are monitored by aligning to the National Collaboration project and Te Pou and Te Rau Matatini work programme Māori KPIs are consistently reported in each of the Midland DHBs	Clinical Governance participates in all key strategic decisions Data quality is improved and reflected in quarterly reports received from Te Pou Regional reports are provided to Clinical Governance on: <ul style="list-style-type: none"> 6 Core Strategies Implementation Seclusion and restraint rates Māori rates of seclusion and restraint A clear regional picture is developed on strategies for improving Māori access and treatment: <ul style="list-style-type: none"> Number of Māori with current recovery plan 7 day follow up for Māori post discharge from inpatient care Māori rates of CTOs Consistent completion of ethnicity data entering services
G2	Improve strategic alliances Midland	Midland MH&A Clinical Governance will align procedurally and functionally with the P&F-ALT	Ongoing	Mental Health & Addiction will ensure membership support to the P&F-ALT	Regional strategic directions are discussed at MR CGN meetings and opinion provided MH&A participates consistently in all strategic planning and decision making

Quality and Safety					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
	Initiative	Description	Timeframe	Deliverable	Gains
Q1	Eating Disorders Inpatient Care MoH	Continued regional provision of eating disorder inpatient services to implement the recommendations from the service review to ensure sustainable inpatient and community services	July 2013 start June 2015 completion	Participate in determining supra-regional funding model going forward Implement agreed model within the Midland region	Midland ED supra-regional services adds value for investment Planning for 2014/15 going forward is agreed by GMs P&F and CEs
Q2	High and Complex Needs MoH	Improved mental health and addiction service capacity for people with high and complex needs	July 2013 start June 2016 completion	Undertake a stocktake project utilising the Northern DHBs definitions <ul style="list-style-type: none"> Seek resources / funding to implement agreed plan Project scope and Implementation Plan finalised Stocktake to include Māori access rates 	A robust paper and recommendations are developed for sign off by GMs P&F and CEs
Q3	Forensic Inpatient Care MoH	Robust regional contribution to the national network of forensic inpatient services.	July 2013 start June 2015 completion July 2013 start June 2016 completion	Align to and ensure participation in the national forensic network for inpatient beds Recommendations are prioritised and implemented Measure <ul style="list-style-type: none"> A reduction in the time people in prisons requiring assessment in forensic services wait for this to occur 6 monthly stakeholder report identifies Māori access rates and length of stay 	National guidelines are implemented across Midland Planned and phased action is undertaken that matches the MoH funding envelope

Service Delivery					
Initiative aligns with Midland objectives:		1: Improve Māori health outcomes		2: Integrate across continuums of care	
		4: Build the workforce		5: Improve clinical information systems	
		3: Improve quality across all regional services		6: Efficiently allocate public health system resources	
	Initiative	Description	Timeframe	Deliverable	Gains
S1	Youth Forensic Implementation MoH	Develop and implement actions for a Community Youth Forensic Service Plan with the agreed number of additional FTEs	July 2013 start June 2016 completed	MoH funding is utilised as prioritised by the MoH Increased access to community youth forensic services and availability of liaison officers in court Quarterly report identifies Māori access rates and length of stay	Midland align to the MoH expectations for funding Quarterly reports are mapped to identify demand and court liaison access rates
S2	Perinatal / Maternal Mental Health & Addiction MoH	Establish a coordinated network for FTE working in Perinatal MH&A to support supervision and workforce development.	July 2013 start June 2015 completed Phase Two: Include primary, well child and whanau ora providers Develop a shared model of care that is regionally agreed and allows for local flexibility	Develop a Phase II project scope and key stakeholders FTE are implemented as described in the RFP Measure Increased access in Midland to perinatal and maternal mental health services	A project is undertaken that provides guidance to the sector and establishes integrated approaches across the continuum Continuum of care is further developed to reduce waiting times Stocktake and model of care drives are consistent best practice Reports on number of people accessing perinatal services to ascertain demand are developed <ul style="list-style-type: none"> Māori access rates and length of stay in services is capture and reported quarterly Annual comparative report is completed

Research and Evaluation					
Initiative aligns with Midland objectives:		1: Improve Māori health outcomes		2: Integrate across continuums of care	
		4: Build the workforce		5: Improve clinical information systems	
		3: Improve quality across all regional services		6: Efficiently allocate public health system resources	
	Initiative	Description	Timeframe	Deliverable	Gains
R1	MH&A regional data management MoH	Maintain PRIMHD support to the NGO sector and include larger NGOs to ensure consistency of reporting Implement HISO Review codes	July 2013 start June 2017 completed	Support continues to be provided to the NGO sector and expanded to include larger NGOs All NGOs are re-mapped to include new codes All NGOs are trained in new codes	Consistent application of PRIMHD continues regionally MoH expectations are achieved and Midland data is accurate MoH expectations are achieved and Midland data is accurate Quarterly reports are extracted from the MoH to ascertain Māori access, length of stay and discharge to provide a Midland regional view
	MH&A alignment to regional IS project Midland	MH&A is supported to develop a flexible solution for Orion Concerto implementation	July 2015 and 2016	Clinical Governance provides oversight and guidance to the Orion Concerto implementation across the Midland DHBs	Working Group is set up with representative from the five Midland DHBs to provide clinical leadership and ensure regional agreements / consistency

Enablers/support					
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
	Initiative	Description	Timeframe	Deliverable	Gains
E1	Regional Workforce Planning Midland	Undertake a regional Workforce Stocktake and Needs Analysis Prioritise Midland Workforce Development initiatives Identify opportunities to build Midland's capacity and capability	July 2013 start June 2016 complete	A clear regional picture is obtained re the Midland workforce demands Workforce priorities are established annually Opportunities for workforce planning are realised when services are developed thereby building capacity Workforce initiatives are aligned to national drivers Trauma Informed Care training is sourced and workshops provided in each of the districts One off funding for Perinatal Infant Mental Health workforce initiatives is fully implemented	Accurate workforce gaps are identified and strategies for improvement is developed Regional workforce strategies and funding streams are implemented Midland meet the MoH expectations Māori Workforce is clearly identified and challenges for the Māori workforce going forward are articulated Capacity and capability of the workforce is enhanced All workshops are integrated involving members from across the continuum to ensure consistency
E2	Mental Health and addiction strategic development Midland	A regional summit is undertaken that focus on: 1. Māori MH&A 2. Addictions	June 2015	Specialty groups provide strategic directions for the service and feed into national direction and drivers	Midland is well positioned to provide direction to the MoH and MHC on Māori mental health and addictions priority areas for development Evaluation reports are completed that: <ul style="list-style-type: none"> Clearly identify challenges for Māori and the Addiction sector going forward Solutions to reduce barriers for Māori are identified Areas of best practice are promoted as exemplars

4.1.6 Midland Regional Trauma System (MRTS)

Chair: Grant Christey, MRTS Director, Waikato DHB

Project Manager: Suzanne Andrew

Vision: The Midland community will be provided with highest quality trauma care

Mission: To lead regional trauma care quality improvement activities in the Midland region

Key Objectives:

- 1) To enable provision of highest quality trauma care focused on the needs of patients
- 2) To improve patient journeys by encouraging collaboration between all trauma care providers
- 3) To develop a trauma quality improvement programme based on trauma registry data
- 4) To ensure that stakeholders and others are informed and aware of MRTS activities and progress
- 5) To ensure adequate resourcing and sustainability of MRTS.

Regional Measures:

- 1) MRTS Trauma Guidelines agreed for use by Midland DHBs
- 2) MRTS Registry data input up-to-date within 12 weeks of data collection
- 3) MRTS Trauma Quality Improvement Programme (TQIP) delivering regular quality reports to stakeholders
- 4) Stakeholder communication plan operational
- 5) Regional educational programme operational
- 6) Midland Trauma Research Centre is functional and producing information for peer review
- 7) Mortality of severely injured (Injury Severity Score >15) is less than 10% in all Midland hospitals
- 8) MRTS adequately staffed, funded, and in an optimal and sustainable state at the end of 2015.

National Measures:

- 1) Trauma registry and TQIP processes are functional and compatible with national trauma systems and initiatives
- 2) National health agencies are regularly informed on the status and progress of MRTS
- 3) MTDS on major trauma patients supplied to the NZMTR by June 2014.

Initiative 1	MRTS Governance – MRTS governance structure is functional and sustainable and the Midland DHBs support the development of MRTS <ul style="list-style-type: none"> Review and agree the Terms of Reference for the Strategic Group and Operational Group Review and align all national initiatives and goals relative to trauma care, as appropriate MRTS profile is enhanced regionally and nationally through communication tools Identify and develop opportunities for MRTS to utilise NEXUS to enhance MRTS cohesion, support for training and professional development, and the development, review and progression of regional documents. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q2/Q4					
Measurable	<ul style="list-style-type: none"> MRTS Strategic Group and MRTS Operational Group Terms of Reference are in place National initiatives and goals are reviewed by MRTS MRTS regional and national profile is enhanced Increased utilisation of NEXUS as a regional tool for the development of MRTS. 					
Inputs & Resources	MRTS					
Responsibilities	MRTS					
Enablers	Midland DHBs e.g. Trauma Oriented Consultant and Trauma Nurse Specialist representatives from each Midland DHB are supported to be actively involved in MRTS.					

Initiative 2	MRTS Registry – support provided by the MRTS Registry for quality improvements <ul style="list-style-type: none"> Track and review progress of MRTS Registry and apply for additional funding and/or resources, as required Revise and update MRTS Registry progress, as necessary Investigate software licenses for the MRTS Registry and the possibility of ‘hosting’ other DHBs nationally in the future to fully utilise MRTS resources Identify ways to reduce dependence on FTE for data handling to improve the efficiency of data input Review ability for direct input at DHB sites into the MRTS Registry e.g. handheld devices, to enable immediate clinical coding and Registry input. Consider alternative funding streams and resources to support the more efficient entry of data into the Registry and make applications, as necessary Develop data audit programme based on Registry function Supply the region’s MTDS on major trauma patients to the NZMTR. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q2 / Q4					
Measurable	<ul style="list-style-type: none"> MRTS Registry progress is tracked and reviewed and applications for additional funding and/or resources are made, as required 					

	<ul style="list-style-type: none"> MRTS Registry progress is revised and updated MRTS Registry software licenses and 'hosting' opportunities have been investigated Review of the dependence on FTE for data handling and the opportunity for direct input at DHB sites into the MRTS Registry has been explored Data entry audit programme developed based on Registry function MTDS on major trauma patients supplied to the NZMTR by June 2014.
Inputs & Resources	MRTS / DHB support in the development of business cases/requests for funding and/or resourcing support, as required.
Responsibilities	MRTS
Enablers	Regional IS (e.g. exploration of handheld devices for direct data entry into MRTS Registry)

Initiative 3	Trauma Quality Improvement Programme (TQIP) – MRTS work plan is developed to improve the quality of trauma services <ul style="list-style-type: none"> Commence identifying quality initiatives using the 2013 Verification Reports to support prioritisation of quality improvements to improve trauma patient care Address deficits identified by the 2013 Verification Reports Track and review progress of initiatives, and associated timeline, within the MRTS work plan Revise and update the MRTS work plan to enable a flexible and responsive tool, as required Identify and progress two or three quality initiatives to improve trauma patients' care pathway Involve trauma patients and their families in TQIP to improve patient centred services Continue to develop IT systems and process to support TQIP Ensure system compatibility with appropriate national health IT systems. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q2/Q4					
Measurable	<ul style="list-style-type: none"> Quality initiatives from the 2013 Verification Report are identified and prioritised Deficits identified in the 2013 Verification Report are addressed MRTS work plan is responsive to identified changes and steady progress is maintained Trauma patients and their families are given the opportunity to provide consumer feedback on trauma services received to enhance TQIP. 					
Inputs & Resources	MRTS/ Regional IS support					
Responsibilities	MRTS					
Enablers	n/a					

Initiative 4	Trauma Quality Improvement Programme (TQIP) – a robust IT platform for TQIP is continued to be developed, including a relational data warehouse (TQUAL), and compatibility with regional and national IT processes, is maintained <ul style="list-style-type: none"> Continue to develop IT platform for TQIP Explore possibility of importing data into TQUAL so that maximal utilisation of MRTS Registry and related data sources is available for quality initiatives Ensure alignment with "Triple Aim" quality approach. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	ongoing					
Measurable	<ul style="list-style-type: none"> TQIP's IT platform demonstrates steady development Data importing into TQUAL is given ongoing consideration 					
Inputs & Resources	MRTS Regional IS support					
Responsibilities	MRTS					
Enablers	Regional IS (e.g. informing of regional and national IT processes, etc.)					

Initiative 5	MRTS Risk Register – develop a Trauma System Risk Register <ul style="list-style-type: none"> Risk Register is updated and maintained Initiatives are prioritised, based on identified risks. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q2/Q4					
Measurable	<ul style="list-style-type: none"> MRTS Risk Register is updated and maintained Prioritised MRTS initiatives reflect identified risk rating 					
Inputs & Resources	MRTS					
Responsibilities	MRTS					
Enablers	n/a					

Initiative 6	MRTS Guidelines and Clinical Transfer Matrices – agreed trauma service guidelines across the Midland region are developed, in line with international best practice, and consistent with the national direction for a range of clinical areas <ul style="list-style-type: none"> Review and amend developed regional Guidelines, as required Develop a timeline for the roll out of the agreed MRTS Guidelines, including agreed sub specialty acute trauma conditions Implement agreed Midland Regional Clinical Transfer Matrices. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q2 / Q4					
Measurable	<ul style="list-style-type: none"> MRTS Guidelines are agreed and reflect regional requirements MRTS Guidelines timeline for roll out is in place Trauma care benchmarking is in place for inclusion in serious/adverse event review Midland Regional Clinical Transfer Matrices are in place. 					
Inputs & Resources	MRTS					
Responsibilities	MRTS					
Enablers	n/a					

Initiative 7	Midland Immediate Medical Response Service – develop a service which is regionally resourced, meeting regional needs and risk mitigation strategies, whilst complementing national emergency management work and aligning with the NZMAT. <ul style="list-style-type: none"> Develop a definition of the service provided by a MIMRS and develop operational manual Review NZ Medical Assistance Team (NZMAT) and Australian Medical Assistance Team (AUSMAT) to ensure compatibility Develop and enact a recruitment strategy for MIMRS Note: this initiative is on hold pending organisational resourcing and support					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q4					
Measurable	<ul style="list-style-type: none"> MIMRS definition and MIMRS operational manual in place, compatible with NZMAT and AUSMAT operations MIMRS recruitment strategy in place 					
Inputs & Resources	MRTS					
Responsibilities	MRTS					
Enablers	Regional HR / Workforce					

Initiative 8	MRTS Community of Research/Learning – utilise NEXUS as a learning tool to support research, evaluation and innovation to enhance learning and opportunities within trauma <ul style="list-style-type: none"> Develop regional training and educational resources, e.g. the MRTS Emergency Ultrasound training course Consider the use of Moodle as a tool to support regional education delivery Ensure DHB funds, as per the Memorandum of Understanding between MRTS and the Midland DHBs, are available for staff training. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	ongoing					
Measurable	<ul style="list-style-type: none"> Regional training and educational resources available via NEXUS and possibly Moodle Staff are released and supported to attend regional training 					
Inputs & Resources	MRTS					
Responsibilities	MRTS					
Enablers	n/a					

Initiative 9	Midland MRTS Conference – consider hosting a trauma conference in 2015, investigate feasibility and support within MRTS so that trauma clinicians in the Midland region maintain competency and skill aligned to current best practice <ul style="list-style-type: none"> Develop a trauma conference proposal for early 2015 for consideration Consider an annual conference if 2015 conference is successful and supported. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q2/Q4					
Measurable	<ul style="list-style-type: none"> Trauma conference proposal developed 					
Inputs & Resources	MRTS					
Responsibilities	MRTS					
Enablers	Midland DHB funding support					

Initiative 10	Midland Trauma Research Centre – develop an organised and supported group of skilled personnel to maximise MRTS data for trauma related research <ul style="list-style-type: none"> Identify partner organisations and specific personnel (universities, trauma care provider agencies, national and international collaborative groups, researchers, etc.) Identify priority projects and research topics Establish processes for data handling, fund management, ethics approval, grant application processes Develop business case for formal recognition and funding support. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q2/Q4					
Measurable	<ul style="list-style-type: none"> MIMRS definition and MIMRS operational manual in place, compatible with NZMAT and AUSMAT operations MIMRS recruitment strategy in place 					
Inputs & Resources	MRTS					
Responsibilities	MRTS					
Enablers	DHB support in the development of business cases/requests for funding and/or resourcing support, as required.					

Initiative 11	Trauma Specialist Workforce – develop specialty workforce competency <ul style="list-style-type: none"> Develop a professional development pathway for staff involved in trauma patient care 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q4					
Measurable	<ul style="list-style-type: none"> MRTS professional development pathway in place 					
Inputs & Resources	MRTS					
Responsibilities	MRTS					
Enablers	Regional HR / Workforce					

Initiative 12	IS Support for MRTS – develop a closer relationship between MRTS and regional and national IS <ul style="list-style-type: none"> Maintain links between MRTS and the regional IS team so that there is an awareness of IS technologies available to support trauma services and patients 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Ongoing					
Measurable	Involvement of regional IS team with the development of the MRTS Registry and Trauma Quality Improvement Programme					
Inputs & Resources	MRTS					
Responsibilities	MRTS					
Enablers	Regional IS support					

Initiative 13	MRTS Structure – develop a proposal to confirm the ongoing structure and funding requirements for MRTS <ul style="list-style-type: none"> Identify future MRTS structure and funding requirements to enable a better understanding of the regional implications for MRTS Develop a proposal and submit to Midland DHBs 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q4					
Measurable	<ul style="list-style-type: none"> MRTS structure, including future funding requirements, outlined in proposal to Midland DHBs MRTS proposal submitted to Midland DHBs for support 					
Inputs & Resources	MRTS					
Responsibilities	MRTS Midland DHB support, including funding support					
Enablers	DHB support in the development of a proposal re MRTS structure and future funding requirements, as required. Midland DHB funding support					

4.1.7 Midland Stroke Network

Chair: Dr Peter Wright

Project Manager: Kerry-Ann Adlam

Context and vision:

Stroke affects approximately 160 people per 100,000 population per year across our region (an estimated 1200 people). Of these approximately one in three die because of the stroke, and another one in three are significantly disabled requiring inpatient rehabilitation. Many of the remainder are left with some more mild disability. Stroke is the leading cause of adult disability in New Zealand. In general stroke admission rates across New Zealand are increasing (more than 5% over the last 4 years, and in those age 45-65 it has increased by 12% over 4 years). The stroke admission rates in Māori have risen two and a half times faster than in other ethnicities over this time, and Māori have been shown to suffer stroke about 10 years younger than other ethnicities. These changes likely represent both our aging population and an increasing risk factor burden in our younger adult population.

The Midland Stroke Network looks to consolidate the work of the last year, with a continued focus on providing consistent high-quality stroke services within the hospital setting, supporting national work on strengthening the primary prevention message and encouraging Māori to access TIA and stroke services. The 2014/2015 plan continues this approach and also looks to strengthen the focus and work on providing patient focused rehabilitation services both in the acute and post discharge periods.

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 (the service will include a nominated lead stroke physician and lead stroke nurse)
2. All Midland residents have access to an acute TIA service
3. All Midland DHBs develop an acute thrombolysis pathway
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 Midland DHBs have established investigation and treatment pathways to optimise medical and lifestyle change to prevent stroke recurrence
6. All staff, patients and their families/caregivers have access to on-going education
7. Inequalities in health outcomes for Māori are reduced
8. Inequalities in health outcomes for the Pacific population are reduced

Measures:

- 6% of potentially eligible stroke patients are thrombolysed
- 80 percent of stroke patients are admitted to a stroke unit or organised stroke service with demonstrated stroke pathway
- Proportion of people with acute stroke who are transferred to inpatient rehabilitation services
- Proportion of the above who are transferred within 10 days of acute stroke admission – target 60%

Line of Sight
National Objectives
<ul style="list-style-type: none">• To improve stroke prevention, stroke event survival, and reduce subsequent stroke events; and• To improve access to organised acute and rehabilitation stroke services.
National milestones and measures
<p>Continue to implement NZ Clinical Guidelines for Stroke Management 2010 (the Stroke Guidelines). This will include:</p> <ul style="list-style-type: none">• People with stroke admitted to hospital are treated in a stroke unit with an interdisciplinary stroke team. Smaller DHBs, as defined in the Stroke Guidelines, are expected to develop models of stroke care that adhere as closely as possible to the criteria for stroke unit care.• All eligible patients, as specified in the clinical definition previously supplied to DHBs, have access to thrombolysis.• All stroke patients receive early active rehabilitation by a multidisciplinary stroke team• All people with stroke have equitable access to community stroke services, regardless of where they live.• All members of the multidisciplinary stroke team participate in ongoing education and training according to the Stroke Guidelines. <p>Measures</p> <p>Provision of quarterly reports that provide progress on:</p> <ul style="list-style-type: none">• 6% of potentially eligible stroke patients are thrombolysed• 80 percent of stroke patients are admitted to a stroke unit or organised stroke service with demonstrated stroke pathway• Proportion of people with acute stroke who are transferred to inpatient rehabilitation services• Proportion of the above who are transferred within 10 days of acute stroke admission – target 60%
Regional Objectives
<ol style="list-style-type: none">1. Improve Māori health outcomes2. Integrate across continuum of care3. Improve quality across all regional services4. Build the workforce5. Improve clinical information systems6. Efficiently allocate public health system resources

Actions – 2014/15

Actions – 2014/15					Milestone/Date	Responsibility
1. The Midland Stroke Network will provide support for DHBs local work plans to implement the 2010 Stroke Guidelines. This will provide Māori and general population with consistent standard of care <ul style="list-style-type: none">Thrombolysis services are available in Lakes DHBAll DHB stroke guidelines and services are in line with the Stroke Guidelines, with some local institution variability expected. Specific guidelines include: TIA, stroke management and thrombolysisSix monthly morbidity and mortality case review to identify thrombolysis quality deficits and issues					August 2014 December 2014 June 2015	MSN
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources	
2. The Midland Stroke Network will provide a conduit for information sharing and implementation of work programmes locally from the national work groups i.e. thrombolysis, rehabilitation and TIA <ul style="list-style-type: none">Recommendations from the national work groups are incorporated into regional and local plans including: Thrombolysis, Rehabilitation, TIA					July 2014 and ongoing	MSN
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources	
3. Support the NZ Stroke Foundation to develop a primary stroke prevention education resource kit for use across the region for GPs, primary care, Aged Residential Care (ARC) and other health care providers to ensure timely primary stroke prevention patient education for Māori and the general population <ul style="list-style-type: none">Ongoing mapping of current education provision and gap analysisEducation resources are available for the primary and community sectorsOngoing evaluation of education needs and resources is undertaken					July 2014 and ongoing	MSN
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources	
4. Ongoing implementation of education programmes for clinicians across the region, this will include regular study days and networking, online learning, a skills and knowledge framework (supported nationally), a regional case review forum, a lead stroke nurses forum and education resources available for use by Māori health key workers to support stroke prevention for Māori <ul style="list-style-type: none">Online learning resources shared across stroke interdisciplinary stroke team nationally and locallyCase reviews occur at all Stroke Network meetingsAnnual regional or national stroke study day supported and deliveredSupport the national Stroke Nursing group to develop a nursing knowledge and skills framework developedExisting and planned learning opportunities shared between Midland DHBsOngoing education between lead stroke clinicians and coding staffSupport the NZ Stroke Foundation to develop Māori health education resourcesSix monthly morbidity and mortality case review to identify quality deficits and issues					July 2014 ongoing July 2014 ongoing By June 2015 By June 2015 July 2014 ongoing July 2014 ongoing By June 2015 July 2014 ongoing	MSN MSN HS project manager (PM) HS PM MSN MSN MSN
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources	
5. Thrombolysis service in geographically remote areas of the Midland region. Ensure access to thrombolysis across the region. <ul style="list-style-type: none">Thrombolysis ‘places of definitive care’ identified in the region and shared with national ambulance/stroke group and COOs in Midland DHBsEvaluation is undertaken with the regional ambulance service to ensure access to thrombolysis is appropriate					December 2014 By June 2015	MSN
1: Improve Māori health outcomes	2: Integrate across continuum of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources	
6. Discharge planning and post stroke care <ul style="list-style-type: none">Recommendations from the Midland rehabilitation stock take are considered by the Midland stroke network and a plan to address issues is developed and implemented					July 2014 ongoing	MSN
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources	
7. Māori Health Stroke services are accessible and utilised by Māori within the Midland region. <ul style="list-style-type: none">Access to acute stroke services is monitored for the Māori population comparative to the non-Māori population (report six monthly)Measures collected including audits are broken down to include ethnicity (report every three months)Initiatives to improve access to stroke and TIA services for Māori are developedSupport the NZ Stroke Foundation to develop Māori health education resources post stroke					July 2014 ongoing July 2014 ongoing March 2015 June 2015	HS analyst HS analyst MSN
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources	

8. Pacific Population Health Stroke services are accessible and utilised by the Pacific population within the Midland region. <ul style="list-style-type: none"> Access to acute stroke services is monitored for the Pacific population Measures collected including audits are broken down to include ethnicity where possible Identify regional issues for the Pacific population accessing stroke services 				July 2014 ongoing July 2014 ongoing March 2015	HS analyst HS analyst
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
9. Key audits and outcome measures are monitored by the Stroke Network. Quarterly outcome measures are monitored: <ul style="list-style-type: none"> Number of stroke and TIA events per quarter % of all stroke patients being cared for in a stroke unit % of acute ischaemic stroke patients thrombolysed % readmission rate post TIA (within 90 days) % post stroke new admissions to aged residential care % of TIA/mild stroke (a stroke without catastrophic or severe consequences) Patients undergoing carotid endarterectomy two weeks from onset of symptoms/stroke Door to needle time for thrombolysis % of Māori accessing stroke services Number of Māori patients 64 and under and over 65 Investigate the feasibility of six monthly case review audits (20) of rehabilitation services for under 65s against agreed criteria and undertake if possible The Midland Stroke Network works with the national rehabilitation group to identify further consistent rehabilitation audit measures The Midland Stroke Network will work with the national stroke leadership group to identify the feasibility of a stroke/thrombolysis register for use across the sector 				July 2014 ongoing By June 2015 By June 2015 By February 2015	HS analyst MSN MSN MSN
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
10. Telestroke pilot To increase thrombolysis service provision to Māori and the general population that live in more rural areas with limited specialist services <ul style="list-style-type: none"> Explore piloting a regional telestroke model to support DHB clinicians with smaller numbers of stroke presentations for thrombolysis Monitor implementation of thrombolysis service across the region and explore need for telestroke service provision 				Review needs again by December 2014 July 2014 ongoing	MSN MSN
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Linkages to Other Work Programmes

Annual Plan:	
Lakes DHB	<ol style="list-style-type: none"> Develop Stroke Thombolysis quality assurance procedures, including processes for staff training and audit Provide dedicated stroke unit for management of people with stroke, thrombolysis treatment and transient ischaemic attack service supported by ongoing education and training for interdisciplinary teams Support national and regional clinical stroke networks to implement actions to improve stroke services
Waikato DHB	<ol style="list-style-type: none"> Developing a reliable minimal audit of all coded strokes/TIAs to ensure data integrity for future reports Reducing Door To Needle time for TPA Developing a patient orientated stroke management pathway across the WDHB
Tairāwhiti DHB	<ol style="list-style-type: none"> Develop clear transportation processes for Stroke patients on east coast to Gisborne Hospital Increase awareness of TIA and its significance with general practice and ED department (i.e. people with TIA are at high risk of early stroke) Develop clear pathways for psychological support for patients with stroke

Appendix 4.2: Regional priorities

4.2.1 Child Health Action Group

Chair: Dr David Graham
Project Manager: Kerry-Ann Adlam

Context:

Over the next three years the Child Health Action Group will plan and work to develop Child Health Services across the Midland region to improve health outcomes and achieve equity in child health.

Child Health in the Midland region has been chosen as a focus area because it has different challenges to the rest of New Zealand in terms of the constitution of the population and the highest levels of poverty and rurality in the country. The Child Health Action Group work plan provides an opportunity to invest in the long term health of our children and future adult population by working together regionally to maximise health gains in a cost effective way.

Further aims include supporting vulnerable children and contributing to the Government's overall priorities by improving services and reducing avoidable expenditure in the justice, health and welfare systems – helping to deliver better public services within financial constraints and helping Build a more competitive and productive economy.

Goals for Child Health in the Midland region

- Improve Māori child health outcomes and achieve equity in child health
- Improve all child health outcomes in the Midland region
- Improve access, timeliness and quality of child health care
- Increase systems integration across the continuum of child health care
- Build and improve the child health workforce
- Improve child health clinical information systems
- Best value for public child health system resources

Key Objectives:

- Recommend regional solutions to meet child health care needs in the primary, community and secondary sectors and implement solutions within current capacity
 - Promote organised systems of care
 - To support continuing work on Information Systems to support Child Health
 - Consider and implement 'choosing wisely' approach
 - Facilitate/promote regional Well Child/Tamariki Ora Quality Improve initiatives
- Raise the profile of regionally-led child health improvement initiatives

How we will do this:

We will undertake a needs assessment in order to:

- Understand the impact of rurality, distance, ethnicity, deprivation and distribution of services on equity of access to services
- Understand population health needs
- Understand intervention rates and equity of access across the region
- Facilitate initiatives that enhance and sustain the delivery of child health services locally and regionally
- Explore ways to better utilise clinical resources across the region
- Explore ways to better integrate care between primary, secondary and tertiary services

Measures*:

- Increased immunisation rates
- Reduced rates of rheumatic fever
- Lower rates of SUDI
- Reduced 'did not attend' (DNA) rates
- Reduced ambulatory sensitive hospitalisation (ASH) rates – specifically gastroenteritis, asthma and community acquired pneumonia
- Improved regional performance against the WCTO Quality Indicators

* by ethnicity, locality and deprivation where possible

Line of Sight
National Objectives
<ul style="list-style-type: none"> Children's Action Plan Child Protection policies Reducing rheumatic fever Increased Immunisation Improving quality for child health services Maternal Smoking Cessation He Korowai Oranga New Zealand Parliament: Inquiry into improving child health outcomes and preventing child abuse with a focus from preconception until three years of age, November 2013 http://www.parliament.nz/en-nz/pb/sc/business-summary/00DBSCH_INQ_11221_1/inquiry-into-improving-child-health-outcomes-and-preventing Implementation of immunisation for gastroenteritis in primary health care from 1 July 2014
Regional objectives
<ul style="list-style-type: none"> Improve Māori health outcomes Integrate across continuum of care improve quality across all regional services Build the workforce Improve clinical information systems Best value for public health systems resources

Actions – 2014/15

Actions				Milestone/Date	Responsibility
1. A Regional Service Plan and Implementation Plan that is based on a population needs analysis for children is developed. <ul style="list-style-type: none"> Regional service plan developed Implementation plan developed to inform 2015/2016 planning process 				March 2015 June 2015	CHAG
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
2. Review of paediatric activity and/or admission rates – Demand Side Evaluation of paediatric activity and admission rates against expected trends (taking in to consideration demographics and population health need/expected intervention rates) Comparison of admission rates across the region and against benchmarks in NZ specifically: <ul style="list-style-type: none"> Admission numbers to paediatric units First specialist assessment (FSA) trends (outpatients) Follow up (FU) rates (outpatients) Emergency department presentations under three hours Top ten paediatric DRGs per PHO Top ten paediatric DRGS per DHB DNA rates by localities (including a review of actions and initiatives across the region that have been implemented to increase attendance) Analyse data/information against ideal state and develop priorities for action 				December 2014	HealthShare Analyst
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
3. Review of paediatric activity and/or admission rates – Demand Side Acute – 0-4 years, asthma and gastroenteritis diagnoses Initially this will ensure coding is appropriate* and consistent – once this is established data will be compared across the five Midland DHBs to understand where best practice is occurring e.g. lower admission rates, decreased LOS etc. From there the best practice model of care will be reviewed and DHBs will consider implementing this model of care for better outcomes for these patient groups *Significant work needs to be undertaken to ensure coding for asthma, viral induced wheeze and bronchiolitis is consistent across the region				June 2015	CHAG
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
4. Review of paediatric activity rates – Demand Side First specialist assessments and follow up in the outpatient setting for paediatric patients <ul style="list-style-type: none"> There are disparities between the five Midland DHBs in terms of numbers of FSA and FU in the outpatient setting for paediatric patients. The action group will work to understand this disparity, benchmark with other DHBs in NZ and then identify an ideal threshold/level for DHBs to achieve Then focus on elimination disorders and eczema and develop models of care that involve the best utilisation of the MDT and best clinical practice across the primary/secondary sectors 				December 2014	CHAG and HealthShare Analyst
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

5. Review of paediatric admission rates - Supply Side Understand the capacity of the paediatric services across the region <ul style="list-style-type: none"> Continue development of supply elements of paediatric services for consideration by action group. Analyse data/information against ideal state and develop priorities for action Stock take of regional surgical capacity and consideration of provision of surgical services within the Midland region 				July 2014 ongoing	CHAG
				July 2014 ongoing	CHAG
				June 2015	CHAG
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
6. Ongoing monitoring of child and youth initiatives across the region and nationally e.g. paediatric early warning systems, high flow oxygen, bodywise and energise. Leverage off existing investments in research. Reporting process in place to ensure the action group is apprised of all ongoing research activity				July 2014 ongoing	CHAG
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
7. Key outcome measures* are monitored by the Child Health Action Group Quarterly outcome measures are monitored: <ul style="list-style-type: none"> Increased immunisation rates Reduced rates of rheumatic fever Lower rates of SUDI Reduced 'did not attend' (DNA) rates Reduced ambulatory sensitive hospitalisation (ASH) rates – specifically gastroenteritis, asthma and community acquired pneumonia Regional performance against the WCTO Quality Indicators We will develop additional measures which may include the following: <ul style="list-style-type: none"> Baseline measures on eczema and elimination disorders will be developed Agreed appropriate outpatient first specialist assessment/Follow up rates Primary health care utilisation for child health Health Roundtable measures Consider outcomes of impacts and benefits of Whānau Ora Length of stay – asthma, gastroenteritis, bronchiolitis and community acquired pneumonia * by ethnicity, locality and deprivation where possible				July 2014 ongoing	HealthShare Analyst
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
8. Workforce - Plan for a sustainable generalist and specialist paediatric workforce <ul style="list-style-type: none"> Identify child health workforce across the primary, community and secondary sectors (head count and FTE) Identify current workforce shortages or vulnerable services If possible identify volume of patient contacts per FTE/occupational role 				June 2015	HealthShare Workforce Analyst HealthShare Analyst
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
9. E-learning modules Investigate broader utilisation of Paediatric e-learning modules from Lakes DHB for SHOs on to the Midland e-learning website <ul style="list-style-type: none"> Review e-learning modules to determine applicability across the Midland region 				June 2015	HealthShare project manager and MVLE coordinator
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
10. Information <ul style="list-style-type: none"> Continued utilisation of child health website - regularly updated Provide a clearinghouse function for information and potentially other resources for Child Health in the Midland region 				July 2014 ongoing	HealthShare project manager
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
11. National Child Health Information Programme (NCHIP) Standardised information systems for child health in primary, community and secondary care <ul style="list-style-type: none"> The action group will support the roll out of the NCHIP programme including the pilot in Thames 				July 2014 ongoing	CHAG
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

12. Map of Medicine The action group will support work to identify, establish and implement agreed pathways through Map of Medicine The following pathways will be developed for 2014/2015: <ul style="list-style-type: none"> • Asthma • Bronchiolitis • Gastroenteritis • Community acquired pneumonia • Eczema • Management of constipation • Skin sepsis • Cellulitis • UTIs • Mental Health Issues - ADHD 				July 2014 ongoing	CHAG
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources
13. Well Child/Tamariki Ora Quality Improvement Framework The child health action group will consider how it can support regional implementation of the WCTO Quality Improvement Framework and will monitor regional performance against the WCTO Quality Indicators to determine regional quality improvement priorities.				July 2014 ongoing	CHAG
1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources

Linkages to

Annual Plan:	
Lakes DHB	<ul style="list-style-type: none"> • Oral health-0-18 year olds and pregnant women • Smoking in pregnancy • Map of Medicine pathways Lakes priorities Sore throats(RH Fever) and Positive pregnancy test pathway (to encourage early registration with LMC) • Localised Mothercraft • Peri natal Mental health • Maternal and Child Health integration programme from Pregnancy test to 6 years of age • Reducing assaults on children-full implementation of FVIP, Shaken baby programme and National Child Alerts system.
BOPDHB	Nothing further to add – see WCTO QIF indicators below
Waikato DHB	<ul style="list-style-type: none"> • Price Volume Schedule 2014-2015 • Health targets <ul style="list-style-type: none"> ○ ED 6 hours ○ ESPI 2 and 5 • Business case for paediatric medicine January 2014 • Health Round Table data collection
WCTO QIF indicators per DHB	See separate document

Linkages to Other Work Programmes

Maternity Regional Services Planning Group Public Health Units

4.2.2 Midland Maternity Action Group (MMAG)

Chair: Corli Roodt (Clinical Midwife Director, Waikato)

Project Manager: Suzanne Andrew

Vision: To lead regional maternity activity on behalf of Midland DHBs that improves patient safety, quality of care, equity of access, and population health outcomes.

Key Objectives:

- Undertake an agreed regional work programme that supports the implementation of the National Maternity Quality and Safety Programme (MQSP)
- Improve consistency of practices and coordination of responsive maternity services through working collegially and cooperatively to develop regional standards, guidelines, etc. to enable the best use of resources
- Improve access to information sharing for LMCs, maternity service providers and consumers
- Maternity workforce development to reduce vulnerability and to increase sustainability.

Initiative 1	Support the reduction of the smoking rates of pregnant women, support the reduction of the SUDI rates for Midland, and support the improvement of breastfeeding rates: <ul style="list-style-type: none"> - Continue the implementation of the Midland safe sleep programme across Midland to reduce Māori SUDI rates, in alignment with national indicator (<0.5 per 1,000 live Māori births). - Enable training around best practice to support attainment of quit smoking support indicator for pregnant Māori women within Midland (95% of in-patient hapū woman offered quit support) - Pilot an initiative that incentivizes smoking quit support uptake amongst pregnant women in Waikato. Evaluation used to inform regional roll-out/ learnings. (95% of in-patient hapū woman offered quit support) - Complete Mama Aroha Breastfeeding training with key health practitioners inclusive of midwives, LMCs / Māori provider staff across Midland region (% of Māori infants fully and exclusively breastfed at 6 weeks (68%), 3 months (54%), 6 months (59%) improving trend evidenced) - Networking and sharing of resources throughout Midland re breastfeeding - Explore the development of IT applications and the use of the regional website to improve access to information for all parents, particularly Māori and vulnerable mothers. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuum of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q4 – 2014/15					
Measurable	<ul style="list-style-type: none"> • All providers of maternity services are trained in promoting safe sleeping messages, as part of the Midland Safe Infant Sleeping (Birth to 1 Year) Policy and the Midland Safe Sleep Programme • Progress towards a rate of <0.5 SUDI/1000 live Māori births. • All maternity providers have access to education around smokefree pregnancy • An increase in the educational resources that maternity providers are able to access i.e. online MoH ABC smoking cessation recommendations programme, and/or study sessions • Progress towards 90% of all pregnant women, particularly Māori women, who identify as smokers at the time of confirmation of pregnancy in general practice or booking with an LMC are offered advice and support to quit, e.g. MoH ABC smoking cessation recommendations programme • An improvement in accessible consistent breastfeeding information • Progress towards a 5% increase of infants fully and exclusively breastfed, particularly amongst Māori, for babies at 6 weeks 					
Inputs & Resources	MMAG / Midland Regional Smokefree Programme / Midland Regional Training Network (MRTN) / Midland GMs Māori Health					
Responsibilities	MMAG/ MQSP sub group / Breastfeeding/BFHI sub group / Midland GMs Māori Health					
Enablers	Midland Regional IS					

Initiative 2	Improve patient care, quality, and safety through establishing a robust maternity/neonatal transfer system – implement consistent system for maternity transfers and repatriations across Midland and beyond: <ul style="list-style-type: none"> - Midland Maternity Services: Transfer and Repatriation Standards - quality indicators and standards for maternity transfers developed and implemented to underpin transfers - Analysis and review of transfer system efficiency and repatriation numbers/ appropriateness. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuum of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q4 – 2014/15					
Measurable	<ul style="list-style-type: none"> • Improved consistency of practices and systems through development of regional wide standards, procedures and processes • Facilitating improved coordination and responsiveness of services to those requiring maternity services in Midland in a cooperative and coordinated manner • Working collegially and cooperatively to make best use of resources and/or to implement regionally consistent systems and processes 					
Inputs & Resources	MMAG / Midland Regional IS					
Responsibilities	MMAG					

Initiative 3	<p>Workforce:</p> <ul style="list-style-type: none"> - Intelligence – design a strategy for a sustainable maternity workforce across the region, including rural and remote rural areas with the skills and knowledge required to meet the needs of women within the Midland population. Ensure stronger engagement with workforce monitoring in conjunction with GMS HR to enable DHBs to understand maternity workforce issues, e.g. a pipeline supply, age, work, and preferences. - Utilisation – identify future maternity workforce requirements and develop plans to ensure ongoing, safe and appropriate maternity care provision. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuum of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Ongoing					
Measurable	<p>Workforce:</p> <ul style="list-style-type: none"> - Intelligence: <ul style="list-style-type: none"> • Robust data collected on numbers of health professionals working in maternity services across the Midland region to understand current workforce in primary care (both rural and urban), secondary, and tertiary settings. • Birthing populations and their outcomes mapped against requirements for maternity care. • Map the learning needs to each occupational group to identify gaps in knowledge, skill and number of health practitioners. - Utilisation – explore: <ul style="list-style-type: none"> • Options for innovative models of service delivery to allow practitioners to work throughout the breadth and depth of their scope, enable role substitution where possible (e.g. midwifery-led clinics), collaborative models including allied health practitioners. • Training and education models to facilitate the inclusion of General Practitioners into rural maternity services. 					
Inputs & Resources	MMAG / Midland Workforce Advisor/Midland Regional Training Network/Midland Workforce Development					
Responsibilities	MMAG / Midland Workforce Advisor/ Midland Regional Training Network/ Midland Workforce Development					
Enablers	MMAG / Midland Workforce Advisor/ Midland Regional Training Network/ Midland Workforce Development					
DHB Contribution	Midland GMS HR					

Initiative 4	<p>Improve access to pregnancy and parenting (P+P) classes, particularly for rural and Māori pregnant women, with the aim to increase the number of vulnerable pregnant women who enrol in P+P / antenatal classes, especially in rural and high deprivation areas:</p> <ul style="list-style-type: none"> - MMAG to support and advise the implementation of P+P service specifications at a local level - MMAG to collaborate with Midland planning and funding divisions to receive regular information/data on P&P utilisation and ethnicity 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuum of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	Q4 – 2014/15					
Measurable	<ul style="list-style-type: none"> • P+P classes well attended • Increased number of Kaupapa Māori P+P / antenatal classes available across the region • Improved Māori attendance. 					
Inputs & Resources	MMAG					
Responsibilities	MMAG/ MQSP sub group / Midland GMS Māori Health					
Enablers	PFALT					

Initiative 5	<p>Improve LMC registration so that access to care is increased – increase the number of women registering with an LMC in their first trimester:</p> <ul style="list-style-type: none"> - Each local MQSP governance board to consider how to improve LMC access and share initiatives/learning/strategies across the Midland region. 					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuum of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	ongoing					
Measurable	<ul style="list-style-type: none"> • Improved LMC registration across the Midland region • Improved access to LMC maternity care across all ethnic groups. 					
Inputs & Resources	MMAG					
Responsibilities	MMAG/ MQSP sub group					
Enablers	Midland Regional IS					
DHB Contribution	Midland DHB MQSP Governance Boards					

Initiative 6	<p>Strengthen consistency of practices through shared educational activities and shared resources – maximise collaboration between Midland regional maternity educators, lactation consultants, BFHI coordinators, safe sleep champions:</p> <ul style="list-style-type: none"> - Investigation into the use of Moodle as an electronic platform for e-learning modules to share education across the region - Regional education plan is developed, with activities and associated expenditure prioritised - Regional education calendar available on regional website for all maternity service providers, including LMCs and medical practitioners - Regional education arranged through MMAG, i.e., offer of a workshop/s in each Midland DHB with a particular focus on perinatal and infant loss and perinatal and maternal mental health. 				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuum of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Milestone	ongoing				
Measurable	<ul style="list-style-type: none"> • Consistent and supported maternity education delivered across region • Increase in focus on the multi-disciplinary team's knowledge around perinatal and infant loss and maternal mental health. 				
Inputs & Resources	MMAG / Midland Regional Training Network (MRTN) / Midland Regional IS				
Responsibilities	MMAG/ ME&ML sub group / Breastfeeding/BFHI sub group				
Enablers	Midland Regional IS				

Initiative 7	<p>Inclusion of consumers in the Maternity Quality & Safety Programme (MQSP) governance boards at each Midland DHB to enable consumer informed decision-making:</p> <ul style="list-style-type: none"> - Consumer voice (via survey, individuals, focus group, complaints and compliments) is collected and informs the future direction of service delivery for the Midland region - Local MQSP consumer representatives have a Midland virtual forum space to share ideas and connect with each other to strengthen consumer input into maternity services. 				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuum of care		3: Improve quality across all regional services
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources
Milestone	ongoing				
Measurable	<ul style="list-style-type: none"> • All Midland DHBs have a consumer representative on their local MQSP governance boards, and their maternity service improvement initiatives are underpinned and shaped by consumer input • Development of a virtual forum space for regional consumers commenced 				
Inputs & Resources	MMAG				
Responsibilities	MMAG/ MQSP sub group				
Enablers	Midland Regional IS				
DHB Contribution	Midland DHB MQSP Governance Boards				

4.2.3 Radiology Services

Chair: Jillian Wright – BOPDHB Clinical Lead: Andrew Klava – LDHB

Project Manager: Philippa Edwards

Why is a focus on radiology service important?

The Midland Region Radiology Network (MRRN) is aware the DHBs are expected to work together at a regional level to make the best use of available resources, strengthen clinical and financial sustainability and increase access to services. The regional services plan priorities have a specific focus on reducing service vulnerability, reducing costs and improving the quality of care to patients. The 2014/15 RSP priorities are noted as:

1. Elective Services
2. Cancer Services
3. Cardiac Services
4. Mental Health and Addictions
5. Stroke Services
6. Health of Older People
7. Major Trauma
8. Information Technology
9. Workforce

Regional Radiology had been highlighted as a vulnerable service previously, but given the change in ministerial focus for 14/15, the MRRN see the direction and make-up of the network changing to include an advisory function.

The MRRN is cognisant that Radiology is a support service that enables other networks to meet national priorities, as noted in the section above. By becoming an advisory/steering group, this will allow them to support the unification, integration and collaboration of the regional priority services.

The network also noted that all services provided by radiology departments maybe impacted by any change of clinical service practices which occur due to a drive to meet these new priorities.

For the purposes of the 2014/15 work programme, the group will be changing its name to the Midland Radiology Advisory Steering Group (**MRASG**)

Work will continue on monitoring and improving the MoH CT/MRI targets as well as invoking change within the regional radiology service through innovative and sustainable change initiatives. These have been highlighted in section 3.

MRAG Overarching Principles:

The MRASG is made up of clinical and management representation from all five regional DHBs. Representation may changes as required, dependent on work program and representative requirements.

All changes or impacts to current/planned/future service delivery models that may impact regional radiology services are discussed and approved within the MRASG forum. Any impacts are reviewed by the MRASG and action plans are then implemented if required. This philosophy ensures service delivery is tailored to the needs of the high risk population groups (such as: Māori), and that any changes in service delivery provision do not impact other regional radiology services without prior agreement from the impacted DHBs.

How will we progress our objectives:

- Determining and understanding our population needs
- Understanding access rates and striving for equity across the region
- Explore ways to better utilise clinical, staffing and capital resources across the region
- Identify regional strategic priorities for radiology services
- Supporting other clinical networks to achieve their outcomes
- Ensure all initiatives involving radiology services will be overseen and approved by the MRASG before implementation
- Strive to be a service provider that supports the Midland regions vision of “all residents of Midland region lead longer, healthier and more independent lives”.

How will we measure our success?

- By measuring against the national indicators, regional KPIs and primary referred indicators as noted below:

1: National Indicators	MoH National Radiology Indicators
Improving Waiting Times for Diagnostic Services for Community and Outpatient Referrals: CT	90% of accepted referrals for scans receive their scan within 6 weeks (42 days).
Improving Waiting Times for Diagnostic Services for Community and Outpatient Referrals: MRI	80% of accepted referrals for scans receive their scan within 6 weeks (42 days).
2: Regional KPI's	Midland Region Radiology KPI's
Diagnostic Services for Inpatient and Emergency Department Referrals: All modalities (CR, CT, MRI, Ultrasound, Fluoroscopy, interventional and Mammography imaging (excluding breast screening))	90% of accepted referrals to have their procedures completed within 24 hours
	98% of accepted referrals to have their procedures complete within 48 hours
Diagnostic Services for Community and Outpatient Referrals: All modalities (CR, CT, MRI, Ultrasound, Fluoroscopy, interventional and Mammography imaging (excluding breast screening)).	75% of reports should be dispatched within 48 hours of procedure performed.
3: Primary Referred Indicator	Primary Referred Indicators
Diagnostic Services for Primary Referred: For CR	70% of accepted referrals for scans receive their scan within 6 weeks (42 days).
Diagnostic Services for Primary Referred: Ultrasound	70% of accepted referrals for scans receive their scan within 6 weeks (42 days).
Diagnostic Services for Primary Referred: For CT	95% of accepted referrals for scans receive their scan within 6 weeks (42 days).

- Supporting National Priorities (not radiology specific) including:
 - ED length of stay
 - Elective Services
 - Cancer MDMs
 - Dementia
- Representation, attendance and participation in national and regional clinical groups to contribute to development of improvement programmes.

Key network linkages	
National Groups	<ul style="list-style-type: none"> National Radiology Advisory Group
	<ul style="list-style-type: none"> MOH National Radiology Service Improvement Initiative
	<ul style="list-style-type: none"> MRTAC – MRT Action Committee
DHB Annual Plans	<ul style="list-style-type: none"> Shorter stays in ED
	<ul style="list-style-type: none"> Improved access to Elective Surgery
	<ul style="list-style-type: none"> The Productive Operating Theatre
	<ul style="list-style-type: none"> Systems integration (Diagnostic Services module)
	<ul style="list-style-type: none"> Shorter waits for cancer treatment
	<ul style="list-style-type: none"> Health of Older Person (Workforce – diagnostic tool, use of CT scanning dementia)
	<ul style="list-style-type: none"> Improved access to Diagnostics (improving waiting times for diagnostic services, including CT and MRI)

Over the next three years, the MRASG plans to continue to develop the following areas across the Midland region:

Priority 1	Midland Radiology Advisory Group (MRAG) (a) Advisory Group to support Ministry priority groups and projects including (but not limited to): Elective Services, Cancer, Cardiac, Health of Older People, (b) Advisory Group to support development and functioning of the National Patient Flow system					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Milestone	(a) Regional Quarterly reporting (as part of regional NHB reporting) (b) DHBs Monthly reporting (as part of National reporting requirements)					
Action	Work with priority groups on sub-projects pertaining to, or requiring radiology service input or information. Participate in activity relating to development and implementation of the National Patient Flow (NPF) system, including adapting data collection and submission, as technically able, to allow reporting to the NPF as required					
Measurable	Recording of the nature and quantity of topics advised on					
Inputs & Resources	Radiology clinical staff from all five DHBs to work with Priority networks on matters pertaining or effecting regional radiology services.					
Enablers	Monitoring and adjusting of workforce to support targets					
DHB Contribution	All. Potential impact with radiology staffing models if change in service delivery required to meet national targets					
Priority 2	National Radiology Service Improvement Project Provide support to DHBs to undertake MOH Service Improvement contracts over 18 months to improve the effectiveness, efficiency and sustainability of radiology services in order that they achieve sustainable reductions in waiting times and achieve Government targets. <ul style="list-style-type: none"> Review of Demand Review of Capacity Production planning Service Improvement Service improvement projects will be at a regional and local level. Some modules will have regional components and some will be local with regional oversight. MOH expectation is that process improvement ideas and learnings are shared amongst regional DHB's. Monitor and improve on MoH CT/MRI Targets					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Action	Act as an advisory group for the MOH service improvement work contacted by each DHB					
Milestone	Six monthly (yet to be defined by MoH)					
Measurable	<ul style="list-style-type: none"> National CT/MRI Wait Time Indicators Regional KPIS on Reporting/Result Available Times post examination Primary referred Wait Time Indicators 					
Inputs & Resources	Expected that each participating DHB will receive a portion of allocated MOH funding for this project. Resource will be required for project management, analyst and potential clinical back fill.					
Enablers	MOH Funding, Information Technology, Local DHB Managers and HOD's					

DHB Contribution	Yet to be defined, outcome of demand and capacity reviews and expected production planning will need to align with DHB expectations.					
Priority 3	MRASG Regional Priorities The Midland Radiology Advisory Group (MRAG) has identified key initiatives to undertake, which align with the common regional objectives and national priority services.					
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care		3: Improve quality across all regional services	
	4: Build the workforce		5: Improve clinical information systems		6: Efficiently allocate public health system resources	
Actions	Produce and action phased plans for the following regional priorities: RP1: Scope and implementation of internal e-referral & e-orders across the continuum RP2: Implementation of Primary Access Criteria RP3: Investigate funding options/models for radiology services RP4: Annual Regional Benchmarking (data is used to determine staffing models, service delivery models and change improvement initiatives)					
Milestone	Quarterly reporting of progress against phased plans					
Measurable	PR1: Availability and uptake PR2: Reduction in inappropriate referrals (captured through Regional benchmarking) PR3: Agreed model PR4: Regional Benchmarking Outcomes					
Inputs & Resources	PR1: IT, Primary Referrers, Radiology departments PR2: IT, Primary Referrers, Radiology departments PR3: Planning and Funding, Corporate Services, Radiology departments PR4: DHB provision of data					
Enablers	All DHBs: Engagement from DHBs and Planning and Funding regarding potential funding models changes. Undefined at this stage					
DHB Contribution	All DHBs. May require redeployment of funding models if change initiatives are required – undefined at this stage.					

4.2.4 Midland Smokefree Programme

Introduction

The Midland DHB chairs CE's and the chair of the Iwi Relationship Board has made a significant commitment to reduce the impact and harm caused by tobacco and smoking by adopting the Midland Smokefree Tobacco Free 2025 vision. It is a strong regional leadership statement that empowers DHB employees and staff to proactively create opportunities for smokers to successfully quit and less attractive for our young people to start.

Smoking is the leading cause of preventable illness and long term conditions such as respiratory disease, heart disease and stroke. Cancer is the leading cause of death in the Midland region (28%). Lung cancer is the forth, foremost cause of cancer in the Midland region yet it is the leading cause of cancer for Māori. The mortality rates for lung cancer in Māori are almost four times higher than non-Māori¹³. More over Māori have higher mortality rates than non-Māori from cardiovascular disease, stroke, heart failure and rheumatic heart disease¹⁴. Smoking during pregnancy causes harm for the mother and child. It often results in low birth weights, preterm delivery, sudden infant death syndrome, pneumonia and asthma for the baby. As a result tobacco use and smoking is a significant cause and stark reminder of the unequal outcomes in health experienced by Māori of the Midland region.

12 year successful quit rates to achieve the Midland smokefree 2025 vision

The smoking prevalence in New Zealand adult population is 15%. The Midland population is 845,700. Approximately 566,619 (67%¹⁵) is estimated to be aged between 15-64 years. Hence approximately 85,000 Midland adults smoke. The 2025 target of <5% prevalence is 28,330. In total 56,670 Midland adult smokers must successfully quit. Or 4,722 successful quits over the next 12 years to December 2025.

Of the 845,700 Midland population 211,925 is estimated to be Māori. The Māori population aged between 15 and 64 is 128,426. The New Zealand Māori smoking prevalence is 36%. As a result it is estimated that 46,246¹⁶ Māori in Midland smoke. This represents more than half the regional smoking population of 85,000. The equity target of <5% to 2025 for Midland Māori is 6,421. Consequently a total of 39,825 Māori smokers must successfully quit over the next 12 years to December 2025 or 3,318 successful quit each year.

The Pacific population of the Midland region is 3% or 25,371. Using a similar age range for 15 to 64 year old (60.6%) as Māori it is estimated that the Midland Pacific adult population is 15,374. Pacific smoking prevalence has dropped from 30.3% in 2006 to 23.2% in 2013. So the number of Pacific adult smokers in Midland is 3566. The 2025, <5% target is 768 and the annual successful quit rate for the next 12 years is 233.

Midland DHB	Population	Adult 15-64	Prevalence	Smokers	Annual quits	<5% 2025
Midland	845,700	566,619	15%	85,000	4,722	28,330
Māori	211,925	128,426	36%	46,246	3,318	6,421
Pacific	25,371	15,374	23.2%	3,566	233	768

Minister's interim target – 18% Māori prevalence by 2018

In May 2013 the Associate Minister of Health announced an interim target to halve the current prevalence for Māori smokers to <18% by 2018.

Midland smokefree priorities

The Midland Smokefree Leadership Group has extracted a set regional priority from a schedule of 22 regional smokefree actions. The priorities areas focus on strengthening smokefree action with Māori.

1. Improve the referral process and pathway for hospitalised Māori smokers to cessation services
2. Establish a referral pathway to ensure that Māori pregnant women who smoke are identified early and supported to take up cessation advice and services
3. Support Kohanga Reo, early childcare centre and Kura to adopt the Tupeka Kore (tobacco free) philosophy as tikanga (best practice).
4. Confirm a comprehensive annual calendar of rangatahi (youth) events and dedicate smokefree / tobacco free promotions and awareness activity to support the event

Midland hospital discharge data

Midland hospital services discharged 35,040 Māori in 2012/13. Of those 12,844 were smokers. Aukati Kai Paipa (AKP) services in the Midland region¹⁷ received 807 referrals from Midland hospital services. The total AKP referrals for the period were 3669. The validated abstinence rate for Midland AKP providers after 3 months¹⁸ is 31%. Quitline reports a successful quit rate of 18%.

This anomaly highlights a clear opportunity to significantly increase the number of hospitalised Māori smoker referral to AKP. With a referral target of 80% of all discharged Māori smoker each year almost 10,000 referrals could be made. With a 3 month validated abstinence rate of 31% it is possible that 3,100 Māori could be smokefree each year. This is a substantial contribution to achieving the regional target of 4,722 quits per year.

¹³ Midland Cancer Network 2009 An assessment of cancer health needs in the Midland Cancer Network region 2009: Available:

<http://www.midlandcancernetwork.org.nz/file/fileid/18959>

¹⁴ Midland Health Network, 2012. Māori Health Profile 2012. Available: <https://www.Midlandhn.health.nz/uploads/maori-health-profile-2012-v3.pdf>

¹⁵ Statistics NZ: National Population estimates: Available:

http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalPopulationEstimates_HOTPA30Jun13.aspx

¹⁶ Statistics NZ. Māori Population estimates: Available: http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/maori-population-estimates.aspx

¹⁷ Midland AKP Report – Reports performance for 13 AKP providers in Waikato Lakes BOP and Taranaki. Tairawhiti data is not provided.

¹⁸ MoH, Midland Aukati Kai Paipa Performance Report 2012/13. *Not published*.

Clinical Objective	<i>Improve the referral process and pathway for hospitalized Māori smokers to cessation services</i>			
Initiative P1.1	<i>Implement a regional “Better help for hospitalized Māori smokers to quit” target</i> <ul style="list-style-type: none"> 90% of hospitalized Māori smokers are offered nicotine replacement therapies 80% of hospitalized Māori smokers are appropriately referred to a cessation service 			
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care	
	4: Build the workforce		5: Improve clinical information systems	
				3: Improve quality across all regional services
				6: Efficiently allocate public health system resources
Measurable	1. DHB leaders approve the adoption of the regional targets 2. Key stakeholders engaged 3. District stakeholders map the referral pathway and confirm quality expectations 4. Workforce needs identified and reported 5. Training for pathway stakeholders is developed and delivered 6. Monitoring and reporting			Milestone Q1 Q2 Q2 Q2 – ongoing Q3 – ongoing 6 monthly
Inputs & Resources	<ul style="list-style-type: none"> DHB smokefree coordinator manage engagements, ongoing staff training, monitoring and reporting Increased cessations capacity at AKP and community Group based cessation training (MoH) 			
Responsibilities	Accountable roles: Smokefree Coordinator and HealthShare Project Manager.			
Enablers	Regional Smokefree Leadership Group. Stakeholder buy-in. MoH support.			
DHB Contribution	<ul style="list-style-type: none"> DHB smokefree coordinator Health Share facilitation 			

Maternity

Helping women who smoke during pregnancy to quit has significant health benefits¹⁹; reducing the risk of foetal abnormality, placental insufficiency, miscarriage, preterm birth and infant mortality and provides a smokefree environment for the child to grow up in.

Approximately 12,776 babies were born in Midland in 2009/10. 2974 births were to maternal smoker. In Waikato 46% of Māori registered with an LMC in the first trimester with 43% registering late in their pregnancy²⁰.

Smoking prevalence among Māori women between the ages of 15 and 19 is 47%. In Māori women aged 20 to 24 the smoking prevalence is 60.8%. Furthermore almost half, (48%) of Māori women between the ages 15 - 64 smoke²¹. In a recent study to understand why Māori women smoke while pregnant²², it was found that 62% socialised with people who smoke. The study found that 48% of the women tried to quit during pregnancy due to the possible harm to the baby's health. The study determined that there is a need to improve understanding of the harm associated with maternal smoking.

Implementing a Maternity pathway for women and particularly Māori and Pacific women will ensure that advice is offered and support is given to quit.

DHB	# Smokers	Babies Non	2009/10	% Smokers
Waikato	1105	4564	5669	19.5%
Lakes	447	1227	1674	26.7%
BOP	816	2213	3029	26.9%
Tairāwhiti	268	518	786	34.1%
Taranaki	338	1280	1618	20.9%
Totals 09/10	2974	9802	12776	

Clinical Objective	<i>Establish a referral pathway to ensure that Māori pregnant women who smoke are identified early and supported to take up cessation advice and services</i>			
Initiative P1.2	<ul style="list-style-type: none"> Develop a smokefree referral pathway for young pregnant Māori mothers 			
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes		2: Integrate across continuums of care	
	4: Build the workforce		5: Improve clinical information systems	
				3: Improve quality across all regional services
				6: Efficiently allocate public health system resources
Measurable	1. Establish a District Smokefree Maternity Leadership Group 2. Engage with district maternity stakeholders 3. Map the referral pathway and confirm quality expectations 4. Identify education and training needs and secure training provider 5. Workforce needs identified and reported 6. Monitoring and reporting			Milestone Q2 Q2 Q3 Q3 Q3 Q4 – 6 monthly
Inputs & Resources	<ul style="list-style-type: none"> DHB smokefree coordinator to manage stakeholder engagements, provide ongoing pathway training, monitoring and reporting Facilitation of the stakeholder group and meeting resources 			
Responsibilities	Accountable role: District tobacco control portfolio and HealthShare Maternity Project Manager.			

¹⁹ Waikato District Health Board Maternity Annual Report 1 July 2012 – 30 June 2013:

²⁰ Waikato District Health Board Maternity Annual Report 1 July 2012 – 30 June 2013

²¹ Ministry of Health. 2011. Māori Smoking and Tobacco Use 2011. Wellington: Ministry of Health

²² Glover. M, Kira. A, 2011. Why ā women continue to smoke while pregnant. NZ Medical Journal: 2011 July 29; 124(1339): 22-31. Wellington

Enablers	Regional Smokefree Leadership Group. Good stakeholder buy-in (LMC). MoH support.
DHB Contribution	<ul style="list-style-type: none"> DHB smokefree coordinator Health Share facilitation

Engaging Kohanga Reo and Kura

Smoking prevalence among Māori women is extremely high at 47% for 15 to 19 years, 60.8% for 20 to 24 and 50.9% 25 – 44 year olds.²³ Kohanga Reo is considered an ideal environment to engage pregnant and young Māori mothers and to promote the denormalisation of Smoking around children. The Report to the Māori Affairs Committee, Inquiry into the Tobacco Industry in Aotearoa²⁴ recommended: *That the government consider a Kaupapa Tupeka Kore approach as a viable Māori framework for Tobacco Control intervention.* This intervention provides a framework to apply Tupeka Kore within Kohanga Reo. *Kore te Tupeka he tikanga no te ao Māori*, Tobacco is not a Māori tradition.

Clinical Objective	Support Kohanga Reo, early childcare centre and Kura to adopt the Tupeka Kore (tobacco free) philosophy as tikanga (best practice).				
Initiative P1.3	<ul style="list-style-type: none"> Initiate an engagement framework to competently engage with Kohanga Reo and Kura to promote to advance the Tupeka Kore tikanga 				
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services		
	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources		
Measurable	<ol style="list-style-type: none"> Facilitate the establishment of District stakeholder project group Complete a stocktake of Kohanga Reo and Kura in the district Engage and consult Kohanga Reo and Kura in the Tupeka Kore framework In collaboration with Kohanga Reo Kura and stakeholders confirm the Tupeka Kore policy Initiate the engagement schedule (xxxx number per year) Monitor progress and report 				Milestone Q2 Q3 Q3 Q4 Q4 – Ongoing Q4 – Ongoing
Inputs & Resources	<ul style="list-style-type: none"> DHB smokefree coordinator to manage stakeholder engagements, provide ongoing pathway training, monitoring and reporting Facilitation of the stakeholder group and meeting resources 				
Responsibilities	Accountable roles: District tobacco control portfolio manager.				
Enablers	Māori Caucus, Smokefree coalition groups, Māori Health, Māori Health providers. Good stakeholder buy-in. MoH support.				
DHB Contribution	<ul style="list-style-type: none"> DHB smokefree coordinator, Meeting rooms, printing and administration, stakeholder coordination, monitoring and reporting Health Share: facilitation, overview and regional reporting 				

Rangatahi

Eliminating smoking initiation is equally as important as getting smokers to quit. The ASH Year 10 Smoking Survey records Māori smoking rates of 10.8%. This figure is almost four times higher than NZ Europeans and about a third higher than Pacific. However youth smoking prevalence increases significantly to 47% of 15 to 19 year olds. Providing appropriate and targeted programmes of promotion and awareness of tobacco harm to this target audience is urgently required.

Clinical Objective	Confirm a comprehensive annual calendar of rangatahi (youth) events and dedicate smokefree / tobacco free promotions and awareness activity to support the event				
Initiative P1.4	<ul style="list-style-type: none"> Develop a calendar of District wide Rangatahi events Deliver a comprehensive Smokefree Tupeka Kore promotions and awareness campaign 				
Initiative aligns with Midland objectives:	1: Improve Māori health outcomes	2: Integrate across continuums of care	3: Improve quality across all regional services		
	4: Build the workforce	5: Improve clinical information systems	6: Efficiently allocate public health system resources		
Measurable	<ol style="list-style-type: none"> Establish a District Smokefree Rangatahi stakeholder group Confirm Terms of Reference Complete an annual calendar of District Rangatahi events Gather or develop event resources Implement promotions and awareness campaign 				Milestone Q2 Q2 Q3 Q3 Q3
Inputs & Resources	<ul style="list-style-type: none"> DHB smokefree coordinator to manage stakeholder engagements, provide ongoing pathway training, monitoring and reporting Facilitation of the stakeholder group and meeting resources 				
Responsibilities	Accountable role: District tobacco control portfolio manager.				
Enablers	HPA. Population Health teams, Māori Health teams. Good stakeholder buy-in.				
DHB Contribution	<ul style="list-style-type: none"> DHB smokefree coordinator, Population Health staff, Printing and promotions, Meeting rooms' facilitation and administration. Health Share facilitation, regional overview and national resource coordination 				

²³ Ministry of Health. 2011. Māori Smoking and Tobacco Use 2011. Wellington: Ministry of Health

²⁴ Hon. Tau Henare, 2010. Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, Report to the Māori Affairs committee. Wellington, House of Representatives

Appendix 5: Regional IS portfolio

NHITB critical priorities

Midland region implementation of the National Health IT Board (NHITB) critical priorities for 2014/15 is as follows:

Initiative	Description	National Measures	Midland Response
eMedicines Reconciliation (eMR) with eDischarge Summary	Implementation of electronic reconciliation of medicines on admission and discharge from hospital.	All DHBs have implemented eMR and the national clinical standard for eDischarges	Taranaki DHB implemented. Orion eMR functionality included within the regional Clinical Workstation solution. DHBs will consider implementation once they have deployed the regional solution (Waikato and Lakes intend to deploy regional CWS in 14-15). Immediate focus is on regional ePharmacy.
Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR)	Implementation of a regional Clinical Workstation (Orion, Concerto) and Clinical data repository (mixed products). <i>The CWS is a web based system, accessed via a single sign-on that connects multiple clinical applications and data sources to provide clinicians with secure access to patient data.</i> <i>A CDR is a database of patient identifiable clinical information such as medications, laboratory results, radiology reports, care plans, patient letters and discharge summaries.</i>	100% of the applicable population have a CDR record available through a regional view	Regional Sysmex CDR intended to be implemented in 14-15. Regional CWS will be implemented in the 13-14 financial year and deployed to Waikato and Lakes DHBs.
Replacement of legacy Patient Administration Systems (PAS)	The 8 DHBs with legacy PAS need to progress implementation of a supported system that is aligned with the regional plan. <i>The PAS supports and manages the administrative details of a patients encounter with a hospital or DHB service. It supports the management of the hospital resources used to provide patient care such as clinical staff, rooms, beds and equipment.</i>	All affected DHBs will be implementing a supported PAS	Not applicable to Midland Region.
National Patient Flow	National Patient Flow will create a new national collection that provides a view of wait times, health events and outcomes in a patient's journey through secondary and tertiary care.	All DHBs have implemented phase 2 of National Patient Flow	All Midland DHBs are planning for NPF implementation. Regional support will be applied where required by DHBs.
Finance Procurement and Supply Chain	The Finance procurement and Supply Chain programme will implement a single finance management information system, common catalogue for the ordering of goods and services, and centralised procurement and distribution processes for DHBs.	As per the HBL implementation plan	As per the HBL implementation plan.
Self-Care Portal	Portals are an on-line IT tool that will enable individuals to have access to their own health information. It will enable patients to communicate with their primary health practitioners and add information to their health record. <i>Each of the General Practice Patient Management System (PMS) vendors are developing portals, and Orion Health is developing a portal in conjunction with Canterbury DHB eSCRIV project.</i>	75% of PHOs provide an after-hours summary to ED 25% of the PHO eligible population have accessed a self-care portal	Regional IS will work with PHOs in the Midland region to support deployment of Self-Care Portal capability.

Regional IS Portfolio

The current Midland Regional IS Portfolio as at 11 June 2014 is as follows:

Midland Region IS Portfolio				
11-Jun-14				
Nationally/regionally aligned				
Row Labels	Capex 14/15 (CF from prev yrs)	Capex 2014/15 (new cash)	Total 2014-2015	Indicative 15/16
BOP DHB		1,788,070	1,788,070	625,000
Endoscopy database (regional)		300,000	300,000	
eOrdering		150,000	150,000	
ePrescribing (ePharmacy)		863,070	863,070	
MRISP Midland One - interoperability and ID Mgt		475,000	475,000	625,000
Lakes DHB	3,311,055	2,100,582	5,411,637	
1 July changes (14/15)		50,000	50,000	
CWS	2,985,994	1,622,582	4,608,576	
ePharmacy (12/13 budget yr)	186,455		186,455	
ePharmacy (13/14 budget yr)	138,606		138,606	
Integrated Quality and Risk Solution		100,000	100,000	
National Child Health		68,000	68,000	
Provation		250,000	250,000	
Taleo/HRMIS electronic interface		10,000	10,000	
Tairāwhiti DHB	430,000	500,000	930,000	
Clinical Workstation (Concerto)		500,000	500,000	
Hospital Medication Management (ePharmacy)	300,000		300,000	
Replacement of Maternity system	130,000		130,000	
Taranaki DHB				
ePA (electronic prescribing and admin)				
PACS				
Quality and Risk Management System				
Video Conferencing				
Waikato IS	1,275,000	803,000	2,078,000	650,000
Hospital Pharmacy	875,000		875,000	
Integrated Quality and Risk Solution		300,000	300,000	
MRISP Clinical Workstation	400,000		400,000	400,000
NCAMP, 3M, MKR (14/15)		150,000	150,000	250,000
Pharmacy system - hospital (UDM Licences)		53,000	53,000	
Regional Endoscopy Solution		300,000	300,000	
Grand Total	5,016,055	5,191,652	10,207,707	1,275,000

Local				
Row Labels	Capex 14/15 (CF from prev yrs)	Capex 2014/15 (new cash)	Total 2014-2015	Indicative 15/16
BOP DHB			-	230,000
Automated voice dictation			-	80,000
Clinical Audit- Replacement for Plato			-	150,000
Lakes DHB		607,511	607,511	
Clinical Physiology PAC's system (Cardiac)		120,000	120,000	
Corporate Document System replacement		100,000	100,000	
Data Centre Power reticulation		80,000	80,000	
Imprivata			-	
Laptops, data show, Winterm/VDU/keyboard		21,011	21,011	
Merge field enhancement iPM		16,500	16,500	
NASC Database replacement		75,000	75,000	
Radiology Modality Isolation		70,000	70,000	
Titanium (Xray component)		115,000	115,000	
Virtual Platform Monitoring Server		10,000	10,000	
Taranaki DHB			-	
Knowledge Management			-	
PACS integration			-	
VOIP rollout			-	
Waikato IS	486,000	2,906,000	3,392,000	2,445,000
Clinical Whiteboard - Rollout for Health Waikato	256,000		256,000	
Contingency (IS)		300,000	300,000	300,000
Controlled Document Centre (intranet)		250,000	250,000	
Controlled Document Centre (CDC)	150,000		150,000	
Costpro	80,000		80,000	
Data Warehouse		400,000	400,000	
IS Toolsets		716,000	716,000	750,000
LIS Print solution		80,000	80,000	
LIS reporting development		200,000	200,000	
Payroll improvement programme		500,000	500,000	
Perimeter redesign (external)		400,000	400,000	295,000
Rapid logon			-	1,100,000
SMX Secure e-mail		60,000	60,000	
Waikato other (not part of IS budget)		200,000	200,000	
Chronic conditions database and assoc work practises			-	
Cardiac Dendrite Phase 3		200,000	200,000	
Echocardiology			-	
Nursing Accuity Model			-	
Oncology Application virtualisation and integration			-	
Vehicle Fleet booking system			-	
Grand Total	486,000	3,713,511	4,199,511	2,675,000

Service Lifecycle Management				
Row Labels	Sum of Indicative budget: Capex 2014/15 (CF from prev yrs)	Sum of Indicative budget: Capex 2014/15 (new cash)	Sum of Indicative budget: Capex 2014-2015	Sum of Indicative budget: Capex 2015-2016
BOP DHB		1,825,000	1,825,000	2,325,000
Infrastructure existing and new capacity pool		1,825,000	1,825,000	2,325,000
Lakes DHB	50,000	1,610,530	1,660,530	
3M Encoder upgrade (14/15)		20,000	20,000	
Additional Citrix licences		26,900	26,900	
Asset Management Desktop (14/15)		494,000	494,000	
Asset Management Network Q3 (14/15)		65,000	65,000	
Asset Management Server (14/15)		92,000	92,000	
Asset Management: Corporate SAN replacement		400,000	400,000	
Asset Management: UPS Batteries, NASC server		39,000	39,000	
Colposcopy Annual upgrade		17,500	17,500	
DIA Compliance (Server 2008 R2)		50,000	50,000	
FMIS upgrade for DIA compliance		246,130	246,130	
IPM Upgrade (13/14 and 14/15)	50,000	80,000	130,000	
MKM Application upgrade		30,000	30,000	
Winscribe (upgrade to VOIP and test sys)		50,000	50,000	
Tairāwhiti DHB		552,600	552,600	
Network lifecycle		10,800	10,800	
PABX Maintenance (reserve)		200,000	200,000	
Platform replacement (server hardware)		68,000	68,000	
Printers/peripherals/other Lifecycle		24,800	24,800	
Structuring cabling and infrastructure Maintenance		15,000	15,000	
Workstation lifecycle		234,000	234,000	
Taranaki DHB		1,000,000	1,000,000	1,000,000
Lifecycle management		1,000,000	1,000,000	1,000,000
Waikato IS	580,000	2,847,000	3,427,000	1,690,000
Application lifecycle (14/15)	90,000	450,000	540,000	
Capacity Augment	12,000	100,000	112,000	300,000
Comms Room remediation		300,000	300,000	300,000
Decommission Galen		300,000	300,000	150,000
Infrastructure lifecycle (14/15)	200,000	500,000	700,000	
IS security backend	278,000		278,000	
MS Licensing True up		150,000	150,000	300,000
Network remediation		200,000	200,000	200,000
Other licencing true up		150,000	150,000	300,000
Router - Compass Dicom		50,000	50,000	
Unified comms - Phase 4		147,000	147,000	140,000
Windows Server Migration 2003-2008		500,000	500,000	
Grand Total	630,000	7,835,130	8,465,130	5,015,000

Appendix 6: 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 an 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 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 Services 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 (i.e. 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	<p>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.</p> <p>(http://www.ssc.govt.nz/glossary/)</p>
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 resources.