



## Regional Services Plan Initiatives and Activities



# Contents

1.	Regional initiatives and activities to achieve our regional objectives.....	4
	Objective 1: Improve Māori health outcomes .....	4
	Objective 2: Integrate across continuums of care .....	8
	Objective 3: Improve quality across all regional services .....	11
	Objective 4: Build the workforce.....	15
	Objective 5: Improve clinical information systems.....	18
	Objective 6: Efficiently allocate public health system resources .....	20
2.	Activity of regional networks, clinical action groups and projects .....	25
	Midland Regional Networks .....	29
2.1	Cancer services (Midland Cancer Network) .....	29
2.2	Cardiac services (Midland Cardiac Clinical Network) .....	36
2.3	Elective services (Regional Elective Services Network) .....	40
2.4	Mental Health & Addictions (Regional Mental Health & Addictions Network) .....	42
	Regional Clinical Action Groups.....	45
2.5	Child Health (Child Health Action Group).....	45
2.6	Health of Older People (Health of Older People Action Group) .....	49
2.7	Maternity Services (Midland Maternity Action Group) .....	51
2.8	Radiology Services (Midland Radiology Action Group).....	54
2.9	Midland Trauma System (MTS) .....	56
2.10	Midland Stroke Group .....	58
	Appendix 1: Work programmes of objective 1 (Māori health), objective 4 (workforce), and objective 5 (information systems).....	61
	Appendix 2: Regional governance.....	79
	Appendix 3: Health services – now and in the future.....	85
	Appendix 4: Future trends on Midland region populations and health services.....	92
	Appendix 5: Glossary of terms .....	<a href="#">94</a>

# List of figures and tables

## LIST OF FIGURES

Figure 1: Population health continuum of care .....	8
Figure 2: Regional and DHB workforce roles and inter-relationship .....	15
Figure 3: Outcomes framework .....	23
Figure 4: Top initiative for delivery by July 2017 for each regional clinical group .....	26
Figure 5: Alignment with the NZ Health Strategy and Roadmap of actions 2016 .....	27
Figure 6: Major causes of death, ranked by age-standardised mortality rates, by gender, Māori and non-Māori.....	37
Figure 7: Mortality rates from ischaemic heart disease, by DHB region, total population, 2012 .....	37

## LIST OF TABLES

Table 1: Current tertiary flows from Midland DHBs.....	85
Table 2: Expected future summary surgical services levels.....	86
Table 3: Expected future medical services levels.....	88
Table 4: Cancer related services in Midland DHBs.....	88
Table 5: Future trends affecting Midland region populations .....	92
Table 6: Future trends affecting healthcare provision .....	93

**Note:** This Regional Services Plan should be read in conjunction with the companion document, '*The 2016-19 Regional Services Plan – Strategic Direction*', and the Annual Plans, Māori Health Plans and Regional Public Health Units Plans of the Midland District Health Boards.

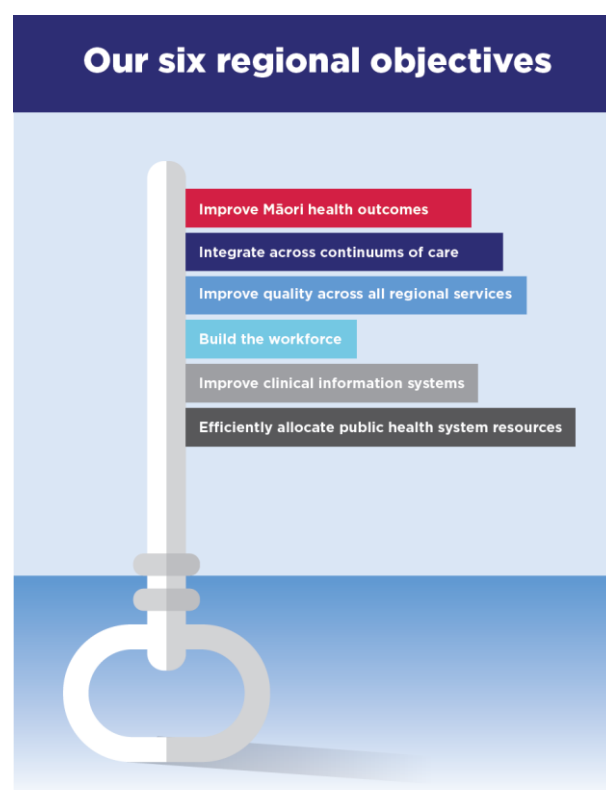
# 1. Regional initiatives and activities to achieve our regional objectives

This document is a companion to the document *2016-19 Regional Services Plan – Strategic Direction*, which sets out at a high level the vision, strategy themes, priorities and objectives of the Midland District Health Boards (DHBs).

*2016-19 Regional Services Plan – Initiatives and Activities* provides detail about how DHB management groups, regional networks and clinical action groups (clinical and management representatives arranged in activity groups) are working to achieve our shared strategic direction.

As an overview, the structure of this document begins in Section 1 by clarifying what each regional objective means and our approach to achieving this. This is accompanied by more detail in Appendix 1.

Section 2 then describes the activities of the regional networks and clinical action groups. Appendices 2 – 6 provide information about regional governance, the membership of the regional networks and clinical action groups, the region's health services now as well as future trends shaping health. Finally, a glossary provides definitions of terms that are used in the document.



## Objective 1: Improve Māori health outcomes

Nga Toka Hauora, the Midland DHB GMs Māori Health, will work with regional networks and clinical action groups (supported by HealthShare) and various partnerships to progress regional work in the 2016-2019 period that supports progressing Māori health equity and the attainment of 'Pae Ora' a healthy future for our whanau. Māori health is a priority for the Midland DHBs based upon six key drivers:

1. Te Tiriti o Waitangi the founding document of our nation (New Zealand Public Health & Disability Act 2000)
2. He Korowai Oranga the National Māori Health Strategy 2014
3. The size and composition of the Māori population (over 200,000+)
4. A disproportionately high health need for Māori within Midland relative to non-Māori
5. A commitment across all five Midland DHBs to work towards Māori health equity
6. A commitment to build Iwi capacity to respond to their own health needs

The Midland DHBs are committed to working towards Māori health equity and ensuring that they provide care that does not vary in quality because of a person's characteristics such as gender, race, ethnicity, geographical location or socio-economic status.

Nga Toka Hauora seeks to ensure that the regional work programme activity aligns to improving performance against national Māori health indicators which have been established by the Ministry of Health (see following page), and are entrenched in all DHB Māori Health Plans (refer Appendix 1).

In alignment with this intent, key areas of focus for Māori health for the 2016-2019 period can be grouped into five key areas:

1. Secretarial support to the Midland Iwi Relationship Board
2. Development of regional Māori health tools
3. Working to reduce the incidence and impact of cancer
4. Working to improve the health of our pepi/tamariki
5. Māori health workforce development

**“Our vision is to work in co-operation with others to achieve ‘Pae Ora’ a healthy future for our whanau - we want our whanau to be physically, socially, culturally, spiritually and financially strong”**

**Midland Iwi Relationship Board  
2016**

Based on these five groupings specific initiatives for the coming period that will be led by Nga Toka Hauora include:

- The Māori Health Equity Framework
- Trendly Monitoring and Reporting Tool enhancement
- Māori Health Excellence Webinars
- He Ritenga Cultural Audit Tool enhancement
- Harti Hauora Child Health Innovation Programme
- Kia Ora Hauora Māori Workforce Development

Nga Toka Hauora will also provide an oversight and advisory role to ensure that initiatives developed by regional networks and clinical 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 finite resources.

Regional workstream groups whose activities impact on Māori health but fall outside the following action table will have an opportunity to meet with Nga Toka Hauora periodically on an 'as needed' basis for advice and guidance. A list of these specific activities is provided in Appendix 1.

## Summary of National Māori Health Indicators

National Priorities	Māori Health Indicators		Why this issue is important
Data Quality	1. Ethnicity data accuracy		Collecting accurate ethnicity data in accordance with the national Ethnicity Data Collection Protocols will improve the quality of ethnicity health data enabling us to effectively measure working towards health equity for Māori.
Access to care	2. 100 % of Māori enrolled in PHOs		PHO enrolment is the first step in ensuring all population groups have equitable access to primary health care services and is therefore a critical enabler for first point of contact health care. Differential access to and utilisation of healthcare services plays an important role in health inequities, and for this reason it is important to focus on enrolment rates for Māori.
	3. Ambulatory sensitive hospitalisation (ASH)	0-4 yrs 45-64 yrs	ASH is a proxy measure for avoidable hospitalisations, and unmet healthcare need in a community based setting. There are significant differences in ASH rates for different population groups and a key focus on activities to reduce ASH must address the current inequities.
Child health <sup>1</sup>	4. Exclusive or fully breastfed at LMC discharge 5. Exclusive or fully breastfed at 3 months 6. Receiving breast milk at 6 months	6 weeks 75% 3 months 60% 6 months 65%	Breastfeeding provides infants with nutritional needs and builds infant immunity against a range of infectious diseases within the first 6 months of life.
Diabetes/ Cardiovascular Disease	7. 90% of 'eligible Māori men in the PHO aged 35-44 years' who have had a CVD risk recorded within the past five years		The burden of cardiovascular disease (heart and stroke) is greatest among the Māori population, and mortality is more than twice as high compared to non-Māori. CVD risk assessments are an important tool to enable early identification and management of people at risk of heart disease and diabetes. Fast access to treatment for heart related attacks is essential to achieve health equity and improve health outcomes for Māori.
Cancer	8. Breast screening rate 70% of eligible woman		Historically, Māori women have significantly higher incidence and mortality from breast cancer compared to non-Māori. Inequities in access to screening services need to be addressed to ensure Māori women experience the benefits of early detection of breast cancer.
	9. Cervical screening rate 80% of eligible woman		In 2012, Māori women were twice as likely as non-Māori to develop cervical cancer, and 2.3 more likely to die from it. Regular cervical screening detects early cell changes that would, over time, lead to cancer if not treated. Nationally, cervical screening coverage for Māori is 62.2%, compared to coverage in European/Other populations with coverage at 82.2%. Improving screening coverage in Māori women is therefore an important activity to improve this equity gap.

<sup>1</sup> Ministry of Health. 2016. Indicators for the Well Child / Tamariki Ora Quality Improvement Framework: September 2015. Wellington: Ministry of Health



National Priorities	Māori Health Indicators	Why this issue is important
Smoking	10. 95% of pregnant Māori women who are smoke free at two weeks postnatal	Hapu Māori wahine have very high smoking prevalence (three times higher than the national prevalence). Smoking during pregnancy increases the risk for pregnancy complications and tobacco smoke harms babies before and after they are born.
Immunisation	11. 95% of infants fully immunised by 8 months of age	Immunization is the most effective way to actively protect your child from preventable diseases, ranging from whooping cough to meningitis and measles (Immunisation Advisory Centre, 2013). Although immunization rates are high there is still a large health equity gap between Māori and non-Māori. Initiatives need to target Māori pēpi in order to achieve health equity.
	12. 75% of the eligible population (>65 years) are immunised against influenza annually	In 2014 Māori had the second highest rate of influenza confirmed hospitalisation, 49.2 per 100,000. The 65 years and over age group also have the highest rates of influenza admissions to ICU. A 75 percent influenza vaccination rate is required to provide the best protection for this age group and in particular for Māori. If we are able to increase immunisation rates for Māori, we will see a significant reduction in overall influenza cases.
Rheumatic Fever	13. 55% reduction in the number and rate of hospitalisations for acute rheumatic fever rate 1.2 per 100,000	Rheumatic fever is a serious but preventable illness that mainly affects Māori and Pacific children and young people aged 4 to 19 years. Reducing rheumatic fever will contribute to achieving equity of health for Māori.
Sudden Unexplained Death in Infancy	14. National SUDI target - 0.4 SUDI deaths per 1,000 live births	The target for SUDI will be lowered from 0.5 to 0.4 SUDI per 1,000 live births. The target has been lowered to match the reduced rate of SUDI among non-Māori infants (0.38 SUDI per 1,000 live births during 2010-2014). Yet there is still a significant difference in SUDI rates between Māori and non-Māori families living in Waikato DHB.
	15. All caregivers of Māori infants are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1 (minimum of 70% of all caregivers)	
Mental Health	16. Mental Health Act: section 29 community treatment order comparing Māori rates with other (per 100,000)	New Zealand has very high rates of compulsion under the Mental Health Act, compared with similar jurisdictions. Māori are nearly three times as likely as non-Māori to be treated under a community treatment order which represents a significant disparity.
Oral Health	17. 95% of Māori preschool tamariki are enrolled in the community oral health service	The inequity between Māori and non-Māori enrolments is significant therefore the need for more Māori targeted initiatives and programs is crucial.

## Objective 2: Integrate across continuums of care

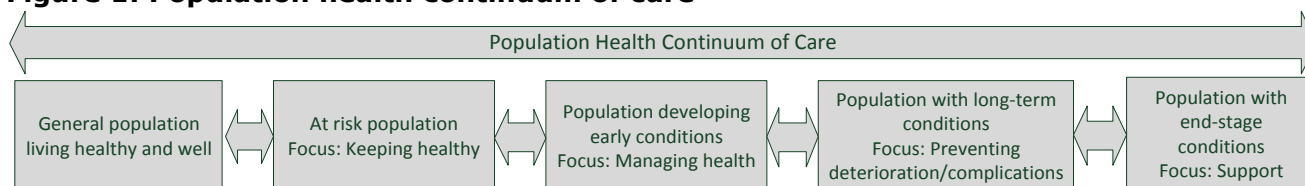
Midland region is committed to developing integrated services across continuums of care. This provides improved quality, safety and the patient's experience of care. It also leads to more timely treatment and care, which in turn can result in better patient outcomes. Improved system integration can also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

Figure 1 (below) describes a population health continuum of care. It describes (reading from left to right) various stages in decline in health and wellbeing, from being healthy and well to having end-stage (end-of-life) conditions. Keeping healthy and people proactively managing their health to prevent deterioration and a complication, is really vital. And 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.

The vision statement of the updated New Zealand Health Strategy puts it well that

**'All New Zealanders live well, stay well, and get well'**

**Figure 1: Population health continuum of care**



There is no single accepted definition of integrated healthcare<sup>2</sup>. However, most definitions include references to seamlessness, co-ordination, patient centeredness, and whole of system working together.

Health and disability services are delivered by a complex network of organisations and people. Integrated healthcare is seen as essential to transforming the way that care is provided for people with long term chronic health conditions and to enable people with complex medical and social needs to live healthy, fulfilling, independent lives<sup>3</sup>. People living with multiple health and social care needs often experience highly fragmented services which are complex to navigate, leading to less than optimal experiences of care and outcomes.

Our response to the challenge requires a strong re-orientation away from the current emphasis on episodic and acute care towards prevention, self-care, better co-ordination, and care that addresses social determinants of health.

<sup>2</sup> The King's Fund: Lessons from experience - Making integrated care happen and scale and pace

<sup>3</sup> A report to the Department of Health and the NHS Future Forum: Integrated care for patients and populations: Improving outcomes by working together <http://www.kingsfund.org.uk/publications/integrated-care-patients-and-populations-improving-outcomes-working-together>



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. A regional example of integration is hepatitis C.

### **Development of an integrated hepatitis C service across the Midland region**

The Midland DHBs are tasked with implementing a single clinical pathway for hepatitis C care across the region in order to provide consistent services, which maximise the wellbeing of all New Zealanders living with hepatitis C. A second objective is to implement integrated hepatitis C assessment and treatment services across community, primary and secondary care services in the region.

Actions in 2016-17 to support the implementation of integrated hepatitis C assessment and treatment services include:

- raising community and GP awareness and education of the hepatitis C virus (HCV) and the risk factors for infection
- providing targeted testing of individuals at risk for HCV exposure
- raising patient and GP awareness of long term consequences of HCV and the benefits of treatment, including lifestyle management and antiviral therapy
- providing community based ongoing education and support (including referral to needle exchange services, community alcohol and drug services, GP primary care services or social service agencies)
- providing long term monitoring (life-long in people with cirrhosis and until cured in people without cirrhosis)
- providing good information sharing with relevant health professionals
- working collaboratively with primary and secondary care to improve access to treatment.

NB: actions relating to Fibroscanning have yet to be agreed as part of the Midland region's hepatitis C transition plan.

### **Measures**

- Quarterly narrative report on progress of the key actions.
- Report six monthly broken down by quarters on the following measures:

Measures	Data and Source
<ul style="list-style-type: none"> <li>• Number of people diagnosed with hepatitis C per annum (by age)</li> </ul>	Total number of people with a positive HCV PCR test in the DHB region (data from five reference labs provided to regional DHBs)
<ul style="list-style-type: none"> <li>• Number of HCV patients who have had a Fibroscan in the last year               <ul style="list-style-type: none"> <li>(a) new patients</li> <li>(b) follow up</li> <li>(by age and ethnicity)</li> </ul> </li> </ul>	Total number of hepatitis C Fibroscans performed annually (data from the delivery of Fibroscans in primary and secondary care)
<ul style="list-style-type: none"> <li>• Number of people receiving PHARMAC funded antiviral treatment per annum (by age and ethnicity)</li> </ul>	Total number of people prescribed antiviral treatment who have hepatitis C (data from PHARMAC provided to regional DHBs)

In addition to the development of an integrated hepatitis C service across the Midland region, a high level summary of actions to integrate across continuums of care is provided in Section 2.

Line of Sight		
<ul style="list-style-type: none"> <li>DHB Annual Plans: Waikato DHB - section 2.2 Delivering on Priorities and Targets; Lakes DHB – section 2B; Bay of Plenty DHB (TBC)</li> </ul>		
Initiative	Milestone/Date	Responsibility
1. Support Midland DHBs in the development and implementation of an integrated hepatitis C service across the Midland DHBs		
1.1 Implement the clinical pathway	Q1 2016-17	HSL PM
1.2 Assess impact and plan for new pharmaceuticals	Q1 2016-17	HSL PM
1.3 Select service provider via EOI and RFP process	Q1 2016-17	Evaluation panel
1.4 Seek approval to proceed	Q1 2016-17	HSL PM
1.5 Support implementation of service across Midland DHBs including eReferrals	Q2-Q4 2016-17	HSL PM
1.6 Support implementation of reporting and measuring requirements	Q2-Q4 2016-17	HSL PM

## Objective 3: Improve quality across all regional services

Quality in health is a fundamental expectation. Within healthcare there is no universally accepted definition of 'quality'. However the US Institute of Medicine (IoM) definition states that quality is *the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.* <sup>[1]</sup>

The IoM has identified six dimensions through which quality is expressed. They are:

- Safety - avoiding harm to service users from care that is intended to help them
- Effectiveness - providing services based on scientific knowledge and which produces clear benefit
- Patient centeredness – providing care that is respectful or responsive to individual needs, values and cultures
- Timeliness – reduced waits and sometimes harmful delays
- Efficiency – maximising resource and avoiding waste
- Equity – providing care that does not vary in quality because of a person's characteristics such as gender, race, ethnicity, geographical location, socio-economic status.

This definition supports the World Health Organisation view of quality and also underpins the New Zealand Triple Aim which the Midland DHBs have adopted.

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.

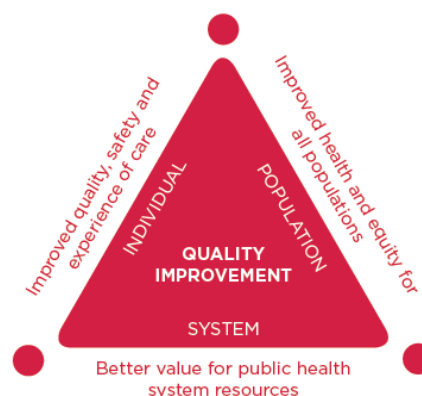
Midland DHBs are committed to work with the Health Quality and Safety Commission (HQSC) in the ongoing development of a quality framework for the New Zealand health system, including further development of DHB Quality Accounts and Quality Safety Markers.

The Midland DHBs have an established Quality and Risk Managers Forum to promote a regional approach to appropriate improvement projects, to work with the Commission to design and implement topic specific approaches and to provide leadership for quality across the region.

The region's Quality and Risk Managers are active participants in the national quality and risk managers group, as well as sitting on a number of the advisory groups attached to the HQSC

### The NZ Triple Aim

The New Zealand Triple Aim underpins the region's activities. The Triple Aim means:



programmes (eg infection control). The Commission also sit on the regional quality group to enable the links to be made.

The region has been particularly active over the past 18 months defining and implementing an electronic quality and risk management system (DATIX), with the last DHB going live with the system at the end of February 2016. This system will enable better monitoring and trending of incidents, complaints and risk. It will support the identification of areas where regional quality improvement efforts are required.



Going forward the focus will be on developing a regional plan for quality that includes local priorities, increased consumer engagement, national imperatives and inclusion of other providers where relevant. In addition there is an opportunity to maximise collective power such as a regional approach to certification requirements to minimise costs wherever possible, better sharing of best practice and the rollout of initiatives across the region.

The region has an increasing number of Improvement Advisors (IA), some of whom were supported by the Health Quality and Safety Commission (HQSC) to undertake in depth training on improvement science, and who now link with the regional steering group.

The aim is to ensure that service users receive safe, high quality care and that as a region we stay focused on quality. In order to achieve the improvements, the key priorities for the next 12 months are:

- Continue to support the national patient safety campaign, developing and supporting clinical leaders and improving the capability of front line staff in the ongoing development of quality and patients safety
- Work with the national and local mortality review committees to align processes and ensure learning, particularly those emerging around peri-operative mortality
- Develop a regional comparison report utilising the Quality and Safety Markers and the national patient experience survey and share learning from those DHBs in the upper quartile against these measures
- Continue to develop a regional approach to core systems such as certification, infection control to enable shared learning and advancement of best practice
- Better integrate quality across the clinical networks, offering advice and support on particularly consumer engagement activity and quality improvement methodology through the Improvement Advisors

In addition to those initiatives under the leadership of the Midland DHBs Quality and Risk Managers Forum, Section 2 describes regional initiatives being progressed in 2016/17 by the regional networks and clinical action groups.

Objective	Actions to deliver improved performance	Measure	Reporting
To reduce the number of falls	<ul style="list-style-type: none"> <li>Complete an update on falls reduction activity across the Midland DHBs</li> </ul>	<ul style="list-style-type: none"> <li>Falls: 90 percent of older patients are given a falls risk assessment</li> </ul>	Q2 and Q4
	<ul style="list-style-type: none"> <li>Update falls pathway on Map of Medicine</li> <li>Increase consumer engagement in the falls reduction programme</li> </ul>	<ul style="list-style-type: none"> <li>Falls: 98 percent of older patients assessed as at risk of falling receive an individualised care plan addressing the risks identified</li> </ul>	Q4
To improve hand hygiene	<ul style="list-style-type: none"> <li>Increase publicity and awareness campaign across all DHBs</li> </ul>	<ul style="list-style-type: none"> <li>Hand hygiene: 80 percent compliance with good hand hygiene practice</li> <li>Midland region: 82% compliance</li> </ul>	Q1-Q4
Safe surgery	<ul style="list-style-type: none"> <li>Continue current phase 1 project and ensure that data is being collected prior to the 'go live' of the new QSM in July</li> </ul>	<ul style="list-style-type: none"> <li>Safe surgery: a new marker measuring the use of the checklist as a teamwork and communication tool will be in use from 1 July 2016. This marker will be finalised by February 2016.</li> </ul>	Q2-Q4
Surgical site infection	<ul style="list-style-type: none"> <li>Present quarterly SSI report to Midland quality meetings</li> <li>Action to be taken where results are below target</li> </ul>	<ul style="list-style-type: none"> <li>SSI: 95 percent of hip and knee replacement patients receive cefazolin <math>\geq 2g</math> or cefuroxime <math>\geq 1.5g</math> as surgical prophylaxis</li> </ul>	Q1-Q4
	<ul style="list-style-type: none"> <li>Develop business case for ICNet and discuss / agree if a regional approach is appropriate</li> </ul>	<ul style="list-style-type: none"> <li>SSI: 100 percent of hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision</li> </ul>	Q2 and Q4
Medication safety	<ul style="list-style-type: none"> <li>Continue discussions on feasibility of achievement of medicines reconciliation by proposed HQSC date of 2016/17</li> <li>Define and implement a Medicine safety programme               <ul style="list-style-type: none"> <li>implement the opioid bundle from the opioid collaborative work</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Medication Safety: implementation of the electronic medicine reconciliation platform</li> </ul>	Q2 and Q4
To promote consumer engagement	<ul style="list-style-type: none"> <li>Develop / refine the consumer engagement framework for the region</li> </ul>	<ul style="list-style-type: none"> <li>Performance updates published by HQSC and included in DHB local quality accounts</li> <li>Quarterly Reporting on patient experience as set out in performance measure DV3 'Improving patient experience'</li> </ul>	Q2 and Q4

Objective	Actions to deliver improved performance	Measure	Reporting
Build quality improvement capability and clinical leadership	<ul style="list-style-type: none"> <li>• Active involvement in the national patient safety week (November)</li> <li>• Support the further development of quality improvement advisors with assistance from HQSC</li> </ul>	<ul style="list-style-type: none"> <li>• Each DHB to have at least 1 quality improvement advisor</li> </ul>	Q2 and Q4
Share best practice	<ul style="list-style-type: none"> <li>• Review the certification process across the region and develop a shared process with regard to patient tracer methodology and improvement from common corrective actions</li> </ul>	<ul style="list-style-type: none"> <li>• Improved adherence to HDS standards</li> </ul>	Q2 and Q4

## 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.

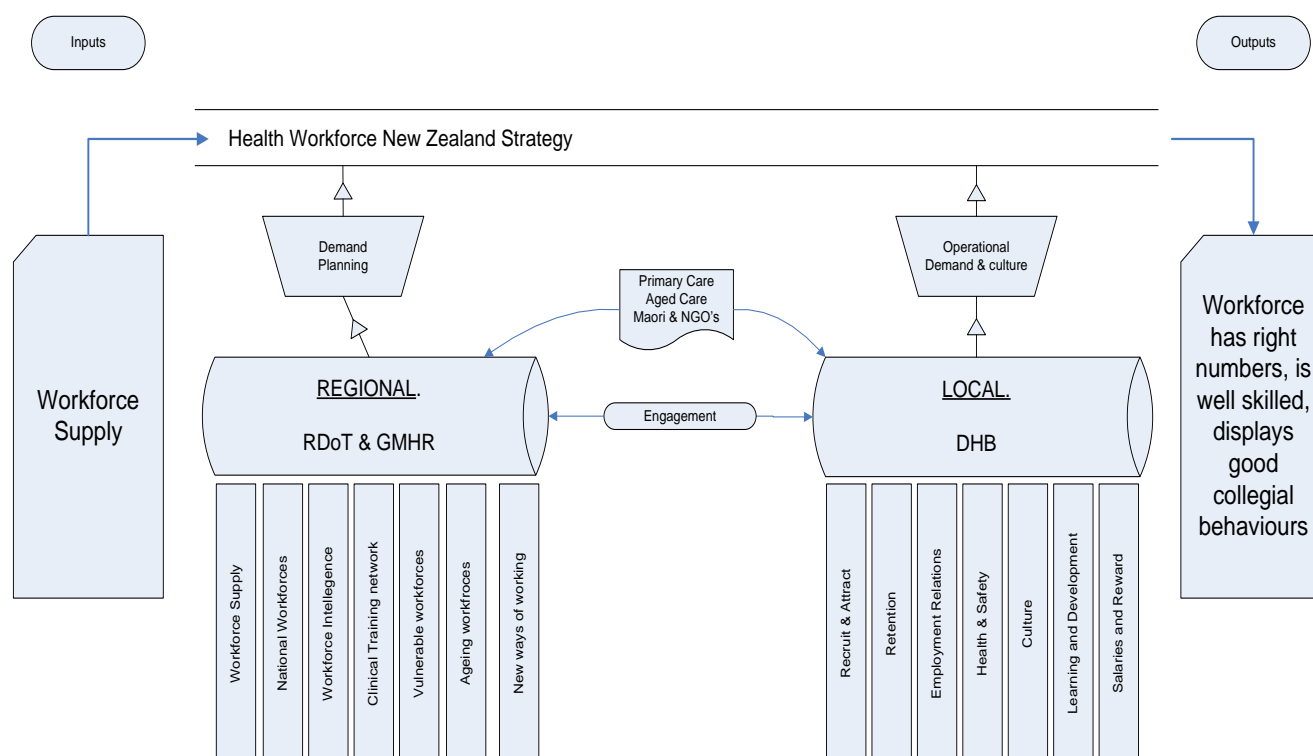
Workforce planning and training is a key enabler to ensure Midland DHBs deliver quality healthcare (as defined in objective 3) and to protect and promote health and wellness. The Midland region has over 10,000 full-time equivalents employed by the DHBs to provide healthcare to its populations. The health 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.

Discipline	FTE	FTE
	Jun-15	Jan-16
Allied & Scientific	1244	<b>1570</b>
Care and support	1258	<b>1127</b>
Corporate and other	2416	<b>2459</b>
Junior Medical	618	<b>679</b>
Midwifery	159	<b>150</b>
Nursing	3751	<b>3948</b>
Senior Medical	641	<b>695</b>

The workforce planning 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 planning and training plan illustrates the collaborative work of the Regional Director of Training (RDoT) and General Managers of Human Resources (GMs-HR) building whole of health system solutions and also working alongside the clinical networks and action groups to meet some of their key deliverables that pertain to workforce and training.

The diagram below (Figure 2) illustrates the relationships between regional and individual DHBs with regards to workforce planning and training activities.

**Figure 2: Regional and DHB workforce roles and inter-relationship**





Workforce continues to be a key enabler both within the Ministry of Health's Guidance for DHB Annual Planning Priorities and the Regional Services Plan Guidelines for 2016/17. Within this Midland RSP we aim to continue to develop the principles of culture, capability, capacity and change leadership. We recognise the 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 and action groups 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 to predict likely future levels of supply so we can judge how many newly qualified health professionals will be required to match population needs. Our workforce modelling is based on Kaplan's Balanced Scorecard<sup>4</sup> and considers demand and supply variables and the current training volumes being delivered against the anticipated demand reflecting population changes.

This plan continues to establish within the Midland region a coordinated workforce and training approach to better determine our current need and potential future workforce needs 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. Due to the unique spread of Pacific peoples in the Midland region, the regional focus is to support specific workforce initiatives set within DHB annual plans to increase participation of Pacific peoples in our health workforce. Finally, it supports the principle to support delivery of care more focused to primary and community care, developing generalists. It is recognised that specialists training within health careers will be limited to a few health care professionals located in particular centres.

GMs-HR provide a pivotal executive role in each of the Midland DHBs to plan and develop the future workforce. The RDoW role, working alongside GMs-HR, provides the link between Health Workforce New Zealand (HWNZ), workforce and training. Alignment of strategic planning between these 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 the GMs-HR will work in tandem with the RDoW in workforce and training planning. Midland region is currently re-evaluating its training hub (Midland Region Training Network – MRTN) to gain the required traction from this body.

This plan recognises the continued national collaboration between District Health Board – Shared Services (DHB-SS) and 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.

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<sup>4</sup> Kaplan, Robert S., and David P. Norton. The balanced scorecard: translating strategy into action. Harvard Business Press, 1996.

Closer engagement and subsequent alignment to the clinical networks and action groups is occurring with the recognition that workforce and training are enablers to support healthcare to our populations, thereby strengthening the workforce capacity and capability in line with service delivery developed within the clinical networks and action groups. This is particularly reflected in the technical expertise from GMS-HR and the RDoW working alongside workforce intelligence and planning analyst support hosted within HealthShare Ltd. This analyst support provides intelligence and data to the GMS-HR and a database repository that will enable GMS-HR/RDoW 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 continuing to age and accordingly key strategies and activities are being progressed 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, the national GMS-HR group and national DHB-SS, Midland DHBs have initiated the development of data cubes (currently for midwifery and cardiac) that will provide a single point of reference for vulnerable workforces within the Midland region DHBs, populated by local DHB sources and national sources.

## Objective 5: Improve clinical information systems

Line of Sight
<ul style="list-style-type: none"><li>DHB Annual Plans: Hauora Tairāwhiti (Sections 5.2.1, 5.2.2), BOP DHB (Sections 5.2.1, 5.2.2), Lakes DHB (Sections 2B.1.5.5, 5.2.1, 5.2.2),</li></ul>

An annual IS Regional Work Plan for 2016/17 financial year will be prepared with a 'line of sight' to regional and national strategic plans and directives. Specifically, with the majority of activities falling under the eSPACE Programme of Work, a model of closer, more collaborative engagement will be adopted. Each of the governance groups that have direct responsibility for the areas covered will provide the Programme with detailed guidance on requirements and aspects of design, and help to ensure that decisions are properly considered with outcomes that are realistic and deliverable. Overall, the IS Regional Work Plan will inform recommendations to DHBs on the IS funding decisions required to support local, regional and national priorities.

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

- Transformation will be delivered via the implementation of a Regional Clinical Workstation utilising solutions from Orion, Sysmex and other suppliers, where technology is the enabler across a range of regionally agreed and prioritised, clinical specialities, in line with the Ministry of Health's strategy of best of suite solutions. Deployment of the solution will be decided by Midland DHBs, but delivery of enhanced functionality will be agreed with clinical networks.
- A regional clinical data repository as a foundation enabler for the scope of the eSPACE programme. The Sysmex CDR is being established under the umbrella of the eSPACE Programme of Work.
- eSPACE as an enabler for achieving the region's 'health and well-being' priorities, backed up by sound business case propositions to drive improved clinical practice, both within and between the Region's health providers.
- The Midland Regional Telehealth Strategy through development and implementation of a work programme and supporting IT road map. The 2016/17 workplan is currently being confirmed, with a likely focus in 2016/17 of reconfirming the strategy/approach that is needed to meet desired outcomes.
- Full participation in the national Health IT Programme 2015-2020 processes to ensure alignment and an opportunity to shape outcomes.

The successful delivery of these initiatives requires ongoing review and prioritisation of current activities at both a local and regional level to enable appropriate resources to be made available.

Alongside the clinical IS delivery are interrelated initiatives that will be planned and delivered in parallel:

- Transition to NIP (National Infrastructure Platform). There has been a significant timing delay to date which combined with vendor delivery issues means that the exact pathway

for delivery is not currently clear and may have some deviation from what was originally anticipated.

- Confirmation of the Regional Reporting Strategy followed by extension of the Midland Regional Platform services to include reporting services capabilities as required.

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. 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 and increasing financial pressure.
- The lack of an agreed functioning service delivery model will impact the ability to deliver the eSPACE Programme of Work.
- 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.
- Some business work plans are not yet defined to a level of detail where there is an ability to sufficiently assess and understand the pre-requisites, funding and resource implications, which may introduce a higher level of change to the work plan than anticipated.

## 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. 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.

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 Midland region is acutely aware of the fiscal constraints impacting health services and the need to focus on innovation, service integration, improved efficiency and reduced waste to support provision of high quality care. Proposals for regional activity must clearly identify the value proposition for patients and/or the system.

As the workplans are developed and endorsed, any resource requirements are identified through a business case process with the Midland GMs Planning and Funding (Gms-P+F) and COOs. Any regional resourcing requests will be prioritised against national, regional and local priorities. Regional activity that needs project or capital funding for Information Service and other capital investments involves discussions with Midland Chief Executives (CEs) and Chief Financial Officers (CFOs).

### **Health Partnership Limited**

Midland DHBs are working with Health Partnership Ltd (HPL), a national agency that is standardising non-clinical services. HPL's initiatives include a national Oracle Solution (formerly Finance, Procurement and Supply Chain), Food Services, Linen and Laundry Services, and a National Infrastructure Platform.

### **HealthShare Limited**

HealthShare Limited (HSL), established in 2001, is a regional Shared Services Agency jointly owned by Waikato, Bay of Plenty, Lakes and Taranaki DHBs and Hauora Tairāwhiti. HSL employs 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 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.

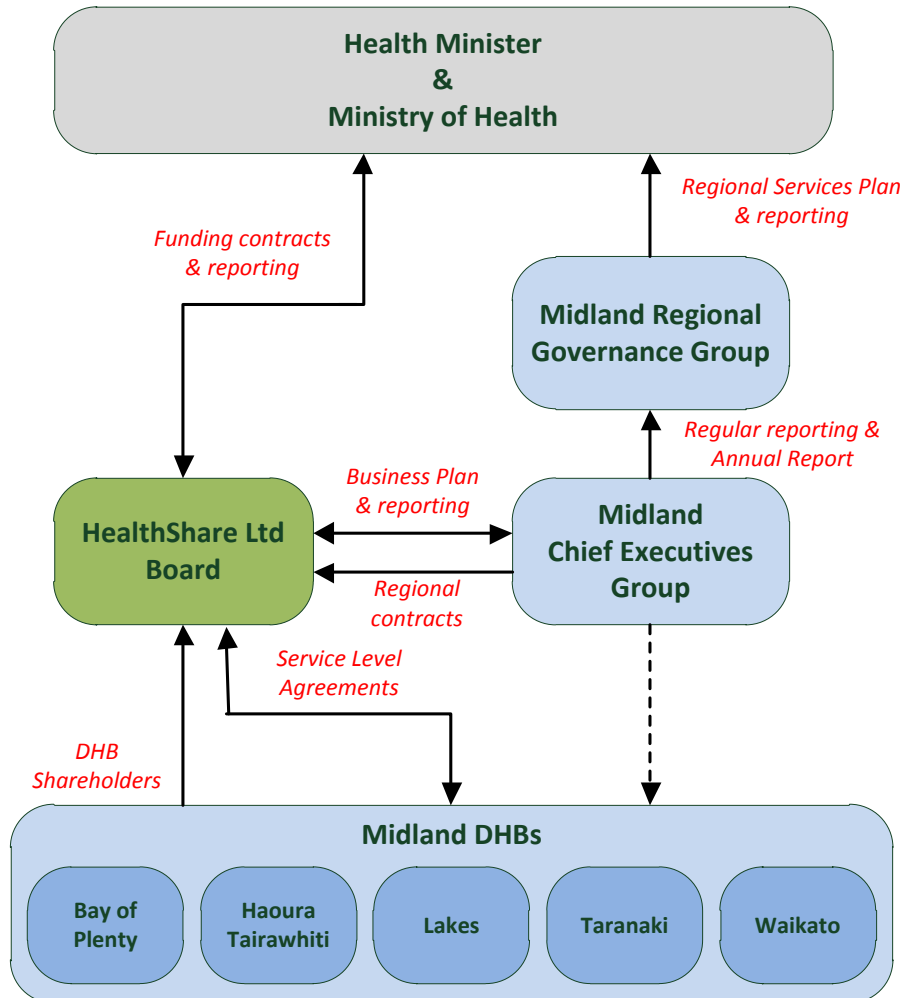
The annually agreed regional services form the basis for HSL's Business Plan which specifies the company's performance framework, the services to be provided, and the associated performance measures. HSL's Business Plan also details, at a service level, the activities that have been purchased by the shareholding DHBs. Midland DHB CFOs recommend to HSL Directors the funding provided by Midland DHBs for the coming financial year.

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

The following regional services are expected to be provided from HSL in 2016/17:

- Regional planning and reporting facilitation
- Regional networks: Midland Cancer Network, Midland Cardiac Network, Midland Elective Services Network, and Midland Mental Health and Addictions Network
- Regional groups: Child Health Action Group, Health of Older People Action Group, Midland Maternity Action Group, Midland Trauma System, Midland Radiology Action Group, Midland Stroke Group, and Regional Emergency Departments Services\*
- 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)

\*NB: These areas are not included in the 2016-19 RSP.



### Outcomes framework (intervention logic)

The outcomes framework on the next page (Figure 3) 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 DHB Annual Plans.



**Figure 3: 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			
^ ^ ^						
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 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
^ ^ ^						
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 - <i>Mauriora!</i>		Mission: Improve health for all; maximise independence for people with disabilities; with tangata whenua support a focus on health		Values: Manaakitanga; Integrity; Accountability	
	Tairāwhiti Vision: Working together to elevate the wellbeing of Tairāwhiti Mahia nga mahi i roto i te kotahitanga kia piki ake to oranga o te Tairāwhiti			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: 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	Child and Youth	Māori health - achieving equity		Health of older people	Long term conditions
	Lakes	Child, youth and maternal health	Mental health and addictions		Health of older people	Long term conditions
	Tairāwhiti	Join Patient, family/centred care	Know Excellent Iwi/ community, family/ whānau knowledge and engagement	Shape Working with community relationships	Vision Building a “will do” culture	Connect Enabling good health and well-being through technology
	Taranaki	Health targets	Māori health /disparities	Health of older people	Wellness/chronic conditions	Addressing system wide approach to integrated services
	Waikato	Financials	Regional Collaboration	Quality Improvement	Addressing Chronic Conditions	Organisational and Workforce Development

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

## 2. ACTIVITY OF REGIONAL NETWORKS, CLINICAL ACTION GROUPS AND PROJECTS

### Midland DHB regional groups

There are a variety of Midland DHB groups that meet to collaborate as a region on a regular basis. Mentioned earlier in the document was Nga Toka Hauora, the Midland GPs Māori (Objective 1), the Midland DHB Quality and Risk Managers (Objective 3) and General Managers – Human Resources (Objective 4). Appendix 2 provides information about the regional governance arrangements for Midland DHBs.

Other important regional DHB leadership groups include

- Midland Regional Governance Group
- Midland Chief Executives Forum
- Regional GPs Planning and Funding
- Chief Medical Advisors
- Chief Operating Officers forum
- Directors of Nursing
- Chief Financial Officers forum
- Directors of Allied Health
- Chief Information Officers (Midland IS Leadership Team)
- eSPACE Programme Board

### Midland DHB Regional Clinical Groups: Regional Networks and Clinical Action Groups

Regional clinical groups enable clinical leaders and managers to shape the development of services so that services are of a high quality, sustainable and there is equal access to these services for people across the region. The goal is to ensure people have the same health outcomes irrespective of geographical location, ethnicity and gender. Another benefit of working together is that there can be some coordination of the public health system resources and support to match demand and capacity.

Regional clinical initiatives are reviewed by Midland DHB executives and agreed by CEs. Much of what occurs is supported with national guidance as part of the annual DHB planning process and aligns with activity each DHB is also undertaking. Each regional initiative is assessed against the region's six strategic objectives to show how these contribute to the region's strategic outcomes and vision. A shading key is used to demonstrate whether activities will have a direct or indirect impact on a regional strategic objective. For milestones, where these are ongoing, then more than one box may be shaded.

Figure four (next page) provides a summary of the highest priority initiative that each clinical group is working on in 2016/17. This is to enable the reader to appreciate a key focus of the clinical group. It needs to be noted that the regional groups are also involved with other important activities.

Figure five provides a summary of the initiatives that Midland DHBs are working on as a region to achieve the New Zealand Health Strategy and Roadmap. Through the work programmes on the following pages there are references which show alignment with the five themes of the New Zealand Health Strategy.

**Figure 4: Top initiative for delivery by July 2017 for each regional clinical group**

Regional Network and Clinical Action Group	Top priority	Quantitative measure of success
Cancer	Midland Cancer Network initiatives that support the Midland DHBs to achieve the Faster Cancer Treatment Health Target	90% of patients referred with a high suspicion of cancer and a need to be seen within 2 weeks have their first treatment (or other management) within 62 days by June 2017
Cardiac	To meet MOH ACS Cath lab timeliness priority through implementing and continuously improving a production planning process for the region to deliver timely access to catheter lab facilities for angiograms	70% of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') by ethnicity
Child Health	The wider implementation of the Harti Hauora tool into Midland DHBs	Harti Hauora reviewed and available for wider implementation DHBs
Electives	Applying to ENT the principles and lessons from the successful implementation of the regional localised Paediatric Surgery model	ENT clinicians are moving between regional DHBs or DHB patients are actively being decanted to neighbouring DHBs to maximise capacity (minimum of 50 patients treated under this model)
Health of Older People	In addition to meeting Ministry expectations for dementia and InterRAI reporting, to develop an analytical method to identify frail elderly in primary care at risk of falls	1.dementia and InterRAI expectations met with reports available to Midland DHBs and Action Group members 2.Define frailty within analytical data attained from a minimum of one DHB and highlight key indicators which demonstrate falls risks.
Maternity	Develop a Midland Breastfeeding Framework to inform and prioritise breastfeeding initiatives in the Midland region	Midland DHBs are provided with a Midland Breastfeeding Framework to inform and prioritise breastfeeding initiatives in the region going forward
Mental Health & Addictions	Supporting Clinical Networks and Clinical Leadership <ul style="list-style-type: none"> <li>• identify how the region is planning to work with clinical leaders to make better use of clinical networks to support improved clinical and financial sustainability of services</li> <li>• identify services within the region that may benefit from the development of a regional clinical network</li> </ul>	Midland DHBs are provided with strong clinical governance leadership in mental health and addictions
Radiology	Development of a regional CT pipeline model with the support of HSL analytics to reconcile available capacity with growing demand	The % and quantity per DHB of Bowel screening cases that are clinically appropriate to be done

		with CT scanning
Stroke	Develop early supportive discharge care pathways for mild to moderate stroke rehabilitation patients	Discharge care pathways for mild to moderate stroke rehabilitation patients are developed
Trauma (MTS)	Midland DHBs to develop action plans to reduce trauma incidence based on known patterns of trauma in collaboration with community groups and utilising the Midland Trauma Research Centre (MTRC)	DHB action plans are developed, in collaboration with community groups, utilising the MTRC developed research tools, and DHB collected trauma data

**Figure 5: Alignment with the NZ Health Strategy and Roadmap of Actions 2016**

NZ Health Strategy theme	Regional Networks and Clinical Action Groups
1. Obesity	Child Health Action Group, Midland Maternity Action Group
2. Long Term Conditions	Regional Hepatitis C project, Cancer, Cardiac, Health of Older People, Mental Health & Addictions, Stroke
3. Service Configuration including Shifting Services	Cancer services, Cardiac services, Elective services, Mental Health & Addictions, Radiology, Stroke, Trauma (MTS)
4. IT (annual and regional plan priority).	Regional IS, Trauma (MTS), Cancer, Cardiac, Child Health

### Midland Regional Public Health Network

Another regional group is the Midland Regional Public Health Network (the Network). The Network provides an avenue for Public Health Units (PHUs) to work together on public health issues affecting the Midland region. As part of the DHB function PHUs provide public health advice and expertise with a general goal of protecting and improving the health of the population with a focus on reducing inequalities.

Midland DHBs and their PHUs work closely together to deliver on the five public health core functions:

1. Health promotion
2. Health protection
3. Preventative interventions
4. Health assessment and surveillance
5. Public health capacity development

In addition to providing advice and expertise to individual DHBs, the Network provides leadership for and strengthens the performance and sustainability of the Midland PHUs. Leadership of the Network comprises the manager and clinical director from each of the four PHUs in the Midland region: Toi Te Ora - Public Health Service (Bay of Plenty and Lakes District Health Boards); Population Health (Waikato District Health Board); Population Health, Hauora Tairāwhiti (Tairāwhiti Hauora) and Public Health Unit (Taranaki District Health Board).

The Network aims to further strengthen relationships with the Midland Regional Clinical Networks and Action Groups to ensure a public health perspective is considered within their

planning. At a national level the Network is a member of the National Public Health Clinical Network (NPHCN), whose membership comprises clinical leader and manager from each PHU and representatives from the Ministry of Health.

The goals of the Midland Regional Public Health Network are to:

- Enhance the consistency, coordination and quality of public health service delivery across the region;
- Support other Midland health networks by promoting the 'population health approach' and providing public health advice on issues that can have a population health outcome.

The Network's work to date has included collaborative annual planning, business continuity planning, supporting the development of Midland position statements on key health issues, setting up a mechanism for a regional approach to health intelligence work, standardising of communicable disease control processes, peer review, staff orientation programmes and support of sole practitioners.

Work streams are in place to support a consistent approach to common areas of work:

- Public health capacity
- Health Promotion Leadership Group
- HealthScape – Public Health Information Management system
- Public Health Intelligence

Future work streams will be determined based on the need to increase the focus on a particular public health issue and/or what might come from the recently released New Zealand Health Strategy.

In determining its direction for 2016/17, the Network will continue to align with the Ministry of Health's five core functions of public health (Health Assessment and Surveillance, Public Health Capacity Development, Health Promotion, Health Protection, and Preventive Interventions). The Network will also continue to focus on:

- Better integration of services within health and across the sector
- Lifting of quality and performance
- Supportive leadership and capability for change

In line with the wider health sector goal of better, sooner, more convenient health services for all New Zealanders, emphasis for the Network will continue to be on effective and efficient working and service delivery.

# Midland Regional Networks

## 2.1 Cancer services (Midland Cancer Network)

**Lead Chief Executive:** Dr Nigel Murray

**Chairs:** Dr Humphrey Pullon, Clinical Director and Brett Paradine Midland COO representative

**Programme Manager:** Jan Smith

### Context

*“working together to achieve better faster cancer care”*

The Midland Cancer Network is guided by the *Midland Cancer Strategy Plan 2015-2020* with a vision of regionally working together as one, we will lift the performance of our health systems by driving quality, improve experience of care, accountability, innovation and value.

The Midland Cancer Network brings together regional stakeholders who are working across the cancer pathway including DHBs, NGOs, GPs and PHOs, cancer service providers, cancer consumers and their family/whānau, hospices and research organisations. Midland encompasses the Bay of Plenty, Lakes, Tairāwhiti and Waikato districts, with an open invitation to Taranaki DHB. Cancer networks work across boundaries to improve outcomes for patients.

Most New Zealanders will have experience of cancer, either personally or through a relative or friend. Cancer is the country's leading cause of death - 30% (Ministry of Health. 2010). 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. Once people are diagnosed with cancer they are now less likely to die from it. This means that people are surviving longer, and being treated for longer periods of time, with different treatments.

Midland has a higher Māori population, more people living in more socio-economically deprived areas both rural and remote areas and those who live in larger cities. Māori have a higher cancer incidence (20% greater), higher cancer 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.

The Midland strategic framework for action takes a total continuum of care approach for the Midland population from prevention and early detection – screening – diagnosis and treatment – follow-up and surveillance – survivorship – palliative care and last days of life. 2016/17 plan aims to build and strengthen the alignment and linkages of the various Midland health services related to the cancer continuum. This is demonstrated in the Line of Sight Section (refer below).

### Key objectives

The Midland Cancer Strategy Plan strategic objectives are to:

1. reduce the cancer incidence through effective prevention, screening and early detection initiatives
2. reduce the impact of cancer through equitable access to best practice care
3. reduce inequalities with respect to cancer
4. improve the experience and outcomes for people with cancer

The strategic objectives are supported by five enablers: infrastructure, information systems, workforce, supportive care, knowledge and research.

### Measures

- Faster Cancer Treatment Health Target 62 day – Midland DHBs achieve at least 90% of patient referred with a high suspicion of cancer and a need to be seen within two weeks have their first treatment (or other management) within 62 days by June 2017
  - DHBs demonstrate improvements in the number of records been submitted with 15-25% of cancer registrations cohort reported within the 62 day health target

**Midland DHBs baseline table: as at 2015/16 Quarter 2 results**

DHB	Bay of Plenty	Lakes	Tairāwhiti	Waikato	Midland
62 day 2015/16 baseline	76.2%	56.3%	65.9%	67.5%	
62 day 2016/17 target	90%				
62 day cohort baseline*	25	3	7	25	60
62 day cohort target*	29	12	5	40	86
31 day 2015/16 baseline	81.2%	91.5%	88.4%	86%	
31 day 2016/17 target	85%				
31 day volume baseline*	97	36	20	125	278
31 day volume target*	115	47	20	161	343

Notes: 2015/16 baseline was determined at 3/2/16; \* per month.

- 31 day indicator (policy priority 30) – 85% of patients with a confirmed diagnosis of cancer receive their first treatment (or other management) within 31 days of decision-to-treat



- Shorter waits for cancer treatment (policy priority 30) – all patients ready-for-treatment wait less than four weeks for radiotherapy or chemotherapy
- Improving cancer multidisciplinary meetings – monitor improvements to the coverage and functionality of the region's multidisciplinary meetings
- Diagnostic colonoscopy (policy priority 29)
  - 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days
  - 70% of people accepted for non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days
  - Surveillance colonoscopy (policy priority 29) – 70% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100% within 120 days.

**Midland DHBs baseline table: as at 2015/16 December 2015 results**

DHB	Bay of Plenty	Lakes	Tairāwhiti	Waikato	Taranaki
2015/16 urgent diagnostic baseline % achieved	76.8%	55%	50%	80.6%	85.4%
2015/16 non-urgent diagnostic baseline % achieved	38.4%	41.6%	40%	59.6%	26.2%
2015/16 surveillance baseline 70% achieved	8.7%	53.6%	68.8%	45.8%	63.8%

Refer to Line of Sight sections for other relevant cancer control measures such as better help for smokers to quit, immunisation, screening, improved access to diagnostics, elective services.

**Line of Sight – for discussion and agreement to ensure delivering whole of system care**

The Midland plan aligns with the *New Zealand Cancer Plan Better, Faster Cancer Care 2015-2018* (NZ Cancer Plan) which provides a strategic framework for an ongoing programme of cancer related activities for the Ministry, DHBs and regional cancer networks so that all people have even more timely access to excellent services that will enable them to live better and longer. The NZ Cancer Plan sets out the cancer related programmes, activities, expectations and services that are to be implemented over the next three years. Cancer networks work across boundaries to improve the outcomes for patients by:

- reducing the incidence and impact of cancer
- increasing equitable access to cancer service and equitable outcomes with respect to cancer treatment and cancer outcomes.

Implementing the priorities of the NZ Cancer Plan is the priority for regional and local planning to improve:

- equity of access to cancer services
- timeliness of service across the whole cancer pathway
- the quality of cancer service delivered.

Integration. Midland Cancer Network work across boundaries to improve outcomes for patients by bringing stakeholders from multiple services and/or organisations across the cancer continuum.

The following summarises linkages and alignment regionally and locally.

- RSP: Please see linkages related to cancer control for:
  - Regional Priority – Cardiac Network – section 1.2
    - Discussions started about joint regional end stage cardiac and palliative care initiative – tbc dependent on resourcing
  - Radiology Services Action Group – section 1.8
    - Improved access to MRI, CT, CTC
    - Implement Midland Oncology Imaging Pathway and Protocols (based on NCN work) in partnership with Midland Radiology Group (tbc - dependent on available resources)

- Workforce: Please see Appendix 1 of the 2016-19 Midland Regional Services Plan
  - National - Recruitment of new palliative care specialist nurses and educators – assume related to Hospice 2015 funding
  - National - Support for the role of nurses performing endoscopies – Midland DHBs do not have any active plans to train 2016/17
  - National - Support for training of physicists – consider national recommendations tbc
  - Waikato Regional Cancer Centre facility upgrade – concept currently under consideration
  - Waikato genitourinary increase in FTE for cancer CNS and nurse led haematuria clinic – business case needs to be developed and resourced is this urology and/or oncology (tbc)
  - Midland advanced palliative care trainees. Waikato advanced palliative care registrar business case – implemented 2015/16
  - Support Tairāwhiti with enhancements to cancer nurse care coordination model of service project, share learnings regionally
  - Support DHBs to implement the *Cancer Nurses Knowledge and Skills Framework*
  - Support DHBs to implement new cancer psychologists and social workers as per the *Midland Psychological and Social Support Services Plan 2015-2018*

- Regional IS: Please see Appendix 1 of the 2016-19 Midland Regional Services Plan
  - Support implementation of the New Zealand Cancer Health Information Strategy (2015) (tbc – dependent on available resources)

<ul style="list-style-type: none"> <li>○ Support Midland e-space programme (tbc – dependent on available resources)</li> <li>○ Develop a high level Midland Cancer Health Information and ICT work plan that links with national and regional strategies/initiatives i.e. FCT, NPF, ProVation, MDM, e-referral, PalCare, Dendrite (tbc - dependent on available resources) – see section 9</li> <li>○ Scope feasibility for Midland of implementing NZCHIS MDM Project (in progress) recommendations for 2017/18 (tbc - dependent on available resources)</li> <li>○ Midland DHBs / IS agree a plan and process for timely and appropriate upgrades for ProVation software no matter what server the DHB is on.</li> <li>○ Midland Cancer Network will continue to develop and maintain the Midland FCT database</li> <li>○ National Radiation Oncology Linear Accelerator and Workforce Plan (due for publication June 2016) will have new metric/data requirements</li> <li>○ National Patient Flow project</li> </ul>
<ul style="list-style-type: none"> <li>● <i>DHB Māori Health Plans: please see Appendix 1</i> <ul style="list-style-type: none"> <li>○ Ethnicity data quality</li> <li>○ Child health breast feeding</li> <li>○ Cervical cancer screening</li> <li>○ Breast cancer screening</li> <li>○ Smoking cessation</li> <li>○ Delivery of whānau or/long term conditions – linkage promote DHBs to include cancer component of whānau ora contracts</li> <li>○ Community based cancer health literacy Kia Ora E Te Iwi programme one per DHB</li> <li>○ Midland Hei Pa Harakeke (Māori Cancer Leadership Group)</li> <li>○ Bay of Plenty Determine, Test and Implement Viable Ways of Improving the FCT Pathway for Māori in BOP Project 2015-2018</li> <li>○ DHBs continue to support and implement the cancer nurse coordinator initiative</li> <li>○ DHBs implement National Standards of Care for AYA patients for Service Provision (in development)</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>● <i>DHB Annual Plans: Please see sections of DHB Annual Plans (if different)</i> <ul style="list-style-type: none"> <li>○ Better Help for Smokers to Quit (Health Target) – section 2.4.4.1 WDHB; section 2B.2.12 Taranaki DHB; 2B.1.4.5 Bay of Plenty; 2B.1.2.5 Lakes; 2.3.3 Tairāwhiti</li> <li>○ Childhood obesity (Health Target) – sections 1.5.8, 2.4.4.1 WDHB; section 2B.2.9 Taranaki DHB; 2B.1.4.2 Bay of Plenty; 2B.1.2.1 Lakes; 2.3.3 Tairāwhiti</li> <li>○ HPV immunisation – section 3.3.2 WDHB; 2B.2.2 Taranaki DHB; 2B.1.3.1 Bay of Plenty; 2B.1.4.2 Lakes; module 7 Tairāwhiti</li> <li>○ Cervical and breast screening – sections 1.4.2; 2.3.2.3; 8.4 WDHB; 1.5.1.1 Taranaki DHB; 3.3, 2B 1.5.1 Bay of Plenty; 2B.1.4.2 Lakes; 1.2.3 Tairāwhiti</li> <li>○ Improved access to elective surgery (Health Target) – sections 2.5.10.3; 8.4 WDHB; 2B.2.2.3 Taranaki DHB; 1.7.2 Bay of Plenty; 2B.1.3.10 Lakes; 1.3.9 Tairāwhiti</li> <li>○ Improved access to diagnostics (MRI, CT, Colonoscopy) – section 2.5.9 WDHB; 2B.2.22 Taranaki DHB; 2B 1.5.7, 3.4.3 Bay of Plenty; 3.6 Lakes; 2.2.2 Tairāwhiti</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>● <i>Bay of Plenty DHB</i> <ul style="list-style-type: none"> <li>○ Community based cancer health literacy Kia Ora E Te Iwi programme one per DHB</li> <li>○ DHB to consider including cancer component into whānau ora/long term conditions contracts</li> <li>○ Undertake a palliative care review to update BOP Palliative Care Plan Q4 2016/17</li> <li>○ Bay of Plenty Determine, Test and Implement Viable Ways of Improving the FCT Pathway for Māori in BOP Project 2015-2018</li> <li>○ BOP expand colonoscopy services with a third room opening for bronchoscopies and upper GI scopes</li> <li>○ BOP colonoscopy backlog – tbc currently working with Ministry of Health</li> <li>○ Tumour review improvement plans</li> <li>○ ProVation PIR following implementation</li> <li>○ National Linear Accelerator and Workforce Plan (due for publication June 2016) will have new metric/data requirements</li> <li>○ Midland DHBs / IS agree a plan and process for timely and appropriate upgrades for ProVation software no matter what server the DHB is on</li> <li>○ Implementation of the Cancer Nurses Knowledge and Skills Framework</li> <li>○ Hospices Innovation Fund initiatives (in progress)</li> </ul> </li> </ul>

<ul style="list-style-type: none"> <li>○ Midland clinicians agreed 10/12/15 to run a Midland Early Detection of Lung Cancer Project 2016/17 – DHBs need to agree to support with some minimal funding – addresses prevention, early detection, health promotion, health literacy and addressing equity issues.</li> <li>○ Work with PHOs to identify actions to implement the prostate cancer management and referral guidance during 2016/17</li> </ul>
<ul style="list-style-type: none"> <li>● <b>Lakes DHB</b> <ul style="list-style-type: none"> <li>○ Community based cancer health literacy Kia Ora E Te Iwi programme one per DHB</li> <li>○ DHB to consider including cancer component into whānau ora contracts</li> <li>○ Continue MCN-Lakes FCT Service Improvement Project 2015-2018</li> <li>○ Continue to support Lakes Paediatric Palliative Care Model of Service Improvement Project</li> <li>○ Continue the Lakes-Waikato medical oncology, radiation oncology and haematology model of service improvement project (in progress)</li> <li>○ Lakes to undertake a palliative care review and to update Lakes Palliative Care Plan – tbc Qtr 4 2016/17</li> <li>○ Tumour review improvement plans</li> <li>○ ProVation PIR following implementation</li> <li>○ Midland DHBs / IS agree a plan and process for timely and appropriate upgrades for ProVation software no matter what server the DHB is on</li> <li>○ Implementation of the Cancer Nurses Knowledge and Skills Framework</li> <li>○ Hospices Innovation Fund initiatives (in progress)</li> <li>○ Midland clinicians agreed 10/12/15 to run a Midland Early Detection of Lung Cancer Project 2016/17 – DHBs need to agree to support with some minimal funding – addresses prevention, early detection, health promotion, health literacy and addressing equity issues.</li> <li>○ Work with PHOs to identify actions to implement the prostate cancer management and referral guidance during 2016/17</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>● <b>Hauora Tairāwhiti</b> <ul style="list-style-type: none"> <li>○ Community based cancer health literacy Kia Ora E Te Iwi programme one per DHB</li> <li>○ Continue planning and development of facility upgrade cancer facility for Medical Day Unit</li> <li>○ DHB to consider including cancer component into whānau ora/long term conditions agreements</li> <li>○ Tumour review improvement plans</li> <li>○ ProVation note: will implement 2016/17 on Waikato DHB platform</li> <li>○ Implementation of the Cancer Nurses Knowledge and Skills Framework</li> <li>○ Hospices Innovation Fund initiative (in progress)</li> <li>○ Improve Tairāwhiti cancer nurse care coordination model of service</li> <li>○ Midland clinicians agreed 10/12/15 to run a Midland Early Detection of Lung Cancer Project 2016/17 – DHBs need to agree to support with some minimal funding – addresses prevention, early detection, health promotion, health literacy and addressing equity issues.</li> <li>○ Work with PHOs to identify actions to implement the prostate cancer management and referral guidance during 2016/17</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>● <b>Waikato DHB</b> <ul style="list-style-type: none"> <li>○ Community based cancer health literacy Kia Ora E Te Iwi programme one per DHB</li> <li>○ Continue to implement MCN-Waikato Faster Access to Cancer Services through a Staged Tumour Approach to Treatment Project 2015-2020</li> <li>○ Continue to implement MCN-Waikato PMB and Endometrial Cancer Project 2015/16-2016/17</li> <li>○ Continue to support development and implementation of Waikato Palliative Care Strategy Plan (in progress)</li> <li>○ Continue to support Midland to implement the Midland Medical Advanced Palliative Care Trainee Model of Service (2015)</li> <li>○ Continue the Lakes-Waikato medical oncology, radiation oncology and haematology model of service improvement project (in progress)</li> <li>○ Waikato Regional Cancer Centre planned linac replacement (green)</li> <li>○ Waikato Regional Cancer Centre facility upgrade – concept currently under consideration</li> <li>○ Develop Waikato medical oncology, radiation oncology and haematology model of service (in align with TDH MOS project 2013/14, BOP MOS project 2014/15 and Lakes MOS project 2015/16- in progress)</li> <li>○ Waikato advanced palliative care registrar business case – in progress</li> <li>○ National Linear Accelerator and Workforce Plan (due for publication June 2016) will have new metric/data requirements</li> <li>○ Midland DHBs / IS agree a plan and process for timely and appropriate upgrades for ProVation software no matter what server the DHB is on</li> </ul> </li> </ul>

- Implementation of the Cancer Nurses Knowledge and Skills Framework
- Hospices Innovation Fund initiatives (in progress)
- Midland clinicians agreed 10/12/15 to run a Midland Early Detection of Lung Cancer Project 2016/17 – DHBs need to agree to support with some minimal funding – addresses prevention, early detection, health promotion, health literacy and addressing equity issues.
- Work with PHOs to identify actions to implement the prostate cancer management and referral guidance during 2016/17.

Initiatives	Milestone/Date	Responsibility
<b>Faster Cancer Treatment (FCT)</b> The FCT programme is a key focus of the Midland and National Cancer Programme. The FCT programme is designed to improve access, timeliness, quality of cancer services, and standardise care pathways for all patients wherever they live. There are several main work streams to the FCT programme such as development and review against national tumour standards, service improvement and/or equity initiatives to ensure achievement of the Health Target and/or implementation of the national tumour standards, one-off FCT projects, improving the coverage and functionality of multidisciplinary meetings (MDMs).		
1. Improve the quality of cancer services by supporting the identification of at least three actions the regional will undertake to improve equity at a systems and/or organisational level (refer to the Equity of Health Care for Māori: A Framework resource)		
1.1. Support DHBs to deliver one Kia Ora E Te Iwi community health literacy programme per DHB	Q4 2016/17	MCN, DHB Māori, Cancer Society
1.2. Support the facilitation of the Midland Hei Pa Harakeke Group	Q4 2016/17	MCN
1.3. Review and update the Midland Māori Cancer Action Plan	Q1 2016/17	Hei pa Harakeke
1.4. Develop and implement standardised equity focused reporting for all initiatives		
1.5. Implement the Midland Patient Information Resource Project 2016/17 – 2017/18 as milestones outlined in the project plan	Q4 2018/2019	Midland DHBs/MCN
1.6. Implement the Determine, Test and Implement Viable Ways of Improving the FCT Pathway for Māori in BOP Project 2015-2018	Q4 2017/18	BOPDHB
1.7. Implement the <i>Midland Psychological and Social Support Services Plan</i> 2015-2018	Q4 2017/18	Midland DHBs/MCN
1.8. Support DHBs to consider including cancer component into whānau ora / long term conditions contracts – completed for Waikato.	Q4 2016/17	Midland DHBs/MCN
1.9. Support Midland DHBs with a “cough cough cough” early detection lung cancer project – clinicians support regional project	ongoing	Midland DHBs/MCN
2. In partnership with DHBs coordinate two regional reviews national tumour standards of service provision and identify key activities to address issues identified as a result of the regional review		
2.1. Undertake a stocktake of myeloma services and gap analysis against the national myeloma standards	Q1 2016/17	MCN in partnership with Midland DHBs
2.2. Midland DHB self-assessments and data analysis completed by October 2016	Q2 2016/17	
2.3. Establish a regional myeloma work group to review findings and develop regional report by December 2016	Q2 2016/17	
2.4. Undertake a stocktake of lung cancer services and gap analysis against the national lung cancer standards	Q3 2016/17	
2.5. Midland DHB self-assessments and data analysis completed by April 2017	Q4 2016/17	
2.6. Midland Lung Cancer Work Group to review findings and develop regional report by June 2017	Q4 2016/17	
3. Identify key activities to address issues identified as a result of completed regional tumour standards reviews for lung (2014), colorectal (2014), gynae-oncology (2015), breast (2015), sarcoma (2015), lymphoma (2016)	Q1-4 2016/17	Midland DHBs in partnership with MCN
3.1. Coordinate DHBs to develop and update Improvement Plans and support monitoring and evaluation against review recommendations		
3.2. Develop Midland Lung Cancer KPI report six monthly to Midland DHBs to support monitoring		
4. Improve the functionality and coverage of Midland multidisciplinary meetings (MDMs)		
4.1. Implement <i>Midland MDM Action Plan</i> (2016) recommendations	Q4 2016/17	MCN in partnership with Midland DHBs
5. Implement actions that support the region to deliver on DHBs AP priorities (where not covered in other initiatives) for cancer such as:		
5.1. Continue to implement MCN-Waikato Faster Access to Cancer Services through a Staged Tumour Approach to Treatment Project 2015-2020	Q1-4 2016/17	MCN Waikato DHB
5.2. Continue to implement MCN-Lakes FCT Service Improvement Project 2015-2020	Q1-4 2016/17	MCN Lakes DHB
5.3. Continue to implement MCN-Waikato PMB and Endometrial Cancer Project 2015/16-	Q2 2016/17	MCN Waikato DHB Lakes DHB MCN

Initiatives	Milestone/Date	Responsibility
20/16/17		
5.4. Continue to support Lakes Paediatric Palliative Care Model of Service Improvement Project	Q1-4 2016/17	Waikato DHB MCN BOP DHB
5.5. Continue to support development and implementation of <i>Waikato Palliative Care Strategy Plan 2016-2021</i>	Q1-4 2016/17	Lakes DHB
5.6. Support BOP to undertake a palliative care review to update <i>BOP Palliative Care Plan 2011-2016</i> - tbc	Q4 2016/17	Tairāwhiti DHB/MCN
5.7. Support Lakes to undertake a palliative care review to update <i>Lakes Palliative Care Plan 2011-2016</i> - tbc	Q4 2016/17	
5.8. Support Hauora Tairāwhiti cancer nurse care coordination project	Q4 2016/17	
6. Support Midland DHBs to ensure that at least 90% of patients referred with a high suspicion of cancer and a need to be seen within 2 weeks have their first treatment (or other management) within 62 days by June 2017	Q1-4 2016/17	MCN
6.1. Develop and maintain the Midland FCT database		
6.2. Update Midland DHB FCT database with other DHB information (except for Tairāwhiti)		
6.3. Undertake Midland DHBs monthly FCT reporting requirements to Ministry of Health (except for Tairāwhiti)		
6.4. Develop regional quarterly FCT analysis for Midland DHBs, by DHB, by ethnicity, by tumour type, by treatment type, by IDF		
6.5. Facilitate the Midland FCT Work Group		
7. Facilitate specific regional actions to improve the timeliness and quality of cancer patient pathway from the time patients are referred to the DHB through treatment to follow-up/palliative care	Q1-4 2016/17	MCN Midland Palliative Care Work Group
7.1. Continue the Midland Routes to Cancer Diagnosis and Treatment Project 2015-2018		
7.2. Continue to implement <i>the Midland Specialist Palliative Care Service Development Plan 2015-2020</i> recommendations		MCN Midland DHBs
7.3. Consider National Adult Palliative Care Review recommendations (due September 2016) and build into regional work programme as able		
7.4. Scope the feasibility of establishing a Midland Urological Cancer Work Group to implement service improvements related to FCT, MDMs and national guidance (tbc - dependent on available resources)		Midland Radiology Group MCN Midland DHBs MCN
7.5. Implement Midland Oncology Imaging Pathway and Protocols (based on NCN work) in partnership with Midland Radiology Group (tbc - dependent on available resources)		Midland DHBs MCN
7.6. Implement the <i>Standards for Service Provision for Lung Cancer Patients in New Zealand 2016</i>		MCN
7.7. Implement the national HSCAN lung cancer definitions (April 2016)		
7.8. Keep watching brief on national phase 2 tumour stream work programme – tumour stream MDM prioritisation criteria; tumour follow-up and surveillance guidance; review and update of provisional tumour standards	Q1 2016/17	
7.9. Support DHBs to implement national for <i>Service Provision for AYA Cancer Patients in New Zealand Including Standards of Care</i> (Provisional 2016) (tbc - dependent on available resources)		
8. Support Midland DHBs to identify actions to maintain timeliness of access to radiotherapy and chemotherapy	Q1-4 2016/17	MCN in partnership with Midland DHBs
8.1. Continue the Lakes-Waikato medical oncology, radiation oncology and haematology model of service improvement project (in progress)		
8.2. Review and update <i>Midland Radiation Oncology Plan</i> following completion of the <i>Radiation Oncology National Linear Accelerator and Workforce Plan</i> (due for publication June 2016) (tbc - dependent on available resources)	Q2 2016/17	
8.3. Review and update Midland Medical Oncology Plan 2013-2018 (tbc)		
8.4. Establish a Midland Haematology Work Group to undertake a stocktake and gap analysis (tbc - dependent on available resources)	Q4 2016/17	Midland Cancer CNS Coordinator Group
8.5. Support Midland DHBs with local initiatives as required	to be determined	
8.6. Support DHBs to implement the <i>Cancer Knowledge and Skills Framework</i>	Q1-4 2016/17	
9. Implementing processes to ensure all new information initiatives align with the <i>New Zealand Cancer Health Information Strategy</i> (2015)	to be determined	MCN in partnership with Midland DHBs
9.1. Scope feasibility for Midland of implementing <i>NZCHIS MDM Project</i> (in progress) recommendations for 2017/18 (tbc - dependent on available resources)		
9.2. Support Midland information systems project such as e-space (tbc - dependent on available resources)		MCN in partnership with Regional IS and DHBs
9.3. Develop a high level Midland Cancer Health Information and ICT work plan that links with national and regional strategies/initiatives i.e. FCT, NPF, ProVation, MDM, e-referral, PalCare, Dendrite (tbc - dependent on available resources)		
10.1 Identify workforce programmes of work that support the actions the region is		

Initiatives				Milestone/Date	Responsibility
undertaking to improve cancer services				Q1-4 2016/17	Waikato DHB as lead, Midland Palliative Care Work Group
10.2 Continue to support Midland to implement the <i>Midland Medical Advanced Palliative Care Trainee Model of Service</i> (2015)					
10.3 Support research and clinical trial initiatives i.e. HRC funded Breast Cancer Research; Supportive Care for Women with Breast Cancer at High Risk; Prostate Cancer initiatives; Palliative Care Research initiatives				ongoing	Waikato Clinical School
10.4 Support DHBs to implement new cancer psychologists and social workers as per the <i>Midland Psychological and Social Support Services Plan 2015-2018</i>					
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

Initiatives				Milestone/Date	Responsibility
<b>2. Improved access to diagnostics for endoscopy/colonoscopy services</b>					
The following actions aim to improve waiting times and quality of endoscopy/colonoscopy services					
2.1. Continue to facilitate the Midland Colorectal and Midland Colonoscopy Work Groups to improve services				Q1-4 2016/17	Midland DHBs
2.2. Establish a Midland Bowel Screening Work Group to start regional conversations regarding pathways and implications should there be national rollout of a bowel screening service				Q1 2016/17	
2.2. Support using the Global Rating Scale (GRS) as part of the National Endoscopy Quality Improvement Programme (NEQIP) by supporting DHBs with operational policies				Q3 2016/17	
2.4. Support DHBs to undertake post implementation review of ProVation for Lakes and BOP DHBs. Support Tairāwhiti implementation as required				Q3 2016/17	BOP and Lakes DHBs
2.5. Support use of the National Referral Criteria for Direct Access Outpatient Colonoscopy - Undertake a regional evaluation of the Midland colonoscopy e-referral 6 months post implementation					MCN
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

Initiatives				Milestone/Date	Responsibility
<b>3. Lead for National Lung Cancer Work Programme</b>					
Midland Cancer Network holds a Ministry of Health Agreement to provide secretariat and project management support for the National Lung Cancer Working Group work programme priorities which are to:					Midland Cancer Network in partnership with National Lung Cancer Working Group
3.1. Develop early detection of lung cancer guidance (timeframe tbc)				Q1 2016/17	
3.2. Develop lung cancer follow-up and surveillance guidance by 30/6/17				Q4 2016/17	
3.3. Develop a revised national lung cancer dataset by 30/6/17				Q4 2016/17	
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

Key:

	<i>Actions are specifically aimed at achieving this objective</i>
	<i>Actions will achieve this objective but as an indirect consequence</i>



## 2.2 Cardiac services (Midland Cardiac Clinical Network)

**Chair:** Dr Gerard Devlin

**Project Manager:** Philippa Edwards

**Lead Chief Executive:** Dr Nigel Murray

### Context:

Cardiovascular diseases are a leading cause of death in New Zealand. They were responsible for 24.7 percent of all deaths in NZ in 2013. Within the set of cardiovascular diseases, ischemic heart disease (IHD) is the biggest killer and within the Midland region the mortality rates of Tairāwhiti, Taranaki and Lakes DHBs are higher than the national average.

The Heart Foundation and Public Health messaging is increasing cardio-vascular health literacy, and improvements in prevention and intervention have been significant. From 2006 to 2013 the annual total number of Acute Coronary Syndrome (ACS) admissions in NZ has fallen by 26% to 15,202. The decrease is not gender, age or ethnic specific however the improvement being greatest for Māori and lowest for Pacific people. In spite of this rates remain higher overall for Māori and Pacific compared with European and Other peoples. The NZ age standardised angiography rates have increased from 33.5 to 48.3 per 100 ACS admissions. The increase is in all ethnic groups; however the rates in European/Others at 50 per 100 remain higher than for Māori and Pacific people at 37.4 per 100 and 39 per 100 respectively. Revascularisation rates mirror the angiography rates with 35.5 in European/Other, 21.4 in Māori and 24.1 in Pacific in 2013.

The impacts of the aging population and increasing prevalence of cardiovascular risk factors such as diabetes and obesity are predicted to impact future cardiovascular demand. 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.

Service performance has steadily improved across the Midland DHBs. The five Midland DHB Cardiac Specialist Services recognise the value in planning and working together. A clear and unified direction is being used whilst forming a virtually integrated regional cardiac service for strategic planning, annual planning and daily operations management. This work will be embedded over the 16/19 timeframe with development of a regional production plans and a strategic Cardiac Service Plan.

The Midland region has a wide range of mortality rates across its five DHBs, low angiogram rates and low revascularisation rates. In 2012/13 the Acute Coronary Syndrome rates per 100,000 adult population ranged from 449 (Capital and Coast) to 784 (Tairāwhiti). The highest incidence was in **Tairāwhiti**, South Canterbury, **Taranaki**, Counties Manukau and Whanganui, while the lowest rates were in Capital and Coast, Auckland, Hutt, **Waikato** and **Bay of Plenty** DHBs.

### Planned Outcomes for 16/17:

The Midland Cardiac Clinical Network (MCCN) work provides a leadership and monitoring role across the Midland Region Cardiac Services to deliver value and high performance in the delivery of services.

In 2016/17 tangible outcomes will be:

1. A region wide production plan for acute and elective cath lab facilities for angiograms and percutaneous interventions (PCI) such as angioplasty and the insertion of arterial stents.
2. Compliance with the MOH acute coronary syndrome (ACS) targets - timeliness of angiogram and the data entry into the ANZACS-QI data registry monitored by each of the five Midland DHBs and by ethnicity
3. A gap analysis across the five Midland DHBs against the NZ National Expected Clinical Standards of assessment and treatment to assess the current state, and to make recommendations to the five Midland DHBs. These include acute chest pain, STEMI myocardial infarction, heart failure, atrial fibrillation, access to Holter and echo diagnostics, tachycardia/palpitations/syncope, structural or valvular heart disease

In 2016/17 leadership will be provided to the Midland region's Cardiac Services:

4. Planning Sub Group - implementation of the shared regional vision for integrated cardiac services across the 5 Midland DHBs and in alignment with the 5 strategic themes in the NZ health strategy
5. Prevention and Rehabilitation Sub Group - work with primary care to identify groups of high risk patients in need of increased access to primary or secondary care services or a higher level of preventative intervention; provide resource for primary care pathway and health literacy initiatives to increase the rate being risk assessed
6. Communication on a range of topics that the NZ Cardiac Network is working on to advice the MOH. Regional interest includes Health Workforce NZ, AED national working group, ambulance service and STEMI pathway, National Expected Clinical Standards, Echo cardiology etc.
7. Identifying and sharing solutions for service improvement issues within individual DHBs
8. Regional IS e-space initiatives

### Key objectives:

The goal of the Midland Cardiac Clinical Networks is to reduce the burden of Cardiovascular Disease across the Midland Region. Its focus will be on wellness of the population while:

- Delivery services in alignment with the NZ Health Strategy 5 strategic themes
- Meet Ministry of Health targets and performance objectives
- Achieve equity by domicile and by ethnicity of populations accessing assessment, diagnostics and treatment for cardiac conditions



- Support the five Midland DHBs and Public Health entities to empower the population in knowledge and skills to increasingly understand and manage their own health conditions
- Living well with long term conditions - ensure health interventions work to reduce risk factors and strengthen protective factors.
- Health quality and safety - take a governance role to ensure patient clinical pathways and access criteria exist across the continuum, ensuring patients with a similar level of need receive comparable access to services, regardless of where they live
- Ensuring patients receive seamless, coordinated care across the clinical pathway
- Ischaemic Heart Disease – ensure high quality assessment, treatment and safe risk management
- Heart Failure management – ensure high quality assessment, treatment and safe risk management

#### Supporting Data:

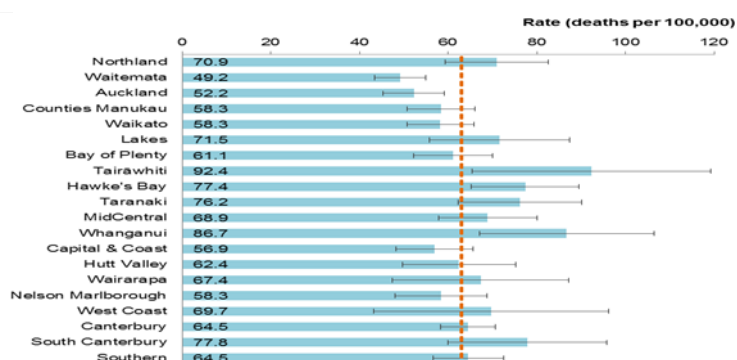
<http://www.health.govt.nz/publication/mortality-2013-online-tables>

**Figure 6: Major causes of death, ranked by age-standardised mortality rates, by gender, Māori and non-Māori, 2010-12**

	Males	Females
<b>Māori</b>	Ischaemic heart disease	Lung cancer
	Lung cancer	Ischaemic heart disease
	Suicide	Chronic obstructive pulmonary disease
	Diabetes	Cerebrovascular disease (stroke)
	Motor vehicle accidents	Diabetes
<b>Non-Māori</b>	Ischaemic heart disease	Ischaemic heart disease
	Suicide	Breast cancer
	Lung cancer	Cerebrovascular disease (stroke)
	Cerebrovascular disease (stroke)	Lung cancer
	Motor vehicle accidents	Colorectal cancer

**Figure 7: Mortality rates from ischaemic heart disease, by DHB region, total population, 2012**

<http://www.health.govt.nz/publication/mortality-and-demographic-data-2012>



Notes:  
The dashed vertical line is the national rate.  
Rates per 100,000 population, age-standardised to WHO World Standard Population; 99% confidence intervals.

#### Measures\*:

The regional measures for cardiovascular services are the same as the national indicators for DHBs. Work will be undertaken by the regional analytics team to attempt to receive data as below. Measures would be monitored for the Māori population comparative to the non-Māori population.

#### Primary Service KPIs

- Monitor the % of patients identified as having CVRA risk >15% who are on recall/ follow up by GP and have management as per clinical guidelines
- % of eligible population having CVRA (already being gathered)  
Indicator 1: 90% of the eligible population will have had their cardiovascular risk assessed in the last five years.  
Indicator 2: 90% of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the last five years.

#### Secondary Service SIRs

- Cardiac surgery: A target intervention rate of 6.5 per 10,000 of population. DHBs with rates of 6.5 per 10,000 or above in previous years are required to maintain this rate.
- Percutaneous revascularisation: 12.5 per 10,000 of population
- Coronary angiography: 34.7 per 10,000 of population.

#### Cardiac Surgery and Cardiology Waitlists and Timeframes

- Proportion of patients scored using the national cardiac surgery Clinical Priority Access (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.
- Patients wait no longer than four months for a cardiology first specialist assessment, or for cardiac surgery.
- Over 95% of patients undergoing cardiac surgery will have completion of Cardiac Surgery registry data collection within 30 days of discharge.

#### Acute Coronary Syndrome

- Have evidence based ACCP pathways that provide measures of ACS risk stratification and timeliness for patients to receive appropriate intervention.

- 70% of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') by ethnicity.
- 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.

\* by ethnicity, locality and deprivation where possible

Line of Sight
<ul style="list-style-type: none"> <li>• DHB Annual Plans: Please see section 2.2, Delivering on Priorities and Targets; 2.5.3 Cardiac Services and Module 7 Performance Measures PP20, PP29, SI4 SIRs, OS8 for Readmissions HF; 2B.1.1.2 Actions to deliver on Annual Plan Priorities; Long Term Conditions – Prevention, Identification and Management Cardiovascular Disease, System Integration Cardiac services; 5.4 Providing Health and Disability Services of Waikato, BOP, Taranaki, Lakes and Tairāwhiti DHBs.</li> <li>• Māori Health: Please see Appendix 1 Objective 1: Improve Māori Health Outcomes</li> <li>• Workforce: Please see Appendix 1 Objective 4 : Build the Workforce Section WF10, WF11</li> <li>• Regional IS: Please see Appendix 1 Objective 5 : Improve Clinical Information Systems - Service Transformation</li> </ul>

Initiative				Milestone/Date	Responsibility
<b>1. Embed the virtual regionally-integrated Midland Cardiac Service as business as usual between the five Midland DHB Cardiac Services. (People powered; Closer to home; High value and performance; Smart system; One team)</b> Regional agreement to deliver value and high performance across the Midland DHB region working as one virtual service. This will involve responding to population demand and aligning regional strategic, annual and daily planning and operations management. During this process opportunities for service improvements will be identified and addressed.  <b>Output / Deliverables</b>  1. Implement and continuously improve ACS forecasting 2. Implement and continuously improve a production planning process for the region based 3. Develop long term capacity modelling to determine what services will be required in the future to deliver equitable OP and IP access across the region and to inform resource and facility planning processes across the region 4. Agree on Standard Operating Procedures and Variance Response Management Plans (SOPs, VRMs) for Cardiac Services to provide agreement on how services will be managed and what responses will be used to manage daily demand variance.					Midland Regional Cardiac Planning Group, DHB Executives
				Q1 2016/17	
				Q2 2016/17	
				Q3 2016/17	
				Q4 2017/18	
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				Milestone/Date	Responsibility
<b>2. IHD</b> <b>A population with increasingly well managed risk factors and timely access to appropriate intervention leading to reduced presentation, readmission rates and mortality due to IHD (Care closer to home; One team; Smart system)</b> <div><div>1. National Expected Clinical Standards across the Midland Region – undertake a gap analysis</div><div>2. Develop a plan and proposals for addressing the gaps between the Midland DHBs individual performance and the National Expected Clinical Standards</div><div>3. Work with the Radiology Network to develop a briefing paper on a regionally integrated CTCA service</div><div>4. Secondary prevention and rehabilitation sub group to identify gaps across the region</div></div>				<div>Q1 2016/17</div> <div>Q2 2016/17</div> <div>Q3 2016/17</div> <div>Q4 2016/17</div>	MCCN, Midland DHB Cardiac Services
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				Milestone/Date	Responsibility
<b>3. Heart Failure Management – effective prevention, delay in onset and management of heart failure to improve quality of life for patients and to reduce acute presentations (Closer to home; One team; Smart system)</b> 1. Understand the burden of HF in the Midland region 2. Efficacy of management of heart failure 3. Assess timely access to treatment 4. Implement National Expected Clinical Standards and develop regional recommendations for future service needs				Q2 2016/17 Q3 2016/17 Q3 2016/17 Q4 2016/17	MCCN, Midland DHB Cardiac Services
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	Milestone/Date	Responsibility
<b>4. Regional IS/IT Projects</b> <ol style="list-style-type: none"> <li>1. Explore development of an outpatient coding system across the five DHBs - similar to the</li> </ol>	Q4 2016/17	MCCN, Midland DHB Cardiac Services

Bay of Plenty DHB paediatric system that is in place. 2. Design a Regional ACS Whiteboard Live Management Tool 3. eSPACE Service Transformation: Cardiology – inclusive of internal e-referrals, shared service data sets, electronic transfer of data between ANZACSQI and DHB CWS fields				Q4 2016/17 ongoing	
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

Key:

	<i>Actions are specifically aimed at achieving this objective</i>
	<i>Actions will achieve this objective but as an indirect consequence</i>

## 2.3 Elective services (Regional Elective Services Network)

**Lead Chief Executive:** Ron Dunham

**COO Lead:** Dale Oliff

**Clinical Lead:** Chief Medical Officer - Dr Martin Thomas

**Project Manager:** Jocelyn Carr

### Key Objectives:

- 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

### Measures\*:

#### Measures to show success annually:

- Increased number of procedures and 'first specialist assessments' (FSA) without compromising quality of care
- Reduced waiting times and maintenance of elective service performance indicator (ESPI) compliance
- Variation in Clinical Priority Access Criteria (CPAC) scoring thresholds are reducing once on nationally approved tools
- Increased number of consistent clinical 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)

#### Measures to show success over the next three years:

- Clinicians and management agree that data quality has improved
- Regional clinical networks can influence how funding is spent within their specialty areas
- 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 when appropriate and natural progression into these roles has been defined
- Data relating to patients being treated by regional services is better understood as are regional pathways that are available
- Regional clinical networks have sub-groups available for allied health and other clinicians to also share their own learning's with their fellow colleagues.

\* by ethnicity, locality, age and deprivation where possible

Line of Sight
<ul style="list-style-type: none"> <li>• <b>Waikato DHB DAP</b> – Improved Access to Elective Surgery (p78 &amp; 79)</li> <li>• <b>Taranaki DHB DAP</b> – Improved Access to Elective Surgery (p112 &amp; 113)</li> <li>• <b>Bay of Plenty DHB DAP</b> – Improved Access to Elective Surgery (p75)</li> <li>• <b>Lakes DHB DAP</b> – Improved Access to Elective Surgery (p131)</li> <li>• <b>Hauora Tairāwhiti DAP</b> – Improved Access to Elective Surgery (p109)</li> </ul>

Initiative	Milestone/Date	Responsibility
<b>1. Advance regional ENT</b> <ul style="list-style-type: none"> <li>• Regional electives tools are created to monitor aspects required of the regional ENT work program</li> <li>• Clinical procedures done for ENT regionally are understood and regional variation has been discussed and agreed as clinically acceptable or a process has been put in place to improve regional consistency</li> <li>• Develop consistent ENT Map of Medicine and clinical pathways, access criteria, and clinical protocols</li> <li>• Regional ENT workforce is understood and support structures in place to reduce risks of short staffing in smaller regional DHBs</li> <li>• Regional variation in CPAC scoring (using national scoring tools) has been reduced</li> </ul> <b>NZ Health Strategy strategic themes alignment:</b> Care closer to home; One team; High value and performance; Smart system	Q1 2016/17  Q3 2016/17  Q4 2016/17  Q4 2016/17  Q4 2016/17	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

Initiative				Milestone/Date	Responsibility
<b>2. Integration of electives information</b>					Project Manager
• Regional DHBs have an opportunity to use regional tools to maximise regional DHB capacity to aid in maintaining ESPI compliance				Q1 2016/17	
• Variations between treatments are known to the region and a forum is available to discuss variations.				Q1 2016/17	
• Regional tools maintain an age, gender and ethnicity lens to aid in reducing inequalities regionally				Q1 2016/17	
• Sustaining progress achieved through previously funded Elective Services Productivity and Workforce Programme (ESPWP) contracts.				Q1 2016/17	
• Central repository of current regional CPAC scores to create regional transparency				Q1 2016/17	
• Groups are regularly meeting to improve the quality of electives data and information/reduce variation building faith for smart systems				Q2 2016/17	
• CPAC scoring tools are being used to reduce variation in regional cases				Q2 2016/17	
• Establish and delivering regional MOU to facilitate cross-boundary service delivery				Q2 2016/17	
• Implementing sub-regional/regional referral management and scheduling systems				Q3 2016/17	
• Develop a regional delivery plan that supports achievement of:				Q4 2016/17	
<ul style="list-style-type: none"> <li>o local intervention rates</li> <li>o maximised regional capacity</li> <li>o optimal use of specialist resources and sub-specialist capability</li> <li>o increased access to less complex surgery</li> <li>o local Health Target Delivery matching demand with elective capacity.</li> </ul>					
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

Key:

	<i>Actions are specifically aimed at achieving this objective</i>
	<i>Actions will achieve this objective but as an indirect consequence</i>

## 2.4 Mental Health & Addictions (Regional Mental Health & Addictions Network)

**Chair:** Professor Graham Mellsop

**Regional Director:** Eseta Nonu-Reid

**Lead Chief Executive:** Ron Dunham

### Mental Health & Addiction Context<sup>5</sup>

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 seek opportunities to improve, for example with earlier and more effective responses, improved outcomes, better system integration and performance, increased access to services, effective and efficient use of resources and stronger whole-of-government partnerships.

Māori continue to have a different experience of a number of mental health and addiction issues (Oakley Browne et al 2006), such as inpatient admission, length of stay, seclusion and compulsory treatment (Ministry of Health 2012a) *clozapine use*, than other groups. In the context of an overall increase in demand, 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.

Some of these problems are structural, with funding and purchasing systems which allow or encourage the development of separate empires. 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 emerging evidence and cutting-edge practice. This plan allows the region to take incremental steps towards achieving these goals.

**Vision:** *“Improving Mental Health and Addiction with Integrated and Supported Systems”* underpinned by:

1. Quality services
2. Sector infrastructure
3. Integration and social inclusion
4. Workforce capacity and capability
5. Health system relationships and integration
6. Early detection and intervention focusing on recovery
7. Information Management

### Key Objectives:

- a) Leading regional mental health and addiction planning
- b) Leading regional service improvement
- c) Supporting the achievement of health targets and policy priorities
- d) Linking to national and regional governance structures and processes
- e) Leading and/or supporting the development of nationally consistent approaches to mental health and addiction
- f) Reducing inequalities in mental health and addiction outcomes
- g) 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.

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<sup>5</sup> Ministry of Health, 2012: Mental Health & Addiction Service Development Plan; *Rising to the Challenge*

Line of Sight
<ul style="list-style-type: none"> <li>DHB Annual Plans: 1.5.3.3; 2B.1.1.6 Lakes; 3.4.3, 2B.1.3.6, 2B.1.4.6 BOP; 2B.2.3, 2B.13, 4.4.1, 1.5.2, 1.8.3.3 Taranaki; 2.3.6, 2.3.4 Waikato; 1.3.10, 2.3.2, module 1, 1.1.5, 1.2.1, 1.2.3, 1.4.10, module 2 Tairāwhiti</li> <li>Workforce: Please see Appendix 1 of the 2016-19 Midland Regional Services Plan</li> <li>Regional IS: Please see Appendix 1 of the 2016-19 Midland Regional Services Plan</li> <li>Improve Māori health outcomes: Please see Appendix 1 of the 2016-19 Midland Regional Services Plan</li> </ul>

Initiative	Milestone/Date	Responsibility
1. Develop a plan to improve physical health outcomes of people with low prevalence disorders <ul style="list-style-type: none"> <li>Undertake a stocktake of Primary Mental Health initiatives across the Midland region that support clients with low prevalence disorders</li> <li>Develop an Integration paper in collaboration with Primary Mental Health to determine an agreed model of care focussing on whole-of-health needs</li> </ul>	Q2 2016/17 Q3 2016/17	Regional Director & Clinical Governance
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	Milestone/Date	Responsibility
2. Supporting Clinical Networks and Clinical Leadership - identify how the region is planning to work with clinical leaders to make better use of clinical networks to support improved clinical and financial sustainability of services <ul style="list-style-type: none"> <li>identify services within the region that may benefit from the development of a regional clinical network</li> <li>Regional strategic directions are discussed at MR CGN meetings and opinion provided</li> <li>MH&amp;A participates consistently in all strategic planning and decision making</li> </ul>	Q1 2016/17 ongoing Q1 2016/17 ongoing	Regional Director & Clinical Governance
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	Milestone/Date	Responsibility
3. Continued regional provision of eating disorder inpatient services (Midland and Northern regions to implement the recommendations from the service review to ensure sustainable inpatient and community services) <ul style="list-style-type: none"> <li>Midland ED supra-regional services adds value for investment by continuing to participate in the Supra-regional implementation of the Model of Care</li> <li>Planning for 2016/17 going forward is agreed by GMs P&amp;F and CEs</li> </ul>	Q4 2016/17 Q4 2016/17	Regional Director & Clinical Governance
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	Milestone/Date	Responsibility
4. Regional co-ordination and oversight of Infant Perinatal service delivery and models of care that support integrated responses to acute care including consult/liaison <ul style="list-style-type: none"> <li>Access to a broader range of options for mothers who are acutely unwell</li> <li>Specialist acute response that facilitates timely and integrated care</li> <li>Monitoring and evaluation of the individual services within the continuum and the continuum as a whole</li> <li>Continue to support the regional Infant Perinatal clinical network to support, connect and grow the expertise of the workforce</li> <li>Progress the Midland Acute Liaison Consultant access with the Northern Region</li> </ul>	Q1 2016/17 Q3 2016/17	Regional Director
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	Milestone/Date	Responsibility
5. Provide a preferred model of care for alcohol and other drug (AOD) withdrawal management service in the DHBs, that will also support the provision of services under the proposed Substance Addiction (Compulsory Assessment and Treatment) Bill to be implemented in 2016/17. <ul style="list-style-type: none"> <li>Continue to progress the Midland AOD Residential Continuum of Care project to ensure recommendations provide a regionally agreed way forward</li> <li>Implement the project recommendations and progress the change management</li> </ul>	Q1 2016/17 Q4 2016/17	Regional Director & Clinical Governance
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	Milestone/Date	Responsibility
6. Midland Mental Health & Addiction Clinical Workstation (CWS) integration <ul style="list-style-type: none"> <li>Continue to progress the Midland Clinical Workstation project in collaboration with regional and local IS</li> <li>Ensure that the Lakes DHB and Hauora Waikato DHB are supported with the implementation</li> </ul>	Q1 2016/17 ongoing Q4 2016/17 ongoing	Regional Clinical Workstation Coordinator

and change management					
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				Milestone/Date	Responsibility
7. Mental Health (Compulsory Assessment and Treatment) Act 1992: section 29 community treatment order. Reduce the rate of Māori on the Mental Health Act: section 29 community treatment orders relative to other ethnicities. <ul style="list-style-type: none"><li>• Monitor the number of people on a Compulsory Assessment and Treatment order and continue to present to Clinical Governance quarterly</li><li>• Complete a literature review and undertake a stocktake that identifies why clients continue to remain on a Section 29</li></ul>					Regional Director & Clinical Governance
				Q1 2016/17 ongoing	
				Q2 2016/17	
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				Milestone/Date	Responsibility
8. Improved Mental Health and Addiction Service capacity and capability for people with high and complex needs <ul style="list-style-type: none"><li>Collection and graphing of packages of care provided for people identified with high and complex needs disorders at a local level</li><li>Monitoring and collating admission data to the Waikato High and Complex Needs beds</li><li>Analysis of local data regionally at six monthly intervals for review by Clinical Governance</li></ul>				Q1 2016/17 ongoing  Q1 2016/17 onging Q1 2016/17 ongoing	
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

Key:

	<i>Actions are specifically aimed at achieving this objective</i>
	<i>Actions will achieve this objective but as an indirect consequence</i>



# Regional Clinical Action Groups

## 2.5 Child health (Child Health Action Group)

**Chair:** Dr David Graham

**Project Manager:** Kerry-Ann Adlam

**Lead Chief Executive:** Ron Dunham

### Context:

Over the next year 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. So that all New Zealanders live well, stay well, get well, we will be people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system (Update of the NZ Health Strategy 2015).

Goals for Child Health in the Midland region

- Achieve equity in child health outcomes in the Midland region
- Improve all child health outcomes in the Midland region
- Ensuring quality health services for all children
- Delivering effective and efficient care and services
- 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
- Support continuing work on Information Systems to support Child Health
- Consider and implement 'choosing wisely' approach
- Facilitate/promote regional Well Child/Tamariki Ora Quality Improvement initiatives
- Raise the profile of regionally-led child health improvement initiatives

How we will do this:

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

\* by ethnicity, locality and deprivation where possible

Line of Sight	
<ul style="list-style-type: none"> <li>Children's Action Plan</li> <li>Child Protection policies</li> <li>Reducing rheumatic fever</li> <li>Increased Immunisation</li> <li>He Korowai Oranga</li> <li>Maternal Smoking Cessation</li> <li>DHB Annual Plans:               <ul style="list-style-type: none"> <li>WDHB please see sections 2.3.2/2.3.5/2.4.1</li> <li>TDHB please see sections 28.2.2/28.2.5/28.2.7/28.2.9</li> <li>BOPDHB please see sections 28.1.3/28.1.3.2/28.1.3.5/28.1.4/28.1.4.1/28.1.4.2</li> <li>Lakes DHB please see sections 1.5.1.2/1.5.2.1/2B1.1.2/2B.1.1.5/2B1.2.2</li> <li>TDH please see sections 1.3.2/1.3.3/1.3.4/1.3.5/1.3.6/2.3/2.3.3</li> </ul> </li> <li>Māori Health: Please see Appendix 1 Objective 1: Improve Māori Health Outcomes; Māori Health Plans: indicators 10, 12, 13, 15</li> <li>Workforce: Please see Appendix 1 Objective 4 : Build the Workforce Section WF10, WF11</li> <li>Regional IS: Please see Appendix 1 Objective 5 : Improve Clinical Information Systems - Service Transformation</li> </ul>	<ul style="list-style-type: none"> <li>Improving quality for child health services</li> <li>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 <a href="http://www.parliament.nz/en-nz/pb/sc/business-summary/00DBSCH_INQ_11221_1/inquiry-into-improving-child-health-outcomes-and-preventing">http://www.parliament.nz/en-nz/pb/sc/business-summary/00DBSCH_INQ_11221_1/inquiry-into-improving-child-health-outcomes-and-preventing</a></li> <li>Implementation of immunisation for gastroenteritis in primary health care from 1 July 2014</li> </ul>

Initiative	Milestone/Date	Responsibility
<p><b>1. Wellness and disease prevention</b></p> <p><b>NZ Health Strategy strategic themes alignment:</b> Close to home, value and high performance, one team, smart system</p> <p>CHAG will focus on activities that have a wellness and disease prevention focus for children in the Midland region. This focus will also include decreasing the acute and chronic burden of disease for tamariki Māori, children living in poverty and other populations suffering a disproportionate burden of disease. For 2016/2017 this will include <b>childhood obesity and oral health</b>. We will:</p> <ul style="list-style-type: none"> <li>Develop a concise regional framework to address childhood obesity and oral health including key service components for prevention, screening/surveillance, and treatment. (This will include regional agreement on key issues affecting childhood obesity and approaches to decrease childhood obesity).</li> <li>Develop a dashboard of outputs and outcomes for monitoring childhood obesity rates and oral health status (including clear discussion of the met and unmet opportunistic care needs) utilising the results based accountability framework of; how much did we do, how well did we do, is anyone better off? This will also include regional development of standardised tools and processes for local implementation to meet the ministerial B4 school check target and standardised oral health reporting specifically by equity.</li> <li>Support the Midland Maternity Action Group to help improve ideal maternal weight and pregnancy weight gain, increased breastfeeding rates and decreased smoking rates during pregnancy.</li> <li>Develop a regional resource of useful tools, models of care, outstanding initiatives and links to relevant information for clinicians and the wider workforce to utilise.</li> <li>Develop an advocacy strategy and action plan to assist local health and government leadership to decrease sugar sweetened beverage (SSB) consumption in children (submissions, activities, actions regarding prevention of SSB consumption, obesogenic environment, equity).</li> </ul> <p><b>Rationale (why does this matter?):</b></p> <p>NZ has one of the highest rates of childhood obesity in the OECD – it is well known that obesity is a contributor to a range of chronic conditions including, diabetes, metabolic syndrome, cardiovascular diseases etc and a major contributor to obesity and tooth decay is the high consumption of sugar sweetened beverages.</p> <p><b>Outputs (what you will see at June 2017):</b></p> <ul style="list-style-type: none"> <li>A concise regional strategy to tackle childhood obesity and oral health including key service components for prevention, screening/surveillance, and treatment.</li> <li>A dashboard of outputs and outcomes related to oral health and obesity across the spectrum of care (prevention, diagnosis, management, secondary prevention, maintenance) linked with current activities utilising the results based accountability framework of; how much did we do, how well did we do, is anyone better off? Also regional development of standardised tools and processes, for local implementation to meet the ministerial B4 school target. A standardised oral health report by equity.</li> <li>A regional resource toolbox (including web based) with best practice resources and information available to clinicians and others working in the childhood obesity and oral health space.</li> <li>An advocacy strategy and action plan to decrease SSB consumption in the region by children.</li> </ul>	<p>Q3 2016/2017</p> <p>Q4 2016/2017</p> <p>Q4 2016/2017</p> <p>Q3 2016/2017</p>	<p>Project Manager</p>

1: Improve Māori health outcomes	2: Systems integration across continuum of care	3: Improve quality across all regional services	4: To build the workforce	5: Improve clinical information systems	6: Best value for public health systems resources
Initiative				Milestone/Date	Responsibility
<b>2. Harti Hauora programme</b> <b>NZ Health Strategy strategic themes alignment:</b> Closer to home, value and high performance, one team CHAG will support the wider implementation of the <b>Harti Hauora programme</b> into other Midland DHBs. We will also support developing the tool for use in the wider sector e.g. Plunket, primary care services. This support will include redevelopment and testing of the tool to utilise in all DHBs, validation and evaluation of the tool in Midland paediatric secondary services initially and then work with the wider sector to implement it more broadly (Plunket, WCTO services, primary and community care).  The Harti Hauora programme was developed because of the inequities that exist in access, timeliness, and quality of health care between ethnic and socioeconomic groups. The Harti Hauora programme came into being in 2015 in WDHB, as a way to help improve the health and wellness of Māori and other at risk children and meet standards set by the Ministry of Health. The tool assesses the child's risks in the following areas: <ul style="list-style-type: none"> <li>• Enrolments and Entitlements – General Practitioner, Well Child/Tamariki Ora (WCTO), Oral health, B4 School check, early childhood education (ECE)</li> <li>• Health Protection – Immunisation status, household smoking exposure, breastfeeding, housing, safe sleep, Car Safety, Shaken Baby, Family Violence Screening</li> <li>• General Health – frequent hospital admissions, BMI/healthy weight, sore throat</li> </ul> <b>Rationale (why does this matter?):</b> <ul style="list-style-type: none"> <li>• Children are missing out on key health milestone checks leading to chronic illness, higher hospitalisation rates and poorer long term health outcomes</li> <li>• Hospitalised children are more at risk of missing out on key health milestone checks</li> <li>• Hospitalisation and/or accessing any child health service provides a useful opportunity to opportunistically screen, intervene and provide follow up packages of care for at risk children</li> </ul> <b>Outputs (what you will see at June 2017):</b> <ul style="list-style-type: none"> <li>• The current Harti Hauora tool will be assessed and enhanced where required for successful integration in paediatric secondary services across the region.</li> <li>• The Harti Hauora tool will be trialled in all Midland paediatric secondary services.</li> <li>• Work will be underway to integrate the current Harti Hauora tool with community based child health services and determine enhancements required of the tool.</li> </ul>				Q2 2016/2017  Q4 2016/2017  Q4 2016/2017	Project Manager
1: Improve Māori health outcomes	2: Systems integration across continuum of care	3: Improve quality across all regional services	4: To build the workforce	5: Improve clinical information systems	6: Best value for public health systems resources
Initiative				Milestone/Date	Responsibility
<b>3. Pathways of care</b> <b>NZ Health Strategy strategic themes alignment:</b> Closer to home, value and high performance, one team) The Child Health Action Group will continue to lead and support work to identify, establish and implement agreed pathways through Map of Medicine. <b>2016/2017 will focus on the management of elimination disorders.</b>  <b>Rationale (why does this matter?):</b> Elimination disorders and in particular childhood constipation is a common health problem around the world affecting up to 29.6% of children. Local clinical experience supports the view that there is a high rate of constipation in children across the region. There is a need to ensure consistent and timely treatment of elimination disorders across the health sector to avoid unnecessary admissions to secondary services.  <b>Outputs (what you will see at June 2017):</b> <ul style="list-style-type: none"> <li>• A completed map of medicine for childhood elimination disorders ready for publishing.</li> </ul>				Q4 2016/2017	Project Manager
1: Improve Māori health outcomes	2: Systems integration across continuum of care	3: Improve quality across all regional services	4: To build the workforce	5: Improve clinical information systems	6: Best value for public health systems resources
Initiative				Milestone/Date	Responsibility
<b>4. Paediatric outpatient coding</b> <b>NZ Health Strategy strategic themes alignment:</b> Closer to home, value and high performance, one team, smart system) We will support a paediatric outpatient coding IT system across the remaining three DHBs- similar to the BOPDHB and WDHB systems in place. Paediatric outpatient coding and electronic growth charts are now being implemented and validated in both WDHB and BOPDHB – CHAG will explore the potential implementation across the remaining DHBs.					Project Manager

<b>Rationale (why does this matter?):</b> There is a need to be able to identify priority conditions and develop pathways of care to ensure consistent practice occurs both locally and regionally. We need to be able to identify changing patterns of referral locally and regionally, identify priorities and health need for youth transitioning into adult services locally and regionally identify capacity against need across the health sector workforce for primary, nursing, paediatricians and allied workforces. We want to be able to provide visibility of referral trends and resources used in outpatient setting for primary/community organisations locally and regionally, to be able to quantify what paediatricians do individually and as a department, and then make data and evidence-based decisions as a service. Without this we were essentially 'flying blind' and relying on anecdote to explain what each of the services provide across the Midland region Finally to identify and eliminate "postcoding" across the region and find where there is unmet need.					
<b>Outputs (what you will see at June 2017):</b> <ul style="list-style-type: none"> <li>• Review of BOPDHB and WDHb systems and outcomes and fit for purpose.</li> <li>• Consider broader implementation of web based paediatric outpatient coding and electronic growth chart in the remaining three Midland DHBs.</li> </ul>				Q2 2016/2017	
				Q4 2016/2017	
1: Improve Māori health outcomes	2: Systems integration across continuum of care	3: Improve quality across all regional services	4: To build the workforce	5: Improve clinical information systems	6: Best value for public health systems resources

Key:

	<i>Actions are specifically aimed at achieving this objective</i>
	<i>Actions will achieve this objective but as an indirect consequence</i>

## 2.6 Health of older people (Health of Older People Action Group)

**Chair:** Dr Phil Wood, Geriatrician

**Project Manager:** TBA

**Lead Chief Executive:** TBC

**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:

- Keeping older people well and independent
- Reducing hospital admissions and rates of long-term residential care
- Providing timely and coordinated services for people with complex needs living in the community
- Reducing inequalities in health outcomes for Māori
- 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 allow the region to better understand its resources and older population.
- Promote organised systems of care
- Collaboration on regional dementia care
- Support continuing work on technological developments which support services

### Measures\*:

#### Measures to show success annually:

- Dementia care is better understood regionally and patient information is available to inform regional discussions where appropriate
- InterRAI data is available to review regionally
- Each Midland DHB is utilising advance care planning or monitoring regional activity
- Reports will be generated identifying frail elderly and they are better understood as a population group
- A reducing trend in falls and fractures regionally

#### Measures to show success over the next three years:

- Regional consistency is able to be monitored and care has improved
- Additional regional standard pathways of care have been developed
- interRAI is able to be used in decision making and clinicians/management agree that desired information is more freely available and data quality has improved
- Data relating to patients being treated by regional services is better understood as are regional pathways that are available

\* by ethnicity, locality and deprivation where possible

Line of Sight
<ul style="list-style-type: none"> <li>• <i>DHB Annual Plans: Please see section 2B.1.5.4 (pg 68-70) Bay of Plenty, 2B.1.3.4 (pg 117-120) Lakes, 2.3 (pg 101-105) Tairāwhiti, 2B.2.17 (pg 94-98) Taranaki and section 2.5.4 (pg 68-70) Waikato.</i></li> </ul>

Initiative	Milestone/Date	Responsibility
<b>1. Continue to improve regional pathways and care around cognitive impairment (dementia and delirium):</b> <ul style="list-style-type: none"> <li>• Provide DHBs with ongoing support and overview so that DHBs identify and strengthen components of dementia care pathways within the parameters of the <a href="#">New Zealand Framework for Dementia Care</a>.</li> <li>• Support regional DHBs with analytics around patients diagnosed with dementia and/or delirium to better inform clinical discussions <ul style="list-style-type: none"> <li>○ Establish baselines with an aim of 10% improvement P/A on agreed metrics</li> <li>○ Numbers of patients presenting to hospital regionally with dementia and/or delirium are able to be identified and discussed with clinicians</li> <li>○ Clinicians are using information provided regionally to continue to inform and develop education pathways</li> </ul> </li> <li>• Complete an analysis of the current state of educational programmes and support groups to support family/whānau carers in operation in the region <ul style="list-style-type: none"> <li>○ Monitor regional education provided by the region's DHBs to Aged Residential Care (ARC), GP and other services</li> </ul> </li> <li>• Regional activity that supports DHBs to build a regional response to reduce variability of education and support programmes available to support family/whānau carers and people living with dementia and/or delirium.</li> </ul>	Q1 2016/17 + ongoing  Q2 2016/17  Q1 2016/17  Q4 2016/17  Q3 2016/17  Q4 2016/17 + ongoing  Quarterly  Q2 2016/17 + ongoing	Project Manager HOP Dementia and Delirium sub groups HSL Analytics
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				Milestone/Date	Responsibility
<b>2. Regional InterRAI</b> <ul style="list-style-type: none"> <li>Regional interRAI information is being collected and presented to the region for initial review</li> <li>Proactively monitor and share interRAI population and service data across the continuum (ie, with workers who offer community services, primary and secondary care clinicians – quarterly) and influence service improvements.</li> <li>Initial regionally consistent reports are available to providers on key interRAI metrics where deemed appropriate by regional DHBs</li> <li>InterRAI information is used to better understand regional populations and improve equity of access</li> <li>Utilise data to inform business case(s)</li> <li>Dashboard developed to enable visibility in all points of care</li> </ul>				Q1 2016/17 Q2 2016/17 + ongoing Q3 2016/17 + ongoing Q4 2016/17 + ongoing Q4 2016/17 + ongoing Q4 2016/17	Project Manager HSL Analytics DHB Portfolio Managers HOP
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				Milestone/Date	Responsibility
<b>3. The Midland region continues to improve Advance Care Planning (ACP)</b> <ul style="list-style-type: none"> <li>Midland DHBs to deliver e-learning management platform to enable access of Midland staff to ACP level 1 training</li> <li>Midland regional governance group to look at tactical delivery of resource as best possible for the Midland region               <ul style="list-style-type: none"> <li>Clarification of co-ordination regionally on ACP</li> <li>Identification of funding streams where appropriate</li> </ul> </li> <li>Midland DHBs to socialise ACP through level one training</li> <li>A regionally consistent approach for ACP is approved</li> <li>Initiatives around ACP are co-ordinated and known by relevant stakeholder</li> </ul>				Q1 2016/17 Q1 2016/17 Q2 2016/17 Q2 2016/17 Q3 2016/17 Q3 2016/17 Q4 2016/17	Project Manager Workforce HWNZ RDOWD GMs HR HOP and sub groups Quality & Risk
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				Milestone/Date	Responsibility
<b>4. Frail elderly in the community setting are better understood as a population, with an initial focus on falls prevention</b> <ul style="list-style-type: none"> <li>Clinical governance approval with a PHO for work to develop frailty triggers in a GP setting.</li> <li>Academic leaders and practitioners inform the analysis to be modelled – including outcome measures, methodology etc.</li> <li>Access available data (in sustainable ways).</li> <li>Use analysts and software tools on current projects/initiatives.</li> <li>Present examples to DHB regional and local groups – clinicians, managers – and across the continuum of service setting</li> <li>Frailty triggers prototyped are established and tested with a second PHO</li> <li>Results are used to inform future planning</li> </ul>				Q1 2016/17 Q1 2016/17 Q2 2016/17 Q3 2016/17 Q3 2016/17 Q4 2016/17 Q4 2016/17	Project Manager HSL Analytics
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

Key:

	<i>Actions are specifically aimed at achieving this objective</i>
	<i>Actions will achieve this objective but as an indirect consequence</i>

## 2.7 Maternity services (Midland Maternity Action Group)

**Chair:** Corli Roodt (Associate Director of Midwifery, Waikato DHB)

**Project Manager:** Suzanne Andrew

**Lead Chief Executive:** TBC

### Key objectives:

- **People powered** – designing people-led maternity service delivery in partnership with consumers
- **Closer to home** – living well in healthy communities, with increased support to pregnant and postnatal women experiencing mental health and alcohol and other drug conditions. Promoting healthy nutrition and activity for pregnant women to reduce the prevalence of adult and childhood obesity. Promoting all birthing options in their local facilities.
- **Value and high performance** – building leaders and capability for the future. Also building a high performing system that promotes health and wellbeing, including pae ora (healthy futures), early intervention, and streamlined care across the settings (primary care, secondary and tertiary services). Fostering and spreading innovation and quality improvements to support equity and efficiency (systems focus)
- **One team** – Midland DHB maternity services working within the MoH's Maternity Quality & Safety Programme to support information sharing and learning, and monitoring performance and variance of the Midland DHBs maternity related data
- **Smart system** – best use of technology and information - improving coordination and expanded delivery of information to support consumer self-management in health through the use of digital solutions, including implementation of the National Maternity Information System Platform (MISP) and *BreastFedNZ* app.

### National MoH measures MMAG is working towards:

- **Breastfeeding**  
Targets: 75% at 6 weeks (full or exclusive); 60% at 3 months (full or exclusive); 65% at 6 months (receiving breast milk)
- **Smokefree pregnancies**  
Target: 90 % of pregnant women (who identify as smokers at confirmation of pregnancy in general practice or booking with a Lead Maternity Carer) will be offered advice and support to quit smoking. Capturing and improving the rates of smoke free at two weeks postnatal.
- **Sudden Unexpected Death in Infancy (SUDI)**  
Target: 0.4 SUDI deaths per 1000 Māori live births. This is the five year rate achieved by non- Māori (95%CI 0.34-0.52) (ref Mortality Data Group, Ministry of Health Well Child Tamariki Ora reporting data)
- **Maternal mental health, including alcohol and drug addictions**  
Increase support to pregnant and postnatal women experiencing mental health conditions, including alcohol and drug addictions (ref. a-j of '1.Perinatal mortality' in the PMMRC Ninth Report 2015).
- **Healthy weight gain in pregnancy / management of bariatric pregnant women**  
Promote healthy weight gain in pregnancy, healthy behaviours and self-management as the MoH shares best practices and identify, publicise and spread examples of innovation that demonstrate improved equity of health outcomes, efficiency, quality and safety, and reduction of harm. Work in partnership with Midland Health Promotion Units to reduce maternal obesity locally.
- **Primary and rural birthing options for women in their local facilities**  
Strengthening maternity services for women who reside in rural areas, including more timely access and more equitable access to community based primary care and services.

### Line of Sight

- National Maternity Monitoring Group 2015/16 Work Programme
- Māori Health Plan template 2016/17: page 5 – child health (breastfeeding), page 8 – smoking cessation: percentage of pregnant Māori women who are smoke free at two weeks postnatal, and page 12 – Sudden Unexpected Death in Infancy (SUDI) – actions required from the Midland DHBs on Māori SUDI rates
- 'Maternal and Child Health Promotion Service Review Consultation Document', MoH (December 2015)
- DHB Annual Plans: minimal reference due to MoH requiring separate annual reporting through the Maternity Quality & Safety Programme
- Waikato DHB DAP - Better Help for Smokers to Quit – smoking during pregnancy (pp16, 54-55, 89, 136); breastfeeding (p89)
- Taranaki DHB DAP - Better Help for Smokers to Quit – smoking during pregnancy (p47, 76, 78, 108, 138, 191); Early enrolment with an LMC (p50); WCTO collaboration (p62); regional linkages (p63, 64, 67); National Maternity Information System Platform (p122)
- Bay of Plenty DHB DAP - Better Help for Smokers to Quit – smoking during pregnancy (p22, 60-62, 87); National Maternity Information System Platform (p77, 107)
- Lakes DHB DAP - Better Help for Smokers to Quit – smoking during pregnancy (pp33, 92-93, 159); newborn enrolment (p68); National Maternity Information System Platform (p, 141, 208); maternity services remodeling (p226)
- Hauora Tairāwhiti DAP - Better Help for Smokers to Quit – smoking during pregnancy (p28, 76-78, 128, 169), increased immunisation (p58); National Maternity Information System Platform (p120, 145)
- DHB Public Health Unit Plans: activities will be informed by evaluation and learning from existing initiatives across Midland region.



Initiative				Milestone/Date	Responsibility
<p><b>Develop a Midland Breastfeeding Framework to inform and prioritise breastfeeding initiatives in the Midland region</b></p> <p>The framework will include:</p> <ul style="list-style-type: none"> <li>an overview of literature</li> <li>New Zealand and Midland research findings</li> <li>quantitative breastfeeding data</li> <li>qualitative feedback from Midland's women and maternity and WCTO health care providers (focus groups, semi-formal interviews, surveys)</li> <li>learning from existing breastfeeding activity within DHBs of the Midland region</li> </ul> <p>The framework will influence the following key overarching themes for breastfeeding in the Midland region that:</p> <ul style="list-style-type: none"> <li>supports, protects and celebrates breastfeeding in the community</li> <li>provides quality support services for women to overcome breastfeeding challenges</li> <li>has maternity and community services that follow best practice breastfeeding standards</li> </ul> <p><b>Key themes will be underpinned by specific priorities and can add value to the current and future work plans, and also support information sharing and learning across DHBs in the Midland region.</b> The framework may be of interest to anyone working directly or have an influence on services provided for young children, women through pregnancy and families.</p>				<p><b>*key MMAG output</b></p> <p>Q1-Q4 2016/17</p>	<p>MMAG; Midland Population/Public Health Units; Midland Māori Health Services; CHAG; Midland DHBs</p>
<p><b>Midland Breastfeeding App – BreastFedNZ – 10,000 downloads of the App is achieved (currently at 4,500)</b></p> <ul style="list-style-type: none"> <li>Interest in the App content is maintained               <ul style="list-style-type: none"> <li>social media management continues</li> <li>Midland breastfeeding friendly accredited spaces added</li> <li>WCTO and pregnancy and parenting service providers added</li> <li>issues and barriers to breastfeeding identified in focus groups of Midland breastfeeding framework are addressed, where applicable</li> </ul> </li> <li>Post-implementation               <ul style="list-style-type: none"> <li>evaluation of effectiveness and uptake (12 month mark: September 2016)</li> <li>content is reviewed against topics of smoke free pregnancies, safe sleeping, mental health messages, alcohol and drugs, maternal nutrition, immunisation, etc</li> <li>increased visibility of Māori breastfeeding women, partner and whanau support in app, website, and resources</li> </ul> </li> <li>Implement the 'Midland Use of Donor Breastmilk Protocol'</li> </ul>				<p>Q1-Q4 2016/17</p>	
<p><b>NZ Health Strategy strategic themes alignment:</b> people-powered, closer to home, value and high performance, one team, smart system</p>				<p>Q2 2016/17</p>	
1: Improve Māori health outcomes	2: Systems integration across continuum of care	3: Improve quality across all regional services	4: To build the workforce	5: Improve clinical information systems	6: Best value for public health systems resources



Initiative				Milestone/Date	Responsibility
<b>Maternal mental health, including alcohol and drug addictions</b> <ul style="list-style-type: none"> <li>Support training opportunities in Midland for perinatal anxiety and depression workshops across maternity and WCTO providers.</li> <li>Share information, resources, and screening tools to help identify women with modifiable risk factors for perinatal related death, and identify areas where MMAG can work collectively to address these (PMMRC 9<sup>th</sup> Report 2015, recommendation 1).</li> </ul> <b>NZ Health Strategy strategic themes alignment:</b> people-powered, closer to home, value and high performance, one team, smart system				Q2 2016/17  Q2 2016/17	MMAG; Midland Māori Health Services; Public Health Units Midland DHBs
1: Improve Māori health outcomes	2: Systems integration across continuum of care	3: Improve quality across all regional services	4: To build the workforce	5: Improve clinical information systems	6: Best value for public health systems resource
Initiative				Milestone/Date	Responsibility
<b>Healthy weight gain in pregnancy /management of the bariatric pregnant woman</b> <ul style="list-style-type: none"> <li>Ongoing implementation of the MoH childhood obesity package, namely initiatives 4, 6 and 7: <ul style="list-style-type: none"> <li>guidance for healthy weight gain in pregnancy,</li> <li>gestational diabetes guidelines, and</li> <li>referral pathways to Green Prescriptions for pregnant women (at risk of gestational diabetes) for LMCs to access via DHB Map of Medicine/Bay Navigator tools</li> </ul> </li> <li>Implement the 'Midland Management of the Bariatric Pregnant Woman Protocol'</li> </ul> <b>NZ Health Strategy strategic themes alignment:</b> people-powered, closer to home, value and high performance, one team, smart system				Q1-Q4 2016/17  Q1 2016/17	MMAG; CHAG; Midland Māori Health Services; Public Health Units Midland DHBs
1: Improve Māori health outcomes	2: Systems integration across continuum of care	3: Improve quality across all regional services	4: To build the workforce	5: Improve clinical information systems	6: Best value for public health systems resources
Initiative				Milestone/Date	Responsibility
<b>Primary and rural birthing for women in the Midland region</b> <ul style="list-style-type: none"> <li>Share resources on how to reduce risks and interventions</li> <li>Review findings of Wintec research project on the experiences of women and LMC using primary facilities in the Waikato to identify learnings across Midland.</li> </ul> <b>NZ Health Strategy strategic themes alignment:</b> people-powered, closer to home, value and high performance, one team, smart system				Q1 2016/17 Q3 2016/17	MMAG; Midland Māori Health Services; Public Health Units; Midland DHBs
1: Improve Māori health outcomes	2: Systems integration across continuum of care	3: Improve quality across all regional services	4: To build the workforce	5: Improve clinical information systems	6: Best value for public health systems resources
Initiative				Milestone/Date	Responsibility
<b>Coding in Midland maternity services</b> <ul style="list-style-type: none"> <li>Explore coding issues across Midland maternity services and work with DHB coders to find a resolution to support improved quality in the reporting of maternity data</li> </ul> <b>NZ Health Strategy strategic themes alignment:</b> value and high performance, smart system				Q1 2016/17	MMAG; Midland DHBs
1: Improve Māori health outcomes	2: Systems integration across continuum of care	3: Improve quality across all regional services	4: To build the workforce	5: Improve clinical information systems	6: Best value for public health systems resources

Key:

	<i>Actions are specifically aimed at achieving this objective</i>
	<i>Actions will achieve this objective but as an indirect consequence</i>

## 2.8 Radiology services (Midland Radiology Action Group)

**Chair and Clinical Lead:** Dr Alina Leigh – Taranaki DHB  
**Lead Chief Executive:** TBC

**Project Manager:** Philippa Edwards

### Context:

The five Midland DHB Radiology Departments work together to share education, information and images regionally and MRAG provides the opportunity for the departments to work on initiatives of a regional nature. MRAG is a resource for the Midland DHBs to provide connectivity between hospital service delivery design and the diagnostic services to support these. MRAG reps attend the National Radiology Action Group (NRAG) meetings quarterly informing radiology conversations at a national level.

Midland DHBs face challenges due to increasing demand, inequitable access, and the sustainability and affordability of services within a financially constrained landscape. Radiology departments are a support service and need to be responsive to DHBs meeting national priorities, targets and the implementation of new service delivery models and pathways. They have the challenge of responding nimbly within a costly equipment based environment and where there are often challenges due to emerging technologies faster than the workforce and skill base.

To be responsive MRAG will pursue radiology participation earlier in the development of clinical pathways and service delivery models.

### Key Objectives:

1. Wellness is a key theme in 2016-19 RSP, using the Pae Ora framework.
2. Aligning with the 5 strategic themes of the NZ Health Strategy
  - **People powered** – people led service design for high need populations with a particular focus on Cancer Pathways and Timelines
  - **Closer to Home** – ensure equitable access criteria that is clinically and financially sustainable and delivered as close to home as is feasible
  - **Value and high performance** – wait time indicators will be used for all modalities and referrers across the region
  - **One Team** – a focus on best practice will be enabled with the implementation of national access criteria based on clinical need. Capability stocktakes across the region will identify where current and potential capacity and bottlenecks exist, enabling a regional approach to capital investment
  - **Smart System** - working with the regional IS e-space team to inform development of e-referrals, data repositories and links to other radiology provider studies performed information. A data informed regional approach to determine the opportunities that exist to meet service demands i.e. CT Colonography, CT Coronary Angiography, MRI Multiple Sclerosis, vascular and interventional access around the region. Working with MOH on National Patient Flow data collection.

### Planned Outcomes for 16/17:

The MRAG work program for 2016/17 initiatives provide for tangible value while also providing a leadership and monitoring role.

In 2016/17 tangible outcomes from the 4 initiatives will be:

1. CT pipeline model - a regional pipeline model for the CT modality to provide DHBs a regional and local understanding of volumes and sources of demand. To support meeting future demand i.e. CTC, CTCA
2. US workforce – a proposal to CEs on the Sonographer workforce shortage with a gap analysis and solutions to home grow Sonographers as an effective option to minimise the workforce shortage within the Midland Region
3. Cancer Streams/Pathways – involvement to improve the value proposition and performance delivered by working closely with the Cancer Network and other services, on their referral criteria, timeliness required, pathway development and the Choosing Wisely methodology
4. Work closely with regional and national initiatives with links to Radiology Services - Clinical access criteria with reference to local pathways, CWS, referral projects, shared RIS links and access, the viability of a virtual regional CTCA service etc.

Additionally leadership, monitoring and benchmarking will be provided for :

- Midland DHB performance against MOH timeline KPIs for CT, CTC and MRI
- Sharing of service improvement initiatives within the 5 Midland DHB Radiology departments to build on the training and momentum provide to date by the MOH

### Measures\*:

1. Ministry of Health CT, MRI, CTC measures and indicators
2. CT– 95% of accepted referrals for CT scans will receive their scan within six weeks (42 days)
3. CT Colonoscopy (Subset of CT) – 95% of accepted referrals for CT Colonoscopy will receive their scan within six weeks (42 days)
4. CT Angiography (Subset of CT) – 95% of accepted referrals for CT Angiography will receive their scan within six weeks (42 days)
5. MRI - 85% of accepted referrals for MRI scans will receive their scan within six weeks (42 days)
6. Agreed National Patient Flow system changes are implemented
7. Representation, attendance and participation in national and regional clinical group activities.

\* by ethnicity, locality and deprivation where possible

Line of Sight
<ul style="list-style-type: none"> <li>DHB Annual Plans: Please see section 2.2, Delivering on Priorities and Targets – Improved Access to Diagnostics under System Integration; 2.5.3 Cardiac Services and Module 7 Performance Measures PP29 –Improved Waiting Times for Diagnostic Services; 5.4 .2 Providing Health and Disability Services ; 2B.1.1.3.9 Sustainable and efficient elective services with improved access to diagnostic’s, of Waikato, BOP, Taranaki, Lakes and Tairāwhiti DHBs.</li> <li>Māori Health: Please see Appendix 1 Objective 1: Improve Māori Health Outcomes</li> <li>Workforce: Please see Appendix 1 Objective 4 : Build the Workforce Section WF3, WF11</li> <li>Regional IS: Please see Appendix 1 Objective 5 : Improve Clinical Information Systems - Service Transformation</li> <li>Midland regional Cancer Network: Please see Section 1.1</li> </ul>

Initiative				Milestone/Date	Responsibility
<b>1. Demand – capacity modelling to respond to national priorities – begin with a CT pipeline model</b> Pipeline modelling will enable advance resource preparation for new and increased demand. It will identify regional capacity opportunities to inform decisions on how to most effectively support achievement of National Priorities and changes in service delivery models including: CT Colonography, CT Coronary Angiograms <ul style="list-style-type: none"><li>Gather CT data on volumes and demand on resources</li><li>Investigate models used by other DHBs i.e. Waikato Hospital and Canterbury DHB models</li></ul>				Q1 2016/17 Q2 2016/17	MRAG, HSL Analytics
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				Milestone/Date	Responsibility
<b>2. Ultrasonography workforce sustainability</b> Evaluate the number of trainee positions across the region to home grow the future Sonographer workforce <ul style="list-style-type: none"><li>Write a proposal for the Midland DHB executives with recommendations on how to ensure there are sufficient trainee positions to support the future Sonographer workforce model.</li></ul>				Q2 2016/17	MRAG
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				Milestone/Date	Responsibility
<b>3. Involvement in cancer streams/pathways at a regional level to reduce delays in patient flows</b> <ul style="list-style-type: none"><li>Access cancer pathway data to inform where radiology needs to improve its timeliness of service delivery</li><li>Be actively involved in the local implementation of the cancer stream work</li><li>Support achievement of the cancer pathways through providing high quality data and analytics to DHB executives and decision makers on the resource required by the DHB to achieve them</li></ul>				Q1 2016/17	MRAG, Cancer Network, HSL Analytics
				Q2 2016/17	
				Q4 2016/17	
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				Milestone/Date	Responsibility
<b>4. National and Local Initiatives</b> <ul style="list-style-type: none"><li>Work with the MOH, Radiology College and the National Radiology Action Group (NRAG) as a conduit of information and actions on national topics i.e. Choosing Wisely, National Patient Flow implementation.</li><li>Updated to align National Criteria with local clinical access criteria to the pathways and through early involvement and strong working relationships to support funding decisions by Funding and Planning</li><li>Work with DHB and Regional IS and IT teams to ensure appropriate and effective functionality of the regional CWS, e-referral and PACS systems including image transfer</li><li>Work with the Cardiac Network to develop a briefing paper on a regionally integrated CTCA service</li></ul>				ongoing quarterly  ongoing as criteria change  ongoing as per eSPACE Q4 2016/17	MRAG, Cardiac Network, Regional IS/IT, Orion
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

Key:

	<i>Actions are specifically aimed at achieving this objective</i>
	<i>Actions will achieve this objective but as an indirect consequence</i>

## 2.9 Midland Trauma System (MTS)

**Chair:** Dr Grant Christey, Clinical Director

**MTS Programme Manager:** Alaina Campbell

**Project Manager:** Suzanne Andrew

**Lead Chief Executive:** Dr Nigel Murray



### Context

Trauma continues to have a major impact on Midland communities, resulting in 5980 admissions in 2014 and 23,839 hospital bed days. The cost of this to the hospitals alone is estimated at over \$43m – the intangible cost to patients and families is enormous. After 5 years of sustained clinical effort, data collection, and data platform building, MTS is now entering its output phase wherein we can use our clinical network and the information we have gathered to reduce the burden of trauma on the community, both in prevention, and in improving our responses at the point where prevention fails.

### Key principles: *Patients come first*

- ensuring highest quality trauma care
- focused on patient needs
- promoting collaboration between all trauma care providers

### Key regional objectives for 2015-17:

- Enhanced data entry and access by DHBs using online tools to identify clinical and system issues
- Midland Trauma Research Centre (MTRC) for enhanced collaboration with community partners
- Web-based, relational data platform 'TQual' to enable effective 'Triple Aim' quality improvement activities.
- Stage 2 of MTS Business Case to enable adequate resourcing and progress of regional and hub services.

### MTS Targets to 2018

#### Operational Targets

- All Midland DHBs entering data via web-based registry
- Midland Trauma Research Centre (MTRC) operational by end 2016
- TQual relational data warehouse operational by end 2016
- All Midland DHBs to receive quarterly updates of their trauma data as Qlik Sense files by June 2016

#### Clinical Targets

- Reduce mortality in severely injured (ISS >12) from 8.4% (2014) to 7.0% (world best practice is 10%).
- Compliance to clinical exsanguination algorithms >90%.
- In-hospital early deaths by exsanguination <3% of severely injured patients.
- >95% data-capture of patients admitted to Midland hospitals as a result of trauma

#### System Targets

Note: trauma Length of Stay (LOS) calculation is the total bed-days per trauma event across hospitals.

- Reduce overall LOS from 4.9 (2014) to 4.5 days (approximately 1800 bed days p.a.)
- Reduce LOS in severely injured from 24 (2014) to 21 days
- Produce quantitative evidence to inform optimal inter-hospital vehicle, staff and resource utilisation

#### Population Targets

- Predominant at-risk community groups identified from incidence studies
- Identification of equity and access discrepancies in Midland trauma population completed by December 2016
- Functional linkage developed with regional and local injury prevention agencies

### Line of Sight

- **Waikato DHB DAP** - support regional collaboration (p86)
- **Taranaki DHB DAP** - Shorter stays in ED – regional collaboration (p103); Trauma patient pathways (p132); Major trauma data collection, workforce, clinical interface, review of case management role (pp132-134)
- **Bay of Plenty DHB DAP** - actions to support delivery of regional priorities (p84)
- **Lakes DHB DAP** - multi trauma patients with SCI - pre hospital destination and referral pathway (p151); major trauma data collection, workforce, clinical interface, review of case management role (pp152-153)
- **Hauora Tairāwhiti DAP** - Midland Regional Services Plan – any service changes provided in RSP (p155)

Initiative	Milestone/Date	Responsibility
<b>1. Trauma specialist workforce is optimal, well trained and sustainable</b> Midland has a quality trauma specialised workforce in a supportive, progressive environment, with the workforce matched to the priority strategic elements, and MTS personnel are supported in career and professional development.		Midland DHBs
<b>Outputs/Deliverables</b>		
<ul style="list-style-type: none"> <li>• Optimal FTE applied to trauma positions within each Midland DHB, with appropriate resources to support training and education (MRTS Business Case - stage 2 endorsement)</li> </ul>	Q1 2016/17	
<ul style="list-style-type: none"> <li>• Implementation of an optimal workforce plan for MTS hub group Recommendations made for clinical and data staff in individual DHBs</li> </ul>	Q2 2016/17	
<ul style="list-style-type: none"> <li>• Define and implement professional development pathways for all MTS members in Midland DHB trauma services – training sessions / study days delivered and attended by June 2017</li> </ul>	Q4 2016/17	

<b>NZ Health Strategy strategic themes alignment:</b> people-powered, closer to home, value and high performance, one team, smart system					
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		Milestone/Date	Responsibility		
<b>2. Maintain clinical interface</b> All trauma staff exposed to current trauma best practice, and trauma staff contributing to trauma forums at regional and national level. Royal Australasian College of Surgeons Trauma Verification Programme and recommendations addressed. MTS to lead an annual trauma symposium, with all trauma staff attending and contributing to the symposium.			Midland DHBs		
<b>Outputs/Deliverables</b> <ul style="list-style-type: none"><li>Adequate staff are employed to meet the clinical needs of patients</li><li>Staff maintain a culture of regular professional consultation and information-sharing on trauma best practice</li><li>Clinical staff members are supplied with information to improve trauma quality, eg, clinical matrices, guidelines, TQIP reports, etc</li><li>Dissemination of the approved Midland Regional Clinical Guidelines and Clinical Matrices, developed in collaboration with Midland DHBs, ambulance providers and the Major Trauma National Clinical Network to ensure national consistency of regional destination policies for major trauma patients, will be through each Midland DHB Trauma Service, supported by the MTS. The Midland Regional Clinical Guidelines will be available on the MTS website for easy accessibility and to ensure version control <a href="http://www.midlandtrauma.nz">www.midlandtrauma.nz</a>.</li><li>Qlik Sense reporting available and functional in all DHBs</li><li>DHBs support appropriate education and training to maintain clinical skills at expert level</li><li>Opportunities for education and training are signalled to all staff</li><li>Patient and family surveys to be conducted at each DHB</li><li>MTS to organise an annual trauma conference.</li></ul>		Q1 2016/17 Q1 2016/17  Q1 2016/17  Q1 2016/17   Q2 2016/17 Q2 2016/17 Q3 2016/17 Q4 2016/17 Q4 2016/17			
NZ Health Strategy strategic themes alignment: people-powered; value and high performance					
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				Milestone/Date	Responsibility
<p><b>3. Maximise data use:</b></p> <p>(a) Midland DHBs to utilise the MTRC to support local prevention activities</p> <p>(b) Midland DHBs to develop action plans to reduce trauma incidence based on known patterns of trauma in collaboration with community groups</p> <p>Completion of the relational database by Waikato IS with a sustainable support plan in place. Trauma data backlog resolved as a priority enabling real time tracking and analysis that is informative, efficient and responsive to stakeholders. The Trauma Quality Improvement Program (TQIP) is fully supported by an accurate and up to date relational database. Successful integration of associated databases into the relational database. The MTRC is fully functioning to maximise the trauma registry and associated high quality data research activity supporting local prevention activities.</p> <p><b>Outputs/Deliverables</b></p> <ul style="list-style-type: none"><li>Complete implementation of TQual (a web-based, relational data platform) to support community focused quality improvement activities</li><li>Ensure all quality and system controls are in place and functioning</li><li>Develop accessible visualisation and analytic tools</li><li>Develop processes to support the efficient and accurate collection and entry of data and quality checking processes at point of contact</li><li>Ensure up-to-date inputting of data at DHB of origin</li><li>Ensure a common language based on the MTS Data Dictionary</li><li>Provide ongoing data management training and education for regional staff</li><li>Inform stakeholders of the full capability of the relational database</li><li>Complete Trauma Verification Program and prioritise interventions to improve trauma patient care</li><li>Involve trauma patients and their families in TQIP to improve patient centred services.</li></ul> <p><b>NZ Health Strategy strategic themes alignment:</b> people-powered; closer to home, value and high performance; one team; smart system</p>					Midland DHBs
				Q1 2016/17	
				Q1 2016/17	
				Q1 2016/17	
				Q1 2016/17	
				Q1 2016/17	
				Q1 2016/17	
				Q1 2016/17	
				Q2 2016/17	
				Q2 2016/17	
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

Key:

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

## 2.10 Midland Stroke Group

**Chair:** Peter Wright, Neurologist, Waikato DHB

**Project Manager:** Kerry-Ann Adlam

**Lead Chief Executive:** TBC

### Context and vision:

Stroke affects approximately 160 people per 100,000 populations 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 has a continued focus to reduce the impact of stroke on the residents of Midland DHBs. This means providing timely and accessible high-quality stroke services within the hospital setting. It also means that those affected by stroke receive timely, adequate and appropriate patient-focused rehabilitation in the acute and post discharge periods (includes social support services). Strengthening the primary prevention message and encouraging Māori to access TIA and stroke services are also priorities.

### Regional Objectives

- To improve primary and secondary stroke prevention and reduce stroke related disability and mortality.
- To improve access to quality assured organised acute, rehabilitation, and community stroke services.
- To ensure all stroke patients have access to high-quality stroke services regardless of age, gender, ethnicity or geographic domicile.

Develop and deliver a regional plan for stroke services supporting the continued implementation of best practice stroke care, ensuring equitable access is provided to all New Zealanders. This should be consistent with the [New Zealand Clinical Guidelines for Stroke Management 2010](#) (the Stroke Guidelines) and include advice provided by the national and regional stroke networks. This will include the following.

#### *Organisation of stroke services*

- People with stroke admitted to hospital are treated in a stroke unit and/or in the setting of an organised stroke service (see PP20 for definitions of a stroke unit and organised stroke services).

#### *Thrombolysis*

- All people with stroke have access to a quality assured thrombolysis service 24/7 (eg, this will include the development of regional plans to provide remote support via Telestroke).

#### *Rehabilitation*

- All eligible people with stroke receive early active rehabilitation services (as defined by the National Stroke Network), supported by an interdisciplinary stroke team.
- All eligible people with stroke have equitable access to community stroke services.

#### *Education, training and audit*

- All members of the interdisciplinary stroke team participate in ongoing education, training and quality assurance and service improvement programmes according to the Stroke Guidelines, and as recommended by the national and regional stroke networks.

#### *Workforce*

- A regional workforce plan that supports the delivery and achievement of sustained, consistent and safe thrombolysis, and comprehensive evidence-based interdisciplinary acute and rehabilitation stroke care provision.
- Identified actions that the region will take to develop and implement an ongoing education programme that supports a sustainable and high-quality clinical workforce.

#### *Information Technology*

- Identified actions that the region will take to support improved information management, eg, establishing a regional oversight role.

To achieve the regional objectives requires

- The Midland region to have and maintain a lead stroke nurse and lead stroke physician
- Active clinical membership and participation into regional network activity
- That Midland DHBs work collaboratively with regional ambulance service to ensure timely access to thrombolysis,
- That advice from the National Stroke Network is fed into the regional network,
- That accurate and timely collection of data occurs so the region can report monthly and
- That quarterly measures are monitored.

### Measures

Use the three DHB Annual Plan measures to identify gaps and opportunities for development of regional models of care.

- 6 percent or more of potentially eligible stroke patients thrombolysed 24/7 (see PP20 for definition of 'eligible')
- 80 percent of stroke patients admitted to a stroke unit or organised stroke service (see PP20 for definitions).
- 80 percent of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission (also report percent of acute stroke patients transferred to inpatient rehab).

#### Notes:

- Service activity information will routinely be presented by ethnic population groups and (where possible) by urban/ semi-urban, rural settings to allow the monitoring of inequalities to occur as well as the closing of any gaps over time.



Line of Sight
Waikato DHB Annual Plan – section 2.5.2; Taranaki DHB Annual Plan – section 2B.2.15; Bay of Plenty DHB Annual Plan – section 2B.1.5.2; Lakes DHB Annual Plan – section 2B.1.3.2, and Hauora Tairāwhiti Annual Plan - section 2.3.3

Initiative	Milestone/Date	Responsibility
<p><b>Health Literacy</b> - Stroke /TIA (as per the FAST campaign) education for the community as well as the primary and secondary workforce.</p> <p><b>NZ Health Strategy strategic themes alignment:</b> People powered</p> <p><b>What are the identified root-causes to be resolved?</b></p> <ul style="list-style-type: none"> <li>Lack of awareness of signs and symptoms of Stroke/TIA (as per the FAST campaign)</li> <li>Lack of resources regarding Stroke/TIA</li> <li>Lack of appreciation of specialisation of Stroke care</li> </ul> <p><b>What does success look like?</b></p> <ul style="list-style-type: none"> <li>Implementation of the Stroke/TIA Map of Medicine pathway</li> <li>Communities are more aware of FAST message</li> <li>Increased presentation for TIA</li> <li>Increased presentation for Stroke within the 4 hour time frame.</li> <li>Increased awareness in the ARC sector</li> </ul> <p><b>What will have changed for you to know that you have achieved the objective?</b></p> <ul style="list-style-type: none"> <li>Increase in presentations for Stroke and TIA</li> <li>Confident, competent workforce.</li> </ul> <p><b>What are the steps to achieving the objective?</b></p> <ol style="list-style-type: none"> <li>Establishing monthly webinar sessions / video conference across the region</li> <li>Support of Stroke study days: national, regional and local days.</li> <li>Support NZ Stroke Foundation awareness raising campaigns.</li> <li>Explore linking Stroke prevention services with existing Cardio-vascular and other health promotion services.</li> <li>Increase consumer/ whānau participation in Stroke service development and delivery</li> </ol>	<p>Monthly</p> <p>At least one regional professional development session offered per year by a DHB Stroke Team</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>	<p>HSL with MSN</p> <p>MSN</p> <p>MSN/ DHBs</p> <p>MSN</p> <p>MSN</p>
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	Milestone/Date	Responsibility
<p><b>Rehabilitation</b> - Ensure rehabilitation services for stroke patients across the region aligns to the “NZ Organised Stroke Rehabilitation Service Specifications (in-patient and community)” that have been prepared by the National Stroke Network (aligns also with the joint Ministry and ACC Hospital to the Home project).</p> <p><b>NZ Health Strategy strategic themes alignment:</b> Closer to home, one team, value and high performance</p> <p><b>What does success look like?</b></p> <ul style="list-style-type: none"> <li>People being discharged home</li> <li>Improved functionality (Driving, working, less dependence on others)</li> <li>Improve psychological well being</li> <li>Improved quality of life</li> </ul> <p><b>What will have changed to know that you have achieved the objective?</b></p> <ul style="list-style-type: none"> <li>Community supported discharge service</li> <li>Under 65 have access to community resources following discharge</li> <li>Reduced number of direct admissions to ARC following a stroke</li> <li>Reduced readmissions following a stroke</li> </ul> <p><b>What are the steps to achieving the objective?</b></p> <ol style="list-style-type: none"> <li>Gather the data for the rehabilitation indicators</li> <li>To complete a current state stocktake of ambulatory Allied Health and nursing rehabilitation and identify any gaps in service and compare against best practice</li> <li>Develop a clear vision and care pathways for rehabilitation patients, based on ESD evidence and best practice for patient clinical complexity</li> <li>A clear time-bound plan (including models of service delivery ie. who to deliver what, where and when) is developed based on the findings of the stocktake and regionally agreed care pathways</li> <li>Hold a Midlands region rehabilitation study day</li> <li>Standardise expectations around post discharge follow up (linking with indicators - objective ‘a’), for example, access to all disciplines / timeframes to be seen / return to work programs/ return to driving programs</li> <li>Develop regional business cases for the implementation of ESD teams for chronic / long term conditions</li> </ol>	<p>Q1 2016/17</p> <p>Q1 2016/17</p> <p>Q1 2016/17</p> <p>Q2 2016/17</p> <p>Q2 2016/17</p> <p>Q2 2016/17</p> <p>Q3 2016/17</p>	<p>MSN and DHBs</p> <p>MSN and DHBs</p> <p>MSN</p> <p>MSN</p> <p>MSN</p> <p>MSN</p> <p>Midland DHBs</p>
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

**Key:**

60



# Appendix 1: Work programmes of Objective 1 (Improve Māori Health Outcomes), Objective 4 (Build the Workforce) and Objective 5 (Improve Clinical Information Systems).

## Objective 1: Improve Māori Health Outcomes

### (1-2) REGIONAL GOVERNANCE AND DECISION MAKING/ REGIONAL MĀORI HEALTH TOOLS

Priority Area	Outcome Reported	Timeframe	Responsibility	Milestones reported against
<b>Regional Governance &amp; Decision Making</b>	<p><b>Ensure Iwi Governance actively participates in planning and decision making</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul>	<b>Q2- Q4 2016/19</b>	<b>Nga Toka Hauora, MIRB, All Boards of Governance Meeting</b>	<ul style="list-style-type: none"> <li>The Midland Iwi Relationship Board (MIRB) is actively engaged in the development of the Māori Health component to the Regional Services Plan (RSP).</li> <li>The Midland Iwi Relationship Board (MIRB) receives quarterly updates on the implementation of the current plan. Work on the development and implementation for the Regional Service Plan will remain part of the MIRB's formal work agenda.</li> <li>The MIRB will maintain an established meeting schedule with the regional All Boards of Governance Chairs forum regional lead whereby joint issues of concern on how to improve Māori Health can be discussed.</li> <li>Nga Toka Hauora the Midland GMs Māori Health will provide secretarial support to the Midland Iwi Relationship Board.</li> </ul>
<b>Regional Tools</b>	<p><b>Establish Regional Tools to Support Māori Health Gain</b></p> <ul style="list-style-type: none"> <li>Trendly report against Midland DHBs performance against Māori Health Plan national indicators completed every 6 months (Midland Māori Health Indicator Report)</li> <li>Webinar Health Excellence Seminars will be completed in a minimum of 2 health priority areas</li> <li>Review He Ritenga Cultural Audit tool for greater alignment to Māori health Indicators and apply audit in one regional service</li> <li>Integrate He Ritenga into Health Share audit schedule</li> <li>Explore the establishment of a Regional Māori Health workforce profile by professional group (annual report)</li> <li>Māori Health Equity Framework integrated into planning documents. One of the features of the Pae Ora framework is that it enables individual DHBs to align their respective local strategies and implementation plans including Māori Health Plans, Annual Plans Public Health Annual Plans, other initiatives, programmes and projects - with the health equity concepts that sit within Pae Ora. This ultimately should bring about a stronger health equity approach to how the plans are delivered.</li> </ul>	<b>Q2-Q4 2016/19</b>	<b>Nga Toka Hauora, Health Share, Human Resources</b>	<ul style="list-style-type: none"> <li>At a national level an online Trendly reporting tool has been developed and will be enhanced further to a gold standard, to more effectively allow Midland DHBs to compare performance and identify high performers who could provide insights to other DHBs on how to lift performance.</li> <li>Webinar Health Excellence Seminars will be completed in a minimum of 2 health priority areas per annum which identify best performers against Māori Health priority areas in DHBs across the country, and endeavours to promote best practise.</li> <li>He Ritenga cultural audit tool will be integrated into day to day auditing function of Health Share. Annual report provides overview of implementation of He Ritenga into Health Share.</li> <li>Each DHB within Midland provides a workforce profile report that identifies the number and percentage of Māori employed by professional group within each of their DHBs. This workforce profile is utilised to track building Māori health workforce capacity development. By 2017 final reporting period a regional workforce profile will be established across Midland DHBs.</li> <li>Pae Ora framework integrated into DHB planning template as a visual display that aligns plans to working towards Māori health equity/ Pae Ora.</li> </ul>

### (3) REDUCING THE IMPACT AND INCIDENCE OF CANCER ON MAORI

Priority Area	Outcome Reported	Timeframe	Responsibility	Milestones reported against
<b>Māori Health Gain- Cancer (Breast and Cervical)</b>	<p><b><i>Reduce Māori Cancer rates, specifically in the area of Breast and Cervical cancer</i></b></p> <ul style="list-style-type: none"> <li>Establish Regional Work- Plan around Breast and Cervical screening</li> <li>Convene Health Excellence wānanga around best practice to improve Māori regional breast screening rates</li> <li>Convene Health excellence Wānanga around best practice to improve Māori regional Cervical Screening rates</li> <li>Deliver Kia Ora E te Iwi cancer health literacy initiative with Māori communities/ NGO's and the Cancer Society</li> <li>Report finalised for BOP review of cancer enablers and barriers initiative 2016</li> <li>Report on Hei Pa Harakeke Māori Cancer Advisory Groups annual work plan, specifically complete</li> </ul>	<b>Q2- Q4 2016/19</b>	<b>Nga Toka Hauora, Midland Cancer Network, Hei Pa Harakeke</b>	<ul style="list-style-type: none"> <li>The annual work plan for Hei Pa Harakeke the Midland Māori Cancer Advisory Group has been integrated into the Midland Cancer Network's work plan.</li> </ul>

#### (4) IMPROVING THE HEALTH OF OUR PEPI/TAMARIKI

Priority Area	Outcome Reported	Timeframe	Responsibility	Milestones reported against
<b>Child Health Immunisation Rheumatic Fever ASH GP enrolment Safe Sleep ASH</b>	<b><i>Implement HARTI Hauora child health programme across Midland to support</i></b>	<b>Q2-Q4 2016/17</b>	<b>Nga Toka Hauora, Child Health</b>	<ul style="list-style-type: none"> <li>HARTI Hauora Child health programme developed into regional programme/ model.</li> <li>Train the Trainers programme on HARTI Hauora child health programme completed across Midland DHBs</li> <li>Evaluation report on train the trainers programme completed.</li> <li>Evaluation of HARTI Hauora child health programme completed.</li> </ul>
<b>Māori Health Gain – Reduce Smoking in pregnancy</b>	<ul style="list-style-type: none"> <li>Report on reducing Māori smoking and SUDI rates</li> <li>Māori women within Midland (95% of inpatient hapu woman offered quit support) - (linked to SUDI model, June 2015)</li> <li>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 hapu woman offered quit support) (linked to SUDI model, June 2016)</li> </ul>	<b>Q2-Q4 2016/18</b>	<b>Nga Toka Hauora/ Midland Maternity Action Group</b>	<ul style="list-style-type: none"> <li>A Hapū Mama quit smoking incentivisation pilot has been completed in the Waikato. Key learnings from this programme and programme evaluation to be shared with others DHBs.</li> <li>Train the Trainers programme on Hapu Mama incentivisation programme completed.</li> </ul>

## (5) MAORI HEALTH WORKFORCE DEVELOPMENT

Priority Area	Outcome Reported	Timeframe	Responsibility	Milestone reported against
<b>Māori Health Workforce Capacity Development</b> (linked to workforce section of RSP)	<b><i>Build Māori Health Workforce Capacity Development</i></b> <ul style="list-style-type: none"> <li>Report against Kia Ora Hauora Midland Māori health workforce development initiative completed.</li> <li>Explore the establishment of a Regional Māori Health workforce profile by professional group (annual report)</li> </ul>	<b>Q2-Q4 2016/19</b>	<b>Nga Toka Hauora, Human Resources</b>	<ul style="list-style-type: none"> <li>Narrative report detailing revised milestones for Kia Ora Hauora completed and targets attained.</li> <li>Targets in place across Midland DHBs for Māori workforce increase in priority areas (refer workforce section of RSP).</li> <li>Each DHB within Midland provides a workforce profile report that identifies the number and percentage of Māori employed by professional group within each of their DHBs. This workforce profile is utilised to track building Māori health workforce capacity development. By 2017 final reporting period a regional workforce profile will be established across Midland DHBs.</li> </ul>

## REGIONAL NETWORK ACTIVITY THAT WILL IMPACT ON NATIONAL MAORI HEALTH INDICATORS

Regional Network and Clinical Action Group	Activity that links directly to lifting performance against National Māori Health Indicators
Cancer	A wide range of activity occurs within this workstream that supports reducing the impact and incidence of cancer. The top priority for the coming period includes implementing Faster Cancer Treatment for people with suspected cancer. Activity within this workstream that aligns to the work of Hei Pa Harakeke the Midland Māori Cancer Advisory Group, seeks to lift performance around Māori cervical screening rates, Māori breast screening rates and Māori quit smoking support rates all of which are Māori health indicator priority areas within DHB Māori Health Plans.
Child Health	The Child Health Action Group has a comprehensive range of activities that will directly impact on Māori child health priority areas. In particular work in regards to oral health, obesity, immunisation and the implementation of the Harti Hauora, a tool which covers a range of health priority areas for tamariki including GP enrolment, rheumatic fever, quit smoking support, oral health, SUDI and ASH will seek to lift performance against Māori health indicator priority areas. HARTI Hauora was developed by Waikato DHB Māori Health in 2015 in conjunction with Waikato DHB Child Health services.
Maternity	The Midland Maternity Action Group is conducting a range of activities in conjunction with the GM s Māori that have the potential to impact on Māori health indicator priority areas. Specifically, MMAG will develop a Midland Breastfeeding Framework to inform and prioritise breastfeeding initiatives in the Midland region. Work will also be undertaken around SUDI in terms of safe sleep and smoking cessation during pregnancy, these along with the focus on breastfeeding are all Māori health priority indicator areas detailed within each respective DHB's Māori Health Plan.
Mental Health & Addictions	Mental Health and Addictions is undertaking a number of initiatives that will improve the way in which regional Mental Health & Addictions Services are delivered to the general population including Māori. A specific link to a national Māori health priority indicator relates to work around monitoring section 29 community treatment orders, this indicator is a Māori Health Plan indicator for all DHBs.
Workforce Development	The Workforce Development Network and the Midland GM's HR have agreed to support the implementation of Kia ora Hauora, Nga Toka Hauora the Midland GM's Māori workforce development programme. In particular targets have been set for Māori staff increase in targeted areas across all five DHBs within the Midland area. It should be noted that this activity aligns to the requirement for all DHBs to provide an annual workforce profile report for Māori comparative to non- Māori by professional group. The intent is to monitor Māori staff increase across different professional group form year to year.
Other Regional Networks and Clinical Action Groups	Regional Networks or Clinical Action Groups such as Electives, Health of Older People, Radiology, Cardiac, Stroke or Trauma (MTS) all will undertake activity that seeks to improve Māori health inequity. As required Nga Toka Hauora the Midland GM's Māori can be approached for advice and guidance on how to effectively meet the needs of Māori.

## Objective 4: Build the Workforce

	Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
Growing the health workforce through strengthening recruitment, retention and repatriation								
WF1	Recruitment and retention strategies	Increase productivity, efficiencies and effectiveness of the recruitment service	1. Implement Onboarding to improve the management of employee inductions, and reduce the cost of recruitment	Functionality available within the e-recruitment system is fully utilised.	6 mths per DHB	Q1-Q3		(1) DHBs recruitment teams and Taleo system administrator
		Standardisation of the recruitment process and service	2. Implement two-way interface between HRIS and Taleo systems to reduce human error and increase efficiency. The interface is contingent on completion of 1. above.	Transactional recruitment processes are automated where possible.	4 mths per DHB			(2) DHBs IS departments, DHBs recruitment teams, HRIS system developer and Taleo system administrator
Financial savings in the DHB investment in recruitment		3. Re-develop suite of regional and individual DHB reporting and analytics metrics, as part of the migration to the new OBI reporting tool	Candidate experiences are enhanced	??	(3) Regional GMs, recruitment team leaders, and Taleo system administrator			
Realignment of roles to focus on target market, candidate care and strategic recruitment improves quality of hire and retention			A new suite of reports is completed in OBI		(4) DHBs Recruitment teams and Taleo system administrator			
Improve reporting on recruitment metrics, such as tracking internal movement, drill down and trending capability			Resources focused toward strategic recruitment, target market, and retention		(5) Regional GMs, DHBs HR consultants and DHBs recruitment team leaders			
Online training provides consistency across DHBs, which also frees up recruiter time		4. Processes are automated, such as offer letters/templates, scheduling of interviews, candidate expressions of interest, agency referrals, internal recruitment	A range of training courses and troubleshooting set up in Moodle, and made available to hiring managers and recruiters	Q4	(6) Moodle developer and Taleo system administrator			
5. Investigate potential for re-scoping/realigning roles to align with strategic direction of recruitment				Q4				
6. Online Taleo training courses available to hiring managers and recruiters								
	Retention and recruitment strategies for rural and primary care workforces	Method to link sector together within a community and to recruit, orient and socialise new health professionals  Enable each Midland DHB to lever off the successes and learnings of each other and to develop shared programmes where these are appropriate  Clinical Training Centres	1. General Practice: 1.1 Develop training placements opportunities for GP trainees in vulnerable populations/hard to recruit centres. 1.2 Consider placements within DHBs for those GP II & III trainees seeking to experience another vocational scope as part of their training 1.3 Determine training, provision and supervision models for GP practice across the Midland region.  2. Working with RNCGP, develop strategies to actively recruit GP registrars with the intent of providing them	GP Registrars matched to vulnerable populations and areas of service need.	Q1-4	✓	✓	HealthShare Ltd (MRTN) in partnership with HWNZ, primary care and Directors of Clinical Training and RDoW, CEs and COOs.

	Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
		Recruitment & Retention	placements for the three years of their fellowship programme.	Pilot programme, supported by DHBs/PHO's and HWNZ				
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. Increased numbers of Māori young people pursue health careers</p> <p>The total population in the Midland region in 2013 was 856,785 (census 2013) with 217,780 or 25% Māori compared with 16% Māori for NZ as a whole. The Midland region target is to increase the numbers of Māori providing health care to Māori and non-Māori.</p>	<p>1. DHB contacts continue to support Kia Ora Hauora coordinator with annual careers events in each Midland DHB in 2015/16.</p> <p>2. Develop protocol with Kia Ora Hauora to enable mentored trainees into DHB careers.</p>	<p>Ensure numbers of Māori continue to grow proportional to their DHB FTE</p> <p>Annual targets are: Waikato: 2% BOP: 1% Lakes: 1% Taranaki:1% Tairāwhiti:1%</p>	<p>Q1-4</p> <p>Q3-4</p>	<p>✓</p> <p>✓</p>	<p>✓</p> <p>✓</p>	(1) GMs Māori and COOs, in partnership with GMsHR, Clinical Schools and Kia Ora Hauora
WF3	Vulnerable, hard to recruit, New & emerging workforces	<p>Midland DHBs will work with the identified workforces to gain:</p> <p>sustainable supply and retention good workforce utilisation increased service flexibility</p>	<p><b>1. Regulated Workforces</b></p> <p>1.1 Sonographers: continue work on the national work programme for Sonographers, in conjunction with HWNZ, RDOs and GMsHR</p> <p>1.2 Midwifery: retain regional microsite. Ensure with HWNZ that 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.</p> <p>1.3 Nursing: The majority of 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 continue to 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 articulate these to and work with HWNZ to develop.</p> <p>Development of a series of supervision workshops for Medical Supervisors</p>	<p>208 nursing graduates, (registered and enrolled nurses), have a formal orientation/new entry to practice programme in place. Flexibility has been built into the programme to allow entry throughout the year.</p> <p>Midland DHBs have 12 candidates on the development pathway.</p>	<p>✓</p> <p>✓</p> <p>✓</p> <p>Q1 – Q4</p>	<p>✓</p> <p>✓</p> <p>✓</p>	<p>✓</p> <p>✓</p> <p>✓</p>	<p>(1 ) HealthShare Ltd (MRTN)</p> <p>(2) Clinical networks in in partnership with GMsHR, RDoW, DONMs/CMA's/ 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
	PGY I & II - Single Curriculum (MCNZ)	1.4 Take a watching brief as this work is completed as part of MCNZ accreditation. Consider career mapping supported by this work.	Earlier exposure to GP practice for a cohort of PGY II				COOs, RMO Coordinators; RDoW supported by GMsHR
	Placement Map	1.5 Development of centrally accessible repositories to support teaching and learning.					
	Share Training Repositories	1.6 Development of innovative placements across the region to support exposure to primary health care.					
	PGY I & II Outpatient and/or Community Attachment	1.7 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.					
	Rural Recruitment & Retention	1.8 <i>Need to</i> identify hospital training needs and opportunities e.g. advanced ED experience, anaesthetic training etc.					
	GP Dual Training	1.9 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.					
	Identify Hospital Training Needs & Opportunities						
	Academic Offerings for Trainees	1.10 Work with HWNZ and the Medical Taskforce to grow our own medical workforce that is fit for purpose, meets health demand and utilises trainees that are NZ citizens/residents	Accurate trainee volumes and demographic information, NZ citizens/residents targeted through ACE process, and support work of the Medical Task Force.	Q2	✓	✓	HWNZ (RDoW), CMA, CEs, COOs, GMsHR RMO Coordinators
		1.11 Mental Health roles: continue recruitment strategies for mental health roles throughout the region – hard to recruit roles include Nursing, allied health, addictions clinicians, Psychologists, service assessors, Psychiatrists in mental health for the older person		✓	✓	✓	COOs, RDoW, Clinical Networks, DAHs, DONMS; supported by GMsHR
		1.12 Work with DHBs to identify potential nurse candidates for the Nurse Endoscopy training programme and DHBs organisational readiness to support candidates.		✓	✓	✓	
		1.13 Oncology workforce: continue work with the Midland Cancer Network on projects related to: implementation of the Midland Oncology Service plan; improving Radiation Oncology Services; support of the		✓	✓	✓	

	Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
			<p>midland Gynae-oncology model of care; the consultant and medical trainee workforce for palliative care and evaluation of the cancer nurse co-ordinator initiative.</p> <p>1.14 Allied health: support multidisciplinary post graduate teaching and learning opportunities based around long term conditions and rehabilitation</p> <p>1.15 From time to time other specialist workforces may 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><b>2. Non-regulated workforces.</b></p> <p>Implement non-regulated workforce training business case – specifically :</p> <p>1. Health Care Assistants – Waikato DHB to consider further training in 2016. Lakes DHB and Taranaki DHB to continue their programmes. Tairāwhiti DHB to consider adapting programmes for 15/16</p>		Q1-4	✓	✓	
			<p><b>2. Non-regulated workforces (continued)</b></p> <p>2. Orderlies – Lakes DHB, BOP DHB, Taranaki DHB to continue programmes in 15/16. Tairāwhiti to continue local programme via the Polytechnic. Waikato DHB to commence in 15/16.</p> <p>3. Allied Assistants – Waikato DHB training started in 13/14. Lakes DHB to continue training in 15/16. Other DHBs to consider adapting WDHB/LDHB programmes</p>		Q1-4	✓	✓	
					✓	✓	✓	
Shaping the future workforce through transformative change								



	Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
WF4	Ageing workforce strategies	<p>The “Ageing Workforce in DHBs Supplementary Survey Report 2014” prepared for the NZ Human Rights Commission details the results of a survey that the Midland DHBs can use to develop a guideline document. This document will ensure DHBs deliver relevant strategies to meet the needs of an ageing workforce. Recognition is given of current strategies being delivered and in many situations this is on a case by case basis.</p> <p>1. To meet the findings of the Report the guideline document will recognise that DHB workers:</p> <ul style="list-style-type: none"> <li>• seek an older age for retirement and seek financial stability</li> <li>• prefer a challenging and rewarding role</li> <li>• want to feel valued and recognised for their skills</li> <li>• seek the same elements in a role as younger people</li> <li>• want to learn and master new skills</li> </ul> <p>2. Flexible Work Arrangement policy and procedures will ensure DHBs comply with legislation.</p> <p>3. DHBs will have the ability to review their activity targeting the ageing workforce for future access.</p>	<p>1. Develop a regional guideline document for local implementation (as required) that will inform relevant strategies to meet the needs of an ageing workforce as informed in the Report. Proposed activity include:</p> <ul style="list-style-type: none"> <li>(i) Implementation of appropriate workplace health and safety strategies</li> <li>(ii) Succession planning for identified critical roles</li> <li>(iii) Career planning on a case by case basis as appropriate</li> <li>(iv) A recognition and values programme that recognises the contribution of older workers to the DHB (age discrimination)</li> <li>(v) Planned exits for employees to enable DHBs to tap into the valuable skills and knowledge of motivated retirees for service delivery, training and mentoring</li> <li>(vi) Reduce pressure on filling vacancies by retaining this workforce on a case by case basis</li> </ul> <p>2. Develop and implement an annual review process that will enable DHBs to evaluate the effectiveness of strategies, to trial new models and to share ideas.</p>	Annual Review	Q3-4			(1) Taranaki as the lead DHB  (2) HR GMs
					Q4	✓	✓	GMsHR
<b>Strengthening health workforce intelligence</b>								
WF5	Workforce Intelligence and modelling	<p>Workforce planning:</p> <ul style="list-style-type: none"> <li>• Improves our understanding of current demographics</li> <li>• Enables us to model workforces for future needs</li> </ul>	<p>Design and build a workforce forecast modelling tool and populate with data to enable workforce modelling and forecasting. Provide demographic information and forecasting model for all workforces identified by the Clinical Networks and GMsHR group and some base line intelligence out lined in workforce delivery WF3.</p> <p>Support Clinical Networks in the design of new models of care based on the workforce modelling tool.</p>		Q4	✓	✓	(1) HealthShare Ltd in partnership with GMsHR, HWNZ and Clinical Networks.

	Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
<b>Building and expanding the capability of the health workforce</b>								
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	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	Establish project board and finalise project plan.	Q1			(1) HealthShare Ltd
			2. Identify funding and cost-effective model for training (HWNZ)		Q2			
			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)	Implement new-graduate training program	Q3			
			4. Define project deliverables (post-graduate training through tertiary provider; competencies and training defined; contract / service level agreement)		Q4 (1)			
			5. Evaluation against defined objectives and benefits					
	Unregulated staff training	Explore options for generic allied health assistant training programme for the support workforce	6. Develop a pilot project plan, define benefits and objectives		Q1			(1) HealthShare Ltd
			7. Identify funding and cost-effective model for training (DHBs/HWNZ)	Finalise project plan	Q2/3			
			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)	Implement project plan	Q4			
			9. Define project deliverables (competencies and training defined; applicability of learning materials for Career Force modules; contract/service level agreement)					
	Psychological and Social Support Services	New regional service	10. Midland Cancer Network support DHBs to implement new cancer psychologists and social workers as per the Midland Psychological and Social Support Services Plan 2015-2018					

	Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
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: The Midland DHBs have 14 candidates under development for prescribing.		Q1 (1)  Q3 (1)  Q3 (1 & 2)  Q3 (1)			(1) HealthShare Ltd (2) Clinical Networks supported by DONMS
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  Stocktake  Skills & Simulation Strategy  Shared Training Repository  Create Regular Network Around Meeting & Simulation Users	Scope models of multi-disciplinary scenario training across region – using the existing Tairāwhiti model.  Scope technology needs sub-regionally.  Complete a comprehensive stocktake of all physical training resources and technical support staff.  Develop a 3-5 year strategic plan to develop a sustainable skills and simulation methodology  Develop a shared repository of teaching and learning resources (i.e. problem based scenarios, classroom bookings).  E-forum planning to develop regional interfaces and conversation to planning.		Q4 (1)  Q2 (1)  Q4 (1)  Q4 (1)  Q4 (1)	✓		(1) HealthShare Ltd in partnership with professional development units /Clinical Directors of Training/Clinical Schools
WF10	Shared learning	Work towards a shared suite of learning resources across the region	1. Advance E Portfolios and E career planning across nursing workforces and allied / technical workforce groups as determined by the DAHs 2. Develop a business case to determine the memorandum of understanding to build whole system architecture for e-learning / portfolio's that includes the South Island. 3. Complete shared learning resources in conjunction with the following clinical networks:  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		Q4 (1)  Q2-Q3 (1)  Q2-Q3 (1 & 2)  Q2-Q3 (1 & 2)	✓  Q4  Q2-Q3(1 & 2)	✓  ✓	(1) HealthShare Ltd in partnership with GMsHR, Regional Training Network and Wintec  (2) E Learning team / HSL / RDOW supported by Clinical Networks.

	Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
			<p>competency training is available and develop regional on line recording ethnicity training.</p> <p>d) Midland Stroke Network – Make available the Auckland Thrombolysis learning tool on the regional E learning network</p> <p>e) Midland Trauma Network –offer Moodle as an online education and policy document network.</p>		2)	<p>Q2-Q3(1 &amp; 2)</p> <p>Q2-Q3(1 &amp; 2)</p>		
<b>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.</b>								
WF11		<p>Future workforce planning for <u>Renal Maternity, Radiology, Stroke and Cardiac services</u></p> <p>Future workforce requirements are identified and plans developed to ensure appropriate care provision continues.</p>	<p>Utility of existing workforce model critiqued against workforce forecasting [Q2 – Renal, Radiology; Q4 – Maternity, Cardiac; Q1-Q4 - Stroke]</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>Develop a concept paper which explores alternative models and use of workforce to future proof service delivery</p> <p>Trial new collaborative models and evaluate specific models as agreed</p>		<p>Q2 &amp; Q4 (1 &amp; 2)</p> <p>Q2 (1 &amp; 2)</p> <p>Q4 (2,3, 4)</p> <p>Q4 (2,3, 4)</p> <p>Q4 (2,3, 4)</p>	<p>✓</p> <p>✓</p>		<p>(1) HSL RDoT &amp; Workforce Analyst Role.</p> <p>(2) Regional Clinical Networks</p> <p>(3) Midland DHBs</p> <p>(4) HSL</p>
	Workforce planning and forecasting for <u>Maternity medical staff</u>	O&G placements in identified areas planned for with RANZCOG.	<p>Quantification of percentage of consultant time spent in obstetrics to ascertain level of obstetric workforce need</p> <p>Quantification benchmarked across other three regions by RDOTs</p> <p>Strategic plan for sustainable obstetric physician service provision inclusive of obstetric anaesthetists, SMOs, RMO training, and placements is developed</p> <p>Increase PGY1 and PGY2 numbers doing RMO runs</p> <p>Explore feasibility of separate obstetrics and Gynae. work for tertiary facilities</p> <p>Complete position paper identifying different global models of obstetric care delivery and make available for analysis</p> <p>Develop a consistent regional approach to PGY1 and 2 O&amp;G runs</p>		<p>Q2 (2)</p> <p>Q2 (1 &amp; 2)</p> <p>Q4 (5)</p> <p>Q2 (2, 3,4)</p> <p>Q4 (2 &amp; 5)</p> <p>Q4 (2 &amp; 5)</p> <p>Q2 (2, 3,4)</p>	<p>✓</p> <p>✓</p> <p>✓</p>	✓	<p>(1) HSL RDoT &amp; Workforce Analyst Role.</p> <p>(2) Regional Clinical Networks</p> <p>(3) Midland DHBs</p> <p>(4) HSL</p> <p>(5) GM-HR</p>

Name	Benefit Description	Deliverable	Measure	2014/15	2015/16	2016/17	Accountability
		Develop a sustainable model of RMO training and mentorship across the region which match anticipated SMO vacancy models		Q2 (2, 3,4)		✓	
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 &amp; 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 Infant Perinatal Mental Health &amp; Addictions</p> <p>Infant Perinatal 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 MH&amp;A Workforce Planning Lead and Te Pou</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 &amp; Workforce Analyst Role.</p> <p>(2) Regional Clinical Networks</p> <p>(3) Midland DHBs</p> <p>(4) HSL</p>
Workforce planning for <u>Child Health Services</u>	<p><b>Workforce</b> - Plan for a sustainable generalist and specialist paediatric workforce</p> <ul style="list-style-type: none"> <li>Identify child health workforce across the primary, community and secondary sectors (head count and FTE)</li> <li>Identify current workforce shortages or vulnerable</li> </ul>		Q4 (1 & 2)				<p>(1) HSL RDoT &amp; Workforce Analyst.</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
		services <ul style="list-style-type: none"> <li>If possible identify volume of patient contacts per FTE/occupational role</li> </ul>						
<b>Supporting national schedules of work determined by HWNZ</b>								
WF12	Community based attachments	Develop and grow capability and capacity for more community based clinical attachments (CBA) for PGY I & II	In conjunction with Medical Council of New Zealand, the Royal New Zealand College of general Practitioners and HWNZ. Lead the coordination of CBA outside General Practice settings, including hospice, urgent care, mental health and community based services.					RDoWD, Resident Medical Officer Units. External health providers.
	Nurse entry to Practice	Engage with stakeholders to maximise funding for NETP placements in Aged Residential Care facilities.	Develop strategies to recruit too and support new graduates into aged residential care facilities that meet the criteria across the Midland region. Developing and sustaining new graduates in the ARC workforce.					
	Strengthen Midwifery first year of practice	In conjunction with Midwifery Council and College of Midwives further implement the first year of midwifery practice within Midland facilities.	Develop strategies to maximise the number of midwifery graduates exposed to first year of midwifery practice programmes either in DHBs or attached to lead midwifery carers					RDoWD DON/Ms and Midwifery leads

## Objective 5: Improve Clinical Information Systems

### NHITB critical priorities

The published<sup>6</sup> National Health IT Board (NHITB) critical priorities for 2016/17 are as follows:

Investment focus	Name of Initiative	Description	National Expectation of Midland Region/DHBs	Midland notes
<b>Medication Management</b>	electronic Prescribing and Administration (ePA)	Implementation of hospital based ePA Using the NZULM as the medicines data source and integrated with: <ul style="list-style-type: none"> <li>ePharmacy</li> <li>eMR</li> </ul> where implemented	All DHBs  <i>While this is for individual DHB implementation, we are aware that some DHBs are working regionally on this project so would like to see activities outlined in the RSPs.</i>	ePA implementation in the Midland Region is dependent on ePA working as required with the NZULM, and a need to demonstrate the working integration between ePA, ePx and the Regional CWS. Taranaki DHB will be the lead implementation for the integrated solution prior to regional rollout. The current non-integrated state, and reliance on Regional CWS, means that regional implementation is unlikely in 2016/17.
<b>Child Health</b>	National Maternity Information System Platform (MISP–NZ)	Implementation of the National Maternity Information System Platform with the MCIS module live	All DHBs	This is managed and delivered direct with the individual DHBs. Please refer to AP's for implementation details.
<b>Data Analytics</b>	National Patient Flow	National Patient Flow provides a patient centred view of wait times, health events and outcomes in a patient's journey through secondary and tertiary care.	All DHBs	This is managed and delivered direct with the individual DHBs. Please refer to AP's for implementation details.

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<sup>6</sup> 2016/17 Planning Priorities for Annual Plans and Regional Service Plans (December 2015)



Investment focus	Name of Initiative	Description	National Expectation of Midland Region/DHBs	Midland notes
<b>Regional EMR</b>	Regional CWS (Including MedMan) Regional CDR Regional PAS  Capability:	A regional platform  These systems need to include: SNOMED CT as the standard system of clinical terminology for all point of care applications. The capture all sources of hospital information, including ED & Theatres, nursing observations and eReferrals triage. Single access by clinicians to all sources of information. Provide data to the National Electronic Health Record (EHR)	All regions	The Midland region will fully participate in the national EMR process as outlined in the Heath IT Programme 2015-2020.  The eSPACE Programme will continue to focus on the delivery of the Regional CWS and CDR in the 1617 year and align to standards such as SNOMED CT. The rollout of functionality will be prioritised with the Programme Governance Board and implemented through a formal regional release process.
<b>National EHR <sup>7</sup></b>	Integration with the national EHR	During the design phase of the national EHR, regions will engage with the national programme to establish sector requirements.  During the implementation phase the regions will continue to support the national programme and integrate their systems with the EHR.	All Regions	The Midland region will fully participate in the national EHR process as outlined in the Heath IT Programme 2015-2020.
Please note that DHBs are to support the implementation of the <a href="#">Cancer Health Information Strategy</a> (please refer to the Cancer guidance on page 13).				

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<sup>7</sup> The Health IT Programme will design and establish a national EHR as a single source of truth for core health information, including allergies and alerts, medications and the patient's problem list. Hospital EMRs will integrate with the EHR to share this information.

## Midland DHBs forecast IS investments (16/17)

Please note that these are forecast investments only and will not be approved until the relevant formal approval processes have been undertaken. Additionally, due to the current financial situation of the Midland DHBs it is expected that ongoing change to this forecast will be required.

Row Labels	2016/17 new investme
<b>Local</b>	<b>10,559,000</b>
<b>Lakes DHB</b>	<b>40,000</b>
Remote access Management reporting	30,000
Rotorua full wireless coverage	10,000
<b>Waikato DHB</b>	<b>10,519,000</b>
Antivirus toolset upgrade/replacement	150,000
Archiving Tool (1617)	350,000
Citrix Netscaler 10.5 upgrade	150,000
Clinical and corporate platform	500,000
Clinical business rules	250,000
Clinical photography image management	300,000
Clinical workstation - eOrders	200,000
Clinical workstation document tree search	100,000
Comms Room lifecycle (1617)	370,000
Contingency (IS) 1617	300,000
Data Analyst toolset implementation	300,000
Data Warehouse Phase 2	400,000
Enterprise reporting content remediation	250,000
eProgres replacement impacts	150,000
External eReferrals improvements	300,000
File server (profile, home drive, appv) rearchitecture	150,000
Internal eReferrals	300,000
Licensing true-ups (MS and other)	600,000
Network remediation (1617)	300,000
Paging system replacement (Waikato)	350,000
Perimeter design (1617)	349,000
Rapid logon	500,000
Team Foundation server	250,000
Web apps Shared web services infrastructure (solns)	500,000
Web apps Shared web services infrastructure (stds)	500,000
WiFi rollout	500,000
Workflow / e-data	1,200,000
Sharepoint workplan	200,000
Telehealth replacement schedule	400,000
eTasks	100,000
Procedure based booking/scheduling (1617)	250,000

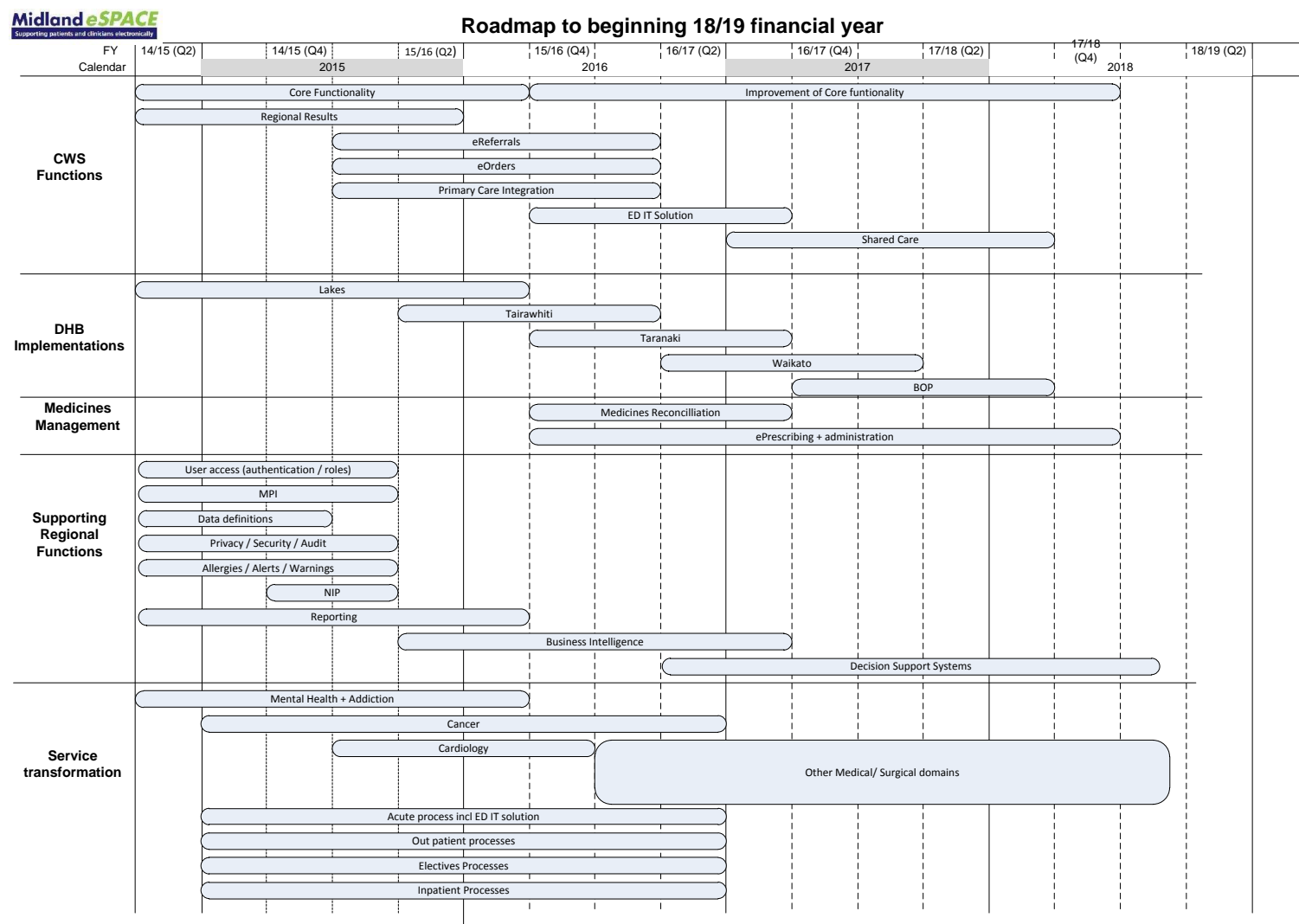
<b>Reg, Local (Reg app), Nat aligned</b>	<b>13,648,378</b>
<b>BOP DHB</b>	<b>2,943,132</b>
eSPACE Programme (1617)*	1,642,084
National Oracle FMIS implementation (BOP)	1,200,000
Regional Microsoft Reporting Services (BOP) 1617	69,860
Regional Netscaler Reconfiguration (BOP)	17,465
SEEMail (BOP)	13,723
<b>Lakes DHB</b>	<b>1,582,416</b>
1617 1st of July changes	30,000
CSC rules engine module	60,000
eSPACE Programme (1617)*	853,866
National Cardiac Registry - Dendrite	135,000
National maternity	150,000
National Patient Flow (P3: Linked events)	149,000
Newborn hearing screening system	60,000
Radiology results into éclair	100,000
Regional Microsoft Reporting Services (Lakes) 1617	30,800
Regional Netscaler Reconfiguration (Lakes)	7,700
SEEMail (Lakes)	6,050
<b>Tairāwhiti DHB</b>	<b>541,920</b>
eSPACE Programme (1617)*	520,131
Regional Microsoft Reporting Services (Tairāwhiti)	15,064
Regional Netscaler Reconfiguration (Tairāwhiti)	3,766
SEEMail (Tairāwhiti)	2,959
<b>Taranaki DHB</b>	<b>1,336,175</b>
eSPACE Programme (1617)*	1,287,372
Regional Microsoft Reporting Services (Taranaki) 1617	33,740
Regional Netscaler Reconfiguration (Taranaki)	8,435
SEEMail (Taranaki)	6,628
<b>Waikato DHB</b>	<b>7,244,735</b>
Access to community pharmacy	100,000
EMRAM level 5 requirements	700,000
eSPACE Programme (1617)*	4,385,924
National Oracle FMIS implementation (Waikato)	1,870,000
Regional Microsoft Reporting Services (Waikato) 1617	130,536
Regional Netscaler Reconfiguration (Waikato)	32,634
SEEMail (Waikato)	25,641

<b>Service Lifecycle Mgt</b>	<b>7,994,000</b>
<b>BOP DHB</b>	<b>2,325,000</b>
Infrastructure existing and new capacity pool	2,325,000
<b>Lakes DHB</b>	<b>845,000</b>
Annual upgrades	420,000
Cisco servers and handsets	300,000
Replacing Long range paging solution	50,000
Windows 2013 implementation (Corp and Clinical environments)	75,000
<b>Taranaki DHB</b>	<b>800,000</b>
Lifecycle Management (15/16 onwards)	800,000
<b>Waikato DHB</b>	<b>4,024,000</b>
Application lifecycle (16/17)	450,000
Capacity Augment (1617)	200,000
Clinical and Corporate Platform refresh	200,000
Decommission Galen	100,000
Grouping of desktop/hardware	700,000
Grouping of lifecycle	1,100,000
Infrastructure lifecycle (16/17)	500,000
MS Licensing True up	300,000
Other licencing true up	300,000
Unified comms - Phase 4 (1617)	174,000

\*Note that the eSPACE figures are based on the original financial profile. The eSPACE 5 year roadmap is currently being updated as part of Project REFLECT and will be subject to eSPACE governance approval.

## eSPACE 5 year roadmap

The eSPACE 5 year roadmap is currently being updated as part of Project REFLECT, and will be subject to eSPACE governance approval.



## Appendix 2: Regional governance

### Regional collaboration framework

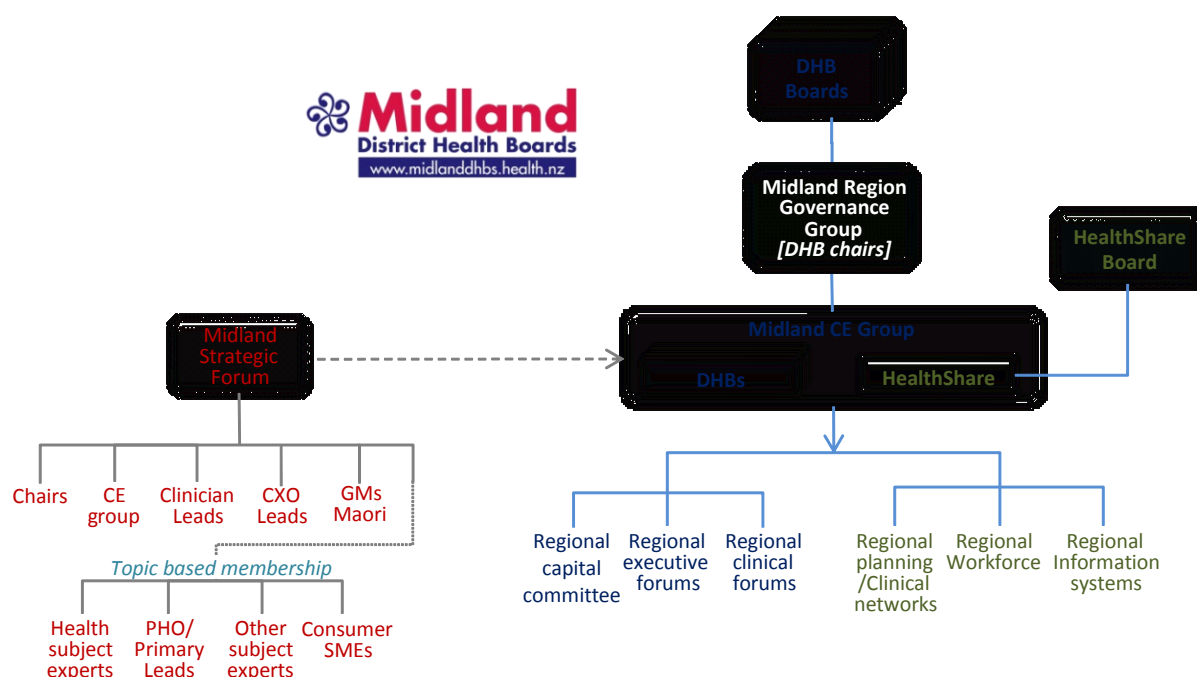
The DHBs have a history of co-operating on issues of regional importance and on new programmes of change. The formalising of a new regional collaboration structure, and the development of associated accountabilities, provides the strategic framework for advancing a more aligned regional programme of work.

It is acknowledged that regional work is complex and occurs alongside the need for DHBs to continue to meet the current health needs of their populations. However, as the Midland region continues to plan for service improvement within the current and mid-term environments, via the Regional Services Plan, the region's governors have signalled their desire to take a longer-term, more integrated, approach to health and community wellbeing. They see the development of a more formal regional collaboration framework as supporting this aspiration and future regional planning.

### Regional Structure

While responsibility for the overall performance of regional activity collectively rests with the five Midland DHB Boards, operational and management matters concerning the RSP and its implementation have been delegated to the Midland Chief Executives Group.

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.



- The Midland Region Governance Group (MRGG) is the key governance group for the region, overseeing and taking accountability and responsibility for regional direction, strategy and key programmes of change. Each member is accountable to their DHB Board and is responsible for informing their DHB of matters of significance, including risk and mitigation strategies, for matters arising from the group's deliberations.
- The Midland CE Group (MCEG) provides active leadership and operational decision making for regional activities. The group is responsible for the resourcing and the

ongoing support and monitoring of progress for agreed work programmes. The group manages any associated issues and risks for the Midland region and/or its DHBs.

- The Midland Strategic Forum (MSF) is a new regional group that enables a broader collaboration with clinicians from across the health sector, including public health, primary care representatives, consumers, and in-sector and out-of-sector experts.

HealthShare Ltd (HSL) is the Midland region's shared services agency and is a limited liability company with the five Midland DHBs holding equal shares. An outline of HSL's services can be found on p.20.

The Regional Capital Committee comprises the five Midland DHB CEs and is responsible for the operational review and associated process approvals for regional capital investment, as documented in the Midland Region Capital Plan, that has previously been agreed through the approved Regional Service and DHB Annual Plans. Strategic discussions on possible new regional capital investment are held at the Midland Region Governance Group and subject to individual DHB Board approval through the normal Regional Services Plan drafting and approval processes.

#### ***Decision Making Principles (for MRGG, MCEG, MSF)***

The purpose of these principles is to facilitate greater levels of regional co-operation and regionalisation within Midland. The principles apply to any significant and substantive decision of a Midland DHB that impacts another Midland DHB. The principles apply to the MRGG, MCEG, and the MSF.

Any significant decision taken by the Midland collaboration groups shall:

- Require the agreement of all Midland DHBs, but it is not necessary that all Midland DHBs will be involved in the implementation of the decision
- Be approved through appropriate approval processes in each DHB
- Provide that no DHB shall opt out of their commitments around decisions that they have agreed to

#### ***Definition:***

Regionalisation does not necessarily mean centralisation. Regionalisation can mean a number of DHBs working together virtually across Midland on a particular function, service or programme of work. Regionalisation may also mean either clinical or non-clinical service provision between two or more DHBs.

#### ***Decision making criteria for regionalisation***

The following criteria shall be applied to any decision involving regionalisation:

- It makes the service more sustainable by improving any or all of -
  - Effectiveness (providing the right services)
  - Efficiency (providing services the right way)
  - Economy (input costs lower now or in the future)
- It reduces service risk
- It improves health outcomes, including equity of access and equity of outcomes across the region, particularly around vulnerable services
- It is aligned to national expectations
- There is an opportunity for local say on clinical services
- It builds clinical capability

- It reduces duplication in clinical and non-clinical services
- It aligns with regional services (clinical and non-clinical) plans
- It acknowledges that, all other things being equal, the provision of clinical and non-clinical services be located as close to the patient (virtual or otherwise) as may be reasonable given the application of the criteria above.

### ***Decision making processes***

The following principles provide guidance to the processes that support regional decision making:

- Decision making processes should support timely decision making. Decisions should be agreed, documented, visible and enacted
- Key initiatives will have a lead appointed who will be accountable for progressing the agreed milestones
- Common briefings to DHB Boards will be used wherever possible
- In relation to decisions made, members of each regional collaboration group have a responsibility to:
  - Communicate with colleagues locally and consult if necessary
  - Ensure that decisions are communicated to and acted on within their own DHB.

### ***Code of Ethics***

Good collaboration/governance requires members to exhibit behaviour of the highest ethical and professional standards. Members of regional collaboration groups and any committees or working parties formed as a result of regional work programmes shall exhibit the following behaviours:

- Good faith: Act honestly and in good faith at all times in the best interests of the Midland region and its community
- Care: Exercise diligence and care in fulfilling the functions of membership
- Regional knowledge: Maintain sufficient knowledge of the Midland region's business and performance to make informed decisions
- Participation: Attend regional group meetings and devote sufficient time to preparation for the meetings to allow for full and appropriate participation in the group's discussions and decision making
- Decisions: Abide by the regional group's decisions once reached notwithstanding a member's right to pursue a review or reversal of a regional group decision
- Relationships: Foster an atmosphere conducive to good working relations
- Behaviour: Treat all others fairly and with dignity, courtesy and respect
- Due diligence: Not agree to Midland region incurring obligations unless he or she believes that such an obligation can be met when required
- Confidentiality: Not disclose to any other person confidential information other than as agreed by the regional group or as required under law
- Collective responsibility: Not to make, comment, issue, authorise, offer or endorse any public criticism or statement having or designed to have an effect prejudicial to the best interests of the Midland region
- Conflicts of interest: Declare all interests that could result in a conflict between personal and regional priorities and comply with the Conflicts of Interest Policy.

## Regional elective services governance

Midland DHBs have a specific governance group overseeing regional elective services. Key functions of the 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

Project Governance Group Membership:

1. Midland CE representative
2. Midland COO representative
3. Action group chair
4. Planning and Funding General Manager representative
5. Senior HealthShare representative
6. Senior clinical representative
7. Taranaki representative
8. Tairāwhiti representative

## 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.

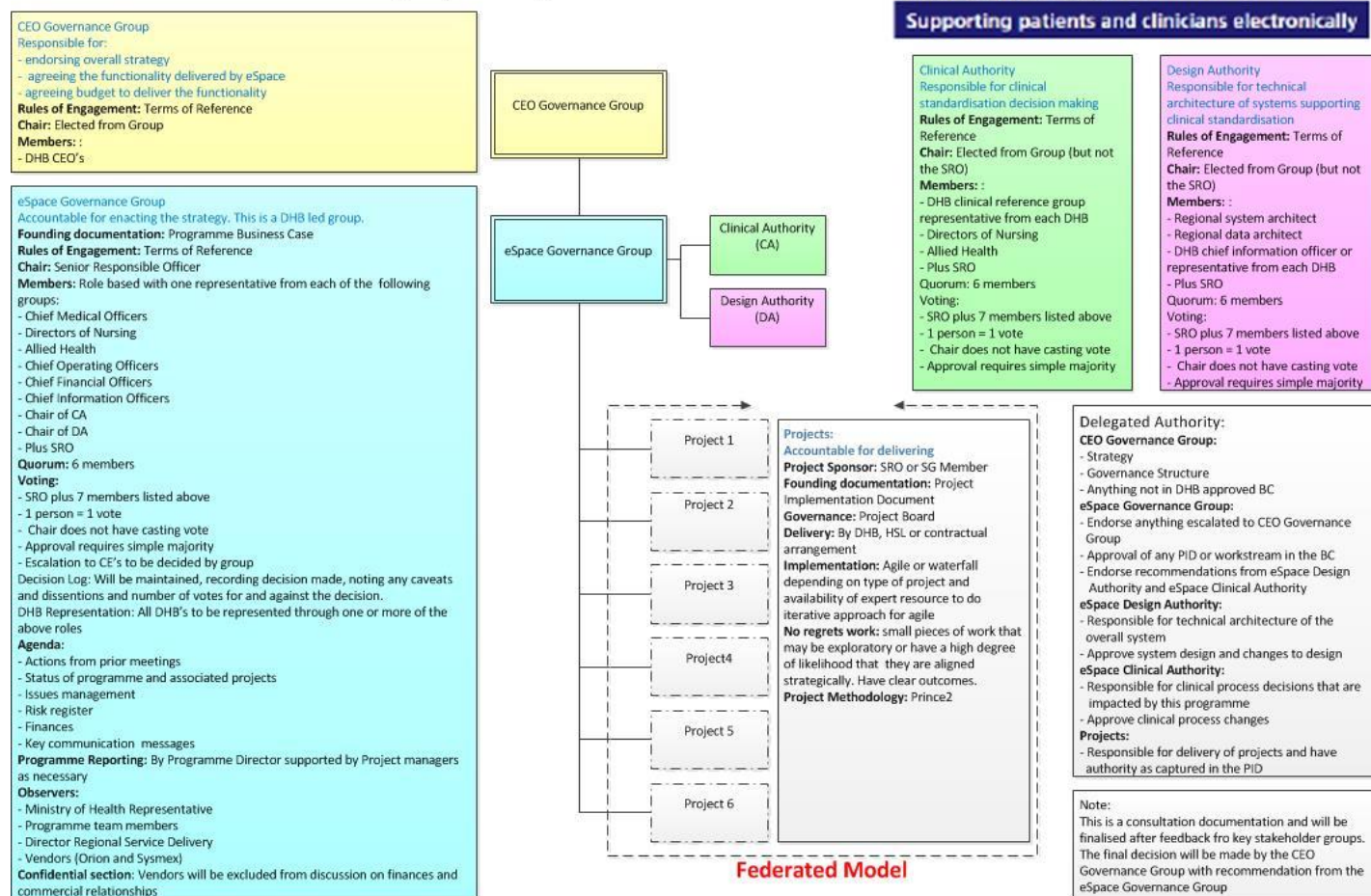
Additionally, there is a need for strong clinical leadership and governance across the multiple activities in the clinical programme of work, however, given the work demands and time pressure that clinical leaders find themselves under, this leadership needs to be applied judiciously to ensure maximum 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 arrangements are tailored in relation to the needs of the various programmes of work in the Midland region, and are aligned to the Midland Coordinated Services model structure.



## Governance on a Page (Draft)



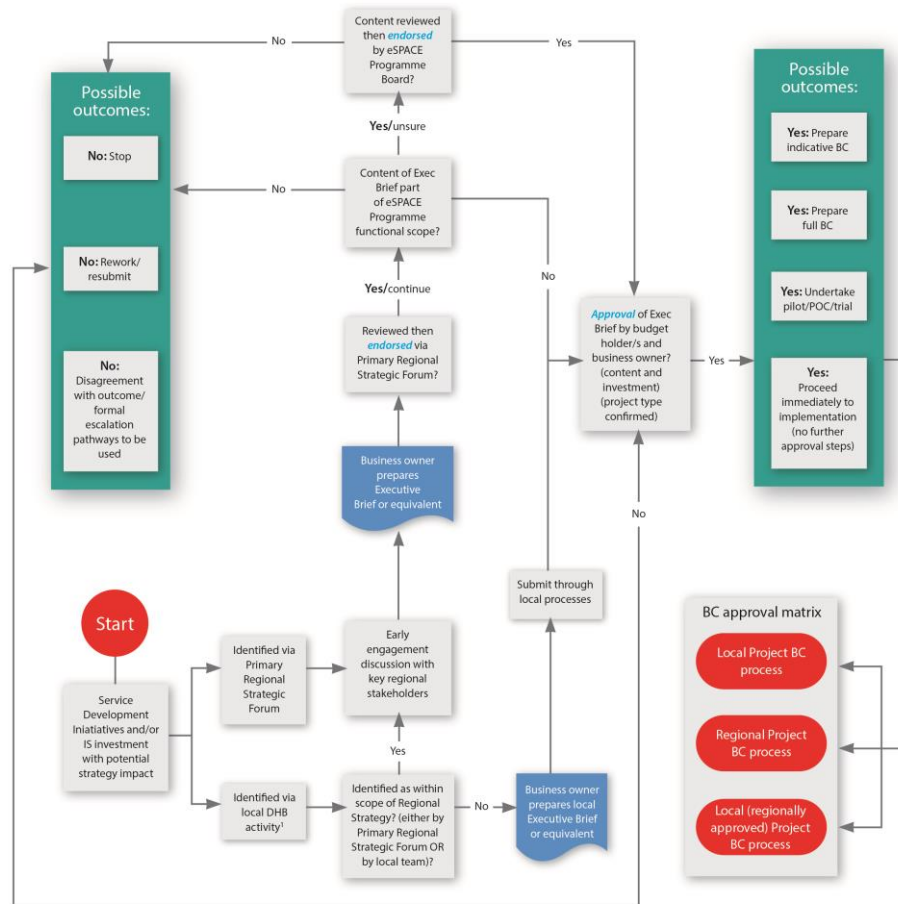
## Regional IS portfolio

Capital IS investment in Midland region is informed by and informs the annual capital planning and budgeting processes at each DHB, and for the region. With a move towards IaaS and SaaS type solutions, and a range of capitalisation policies across the region, the portfolio is now updated to include potential non-capital investment which is still required to align to approved governance structures.

Requests for IS investment are evaluated based on business priority, affordability and achievability via agreed processes and governance structures. See diagram below.

Approved business cases are delivered through regional programmes and projects. Programme and project teams are formed in HealthShare through permanent appointments or DHB staff secondments. A programme approach is used to ensure a focus on benefits and business case delivery for the eSPACE components, while projects deliver the discrete service components that programmes require.

## MIDLAND PORTFOLIO APPROVAL PROCESS: INITIAL APPROVAL STAGE - DRAFT



<sup>1</sup>Early visibility of all IS investment via Midlands portfolio processes

Strategic Plan Alignment	Primary Regional Strategic Forum	Likely Business Owner	Likely Budget Holder
Regional Services Plan	Relevant Regional Clinical Network	RCN Chair	Multi-DHB, COO's
Regional Telehealth Strategy	Regional Telehealth Forum	Regional Telehealth Forum Chair	Multi-DHB, COO's
RSP: Regional infrastructure strategy	IS Leadership Team	Lead CIO	Multi-DHB
RSP: Clinical systems workstream	eSPACE Programme Board	HSL CEO	eSPACE Programme Board
Other plans?			

## 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 1 provides an overview of highly specialised referral flows by different DHBs within the region.

Table 1: 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	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 elective surgery, including 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 an emphasis 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;
- Sub-specialisation (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 may reduce the extent to which general surgeons provide screening endoscopy services;
- More services may 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 2: 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 and Taranaki DHBs, and Hauora Tairāwhiti to deliver 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.

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 3 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 sub-specialisation.

Table 3: 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 two regional cancer networks: Midland Cancer Network for Bay of Plenty, Lakes and Waikato DHBs and Hauora Tairāwhiti. 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 Hauora 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 4: 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	Hauora Tairāwhiti (local)
	Highly specialised surgery	Waikato and Auckland DHBs
	Mammography symptomatic	Hauora Tairāwhiti (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 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 Role Delineation Model (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.



### 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 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 report the entire region with sub-specialty skills such as Cardiac CT and MRI, or cover overnight reporting for scans not requiring attendance by a local Radiologist. 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.

### **3.6 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. 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).

## Appendix 4: 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 5: 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
<b>Demography</b> 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.
<b>Social Changes</b> <ul style="list-style-type: none"> <li>Increasing rates of obesity</li> <li>Changing consumer expectations</li> <li>Lifestyle changes</li> </ul>	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 6: 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
<b>Technology</b> Technological advances in fields such as: <ul style="list-style-type: none"> <li>• Genomics</li> <li>• Imaging</li> <li>• Diagnostics</li> <li>• Pharmaceuticals</li> <li>• Medical devices</li> <li>• Nanotechnology</li> <li>• Telehealth &amp; IT</li> </ul>	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.
<b>Models of care</b> Changing models of care incl: <ul style="list-style-type: none"> <li>• Integrated family health centres</li> <li>• Clarification of roles/functions of small rural hospitals</li> <li>• Strengthening of secondary services with increasing nursing specialization</li> <li>• Use of specialty centres</li> <li>• Greater integration of Māori models of care</li> </ul>	Health promotion and prevention services maybe 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.
<b>Workforce changes</b> <ul style="list-style-type: none"> <li>• Ageing &amp; retiring workforce</li> <li>• Reduced willingness to work antisocial hours</li> <li>• More part time employees</li> <li>• Increased subspecialisation</li> <li>• Changing workforce roles</li> </ul>	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 5: Glossary of terms

<b>Activity</b>	What an agency does to convert inputs to outputs.
<b>Capability</b>	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.
<b>Efficiency</b>	Reducing the cost of inputs relative to the value of outputs.
<b>Effectiveness</b>	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.
<b>Intervention logic model</b>	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
<b>‘Living within our means’</b>	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.
<b>Management systems</b>	The supporting systems and policies used by the DHB in conducting its business.
<b>Objectives</b>	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’.
<b>Outcome</b>	<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 <a href="http://www.ssc.govt.nz/glossary/">http://www.ssc.govt.nz/glossary/</a>)</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>
<b>Outputs</b>	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).
<b>Performance measures</b>	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 <a href="http://www.ssc.govt.nz/performance-info-measures">www.ssc.govt.nz/performance-info-measures</a> )
<b>Productivity</b>	Increasing outputs relative to inputs (i.e. either more outputs produced with the same inputs or the same output produced using fewer inputs).

<b>Regional cooperation</b>	<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"> <li>• Northern: Northland DHB, Auckland DHB, Waitemata DHB and Counties Manukau DHB</li> <li>• Midland: Bay of Plenty DHB, Lakes DHB, Hauora Tairāwhiti, Taranaki DHB and Waikato DHB</li> <li>• Central: Capital and Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, MidCentral DHB, Waitemata DHB and Whanganui DHB</li> <li>• Southern: Canterbury DHB, Nelson Marlborough DHB, South Canterbury DHB, Southern DHB and West Coast DHB</li> </ul> <p>Regional cooperation for some clinical networks may vary slightly. For example, Central Cancer Network contains eight DHBs: Taranaki DHB and Hauora Tairāwhiti in addition to the Central Region DHBs.</p>
<b>Results</b>	<p>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. (<a href="http://www.ssc.govt.nz/glossary/">http://www.ssc.govt.nz/glossary/</a>)</p>
<b>Strategy</b>	<p>See ownership (<a href="http://www.ssc.govt.nz/glossary/">http://www.ssc.govt.nz/glossary/</a>)</p>
<b>Sub regional cooperation</b>	<p>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.</p>
<b>Targets</b>	<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>
<b>Values</b>	<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. (<a href="http://www.ssc.govt.nz/glossary/">http://www.ssc.govt.nz/glossary/</a>)</p>
<b>Value for money</b>	<p>The assessment of benefits relative to cost in determining whether specific current or future investments/expenditures are the best use of available resources.</p>