

Introduction

This Primary Healthcare and Community Services purchasing intent and its companion document the Secondary Healthcare Services Purchasing Intent outline the current and new healthcare services the Bay of Plenty District Health Board intends to purchase over the next 3 years (to 2010) on behalf of its population. These papers will inform the BOPDHB's prioritisation and implementation of optimum services to enable the most productive use of limited and valuable resources, particularly workforce.

Purpose of this document

The key purpose of these purchasing intents is to make more explicit those activities and services that require additional effort or attention to achieve improvements in the performance of the local health system. These performance improvements will rely on reducing variation in processes, eliminating gaps in service provision by fostering active collaboration between services area, ensuring the timely development of appropriate and sustainable infrastructure and focusing on achieving the greatest improvement in health status for the resources available (value for money.) Core to the achievement of health status improvement will be the further development of integrated patient-centred, evidence based care Primary healthcare and community services across the district.

This purchasing intent will enable:

- Key stakeholders to plan and prepare for new or redesigned services
- Workforce and asset plans to be further developed
- To assist Primary and Community service providers to develop some certainty around service development.

Structure of this document

This paper is based a set of core underpinning principles mandated by the Board and builds on existing services and infrastructure. It includes service changes or developments that have already been agreed by the Board but have yet to be fully implemented. and where possible new service enhancements likely to arise from Health Needs Assessment and Service Reviews.

These services include enhancements agreed to in:

- BOPDHB District Annual Plan
- Actions required by Primary healthcare and Community to support services developments identified in the Secondary Services Purchasing Intent
- Midland DHB regional plans, eg cancer, cardiology, diabetes, renal, rheumatology, mental health
- BOPDHB Strategies such as Te Ekenga Hou, PHO Concept Plan
- National initiatives, eg introduction of neonatal hearing screen
- Mandated Programmes of Care, eg chronic conditions, acute care
- Service review reports and action plans such as the BOPDHB Action Plan to Address recommendations of the Primary and Community Health Service Review for Eastern Bay of Plenty and the Evaluation of the Implementation of the BOPDHB Palliative Care Strategy
- Yet to be completed health needs assessment such as the Review of Population Need for Elective Services and Current Provision and the Projected Population Need for Service Provision – Western Bay of Plenty
- Programmes of Care in development, including
 - Mental Health
 - Sexual and reproductive health
 - Child and youth

General timeframes have been proposed and an indication of revenue status is also identified for each proposed service enhancement. It should be noted however that implementation of the services will require further work including prioritisation of actions, development of service specifications and agreement between key stakeholders before service contracts are developed.

Purchasing Intent

The BOPDHB commits to maintaining the current level of investment in Primary healthcare and community services, and intends to increase the level of resource committed to service improvements. Within this quantum of funding the BOPDHB wishes to purchase:

- Wherever possible, services planned and provided utilising a district-wide approach
- An increased range of community based and delivered services.
- The transition of some current secondary care provided services, into community settings such as skin lesion surgery
- Standardised clinical processes including alignment to best practice benchmarks across sectors and providers wherever it is practical, cost-effective and appropriate.
- Increased provision of community-based care outpatient and day patient services by secondary care

- Cost effective practical system improvements.
- Services, which are targeted on improving the equitable distribution of resources to improve health outcome.
- Evidence based models of care and integrated services that provide a seamless patient pathway and effective interventions that deliver increased benefits to patients and communities

Resourcing

The BOPDHB will be increasing investment in Primary Healthcare and Community services. The level of investment will be constrained by the fixed resources within the DHB's current funding envelope.

BOPDHB has prioritised this evidence based investment to significantly improve access to care, care outcomes, and sector capacity and capability. Roll out of the service enhancements outlined in this document will be evaluated to ensure that the expected results from this level of investment are returning the benefits expected.

The BOPDHB is committed to the full implementation of this purchasing intent. However it is understood that external factors such as changes to national health priorities, emergent pandemics and the need to ensure organisational financial sustainability may result in a modification of this intent and the implementation timeline.

The document consists of two sections the first section details service enhancements and the second section deals with sector development. The specific service areas are provided in the table below

Section A:	Section B:
• Acute care	• Primary Care
• Chronic conditions	• Aged Residential Care
• Palliative care	• Elective Services
• Health of Older People	• Referred Services
• Children and Young People	• Informatics
• Maori Health	
• Health Equity	
• Mental Health	

Primary and Community Services Purchasing Intent Plans 2007-2010

Acute Care

Context: Acute Care is the provision of appropriate, timely, acceptable and effective management of conditions with sudden onset and rapid progression that require urgent attention. The focus of the Acute Care Programme of Care is to ensure consistent access to all levels of acute care, improved the patient pathway through care and to ensure that the right level of care is delivered in order to maximise recovery and minimise disability.

Actions	Comments	Timeframe	Revenue
<p>Continue to work with communities to address access issues to after hours care in rural and isolated communities, this may include:</p> <ul style="list-style-type: none"> ▪ Developing new nursing models ▪ Increasing training opportunities ▪ Reviewing funding models to support after hours care ▪ Integration of afterhours care planning with developments in palliative care ▪ Chronic conditions ▪ Increasing community care options in place of hospital admission where practicable and safe (expanded CPO model) 		2007 ongoing	New and Existing
<p>After hours primary care provision and primary care attendances in the Emergency Department Whakatane Hospital. Work with the Provider Arm and primary care to undertake a review of the need for afterhours care to identify afterhours accident and healthcare services requirements for the EBOP.</p>	DAP action and identified as an action to address Grafton report	2008	Existing
<p>Scope options to improve community and primary care access to diagnostic procedures to support the implementation of the BOPDHB Chronic Conditions Programme of Care and Acute Care POC particularly primary care based patient management interventions (see referred services section)</p>	<p>In order for the successful implementation of the Chronic Conditions and Acute Care PoC easy access to diagnostics will be required this may include:</p> <ul style="list-style-type: none"> ▪ Point of consultation testing ▪ Community radiology ▪ Electronic viewing and reporting (PACS) 	2010	To be confirmed

	<p>system</p> <ul style="list-style-type: none">▪ Funding for Acute Outpatient clinics▪ Utilise Lab Clinical Board advice to improve quality.		
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Chronic Conditions

Context: This section describes the infrastructure and services the BOPDHB will develop to manage modifiable chronic conditions and also includes specific interventions to address cancer, cardio vascular disease, respiratory disease and diabetes. The BOPDHB programme of Care for Modifiable Chronic Conditions identifies 5 intervention packages

- Preventing Chronic condition
- Management of precursor chronic conditions
- Early Chronic Condition Management
- Advanced Chronic Condition Management
- End-stage Chronic Condition Management

For these intervention packages to be effective they must be supported by 4 key infrastructure elements, these elements include:

- **Condition Management** where patients and their family whānau are supported with knowledge and skills in order to self manage their chronic condition(s). This approach includes both general health care and a more disease specific focus, where necessary Health care providers have access to systems and tools that will enable them to support patients, families and whānau in this manner.
- **Delivery systems** designed so that services are patient /family/whānau centered and culturally acceptable, and delivered by multidisciplinary teams providing seamless self-management, care management and care coordination to the person and their family/whānau.
- **Decision support** includes provision of evidence based treatment and referral options and tools so that the right treatment at the right time is provided by the right level of healthcare. This may include electronic risk assessment and decision support tools that allow GP's to develop individualised patient risk management plans consistent with the most up to date evidence.
- **Clinical Information** will require access to clinical information between all healthcare services. This access will be supported by technology and will enable information to be used to support infrastructure and resource development including for example work force development planning.

Implementation of these interventions will need to include; building sector infrastructure, redesigning/ designing new services and developing tools and supports. Each of these action areas will need to integrate and align with other BOPDHB strategies and programmes including the:

- Palliative Strategy
- Cancer control Action Plan
- HEHA Plan
- Health of Older People Strategy
- Mental health

Implementation of the PoC intervention packages addresses issues identified in the Grafton Group Report

Actions	Comments	Timeframe	Revenue
<p>Conduct service redesign to implement the BOPDHB Chronic Conditions continuity of care model including:</p> <ul style="list-style-type: none"> • Consistent referral criteria/systems for the use of all parts of the continuum of care: • Development of care co-coordinators to facilitate the delivery of appropriate services • Map the patient journey for major chronic conditions • Patient self management support services 	<p>DAP</p> <p>Redesigned system and services in place</p>	<p>2007/08</p>	<p>Existing and New</p>
<p>Preventing Chronic Conditions HEHA, population based, public health initiatives and PHO health promotion activities will be delivered in the primary health care and community settings. Prevention interventions will include components of the following approaches</p> <ul style="list-style-type: none"> • Public Health programmes to develop safe and supportive environments • Comprehensive awareness raising, behaviour modification, and, risk identification (brief opportunistic interventions) including drug and alcohol use. • Nurse Led Kaupapa Maori Community Based Services targeting high need and rural areas • Advice and support for smoking cessation • Access to community nutrition /dietician information and expertise • Targeted PHO plans to improve access to prevention services • NGO based Maori specific Kaupapa based programmes • Primary care based mental health programmes to provide support and counselling • Expanded well child services to include Healthy Starts <ul style="list-style-type: none"> ○ Kaupapa based ante natal classes, to reduce the number of low birth weight babies, ○ Improved immunization uptake ○ Breastfeeding ○ Smokefree households 	<p>Delivery system</p> <p>Prevention interventions will require some expansion of existing roles and introduction of new roles into community and non health agencies such as schools, social support agencies and sports trusts</p> <p>Toi Te Ora Public Health Service Plan -Non Communicable diseases</p> <p>EBOP PHO Health Promotion Plan</p> <p>HEHA Ministry Approved plan -Breastfeeding</p>	<p>2007/08</p> <p>2007/08</p> <p>2007/08</p>	<p>Existing</p> <p>Existing</p> <p>Existing and New</p>

<ul style="list-style-type: none"> • Increase the number of fluoridated water supplies • Lifestyle support programmes provided by non-health agencies eg. Sport BOP • Improve community access to prevention information and referral options into existing service, through community agencies such as Information Centre, Women's Refuge, Churches, Ministry of Social Development programmes, and school curriculum • Implement the District HEHA Plan and administer the Nutrition Fund for schools to reduce chronic conditions through primary prevention 	<p>HEHA Ministry Approved Plan -Nutrition Fund in Schools and Early Childhood Centres</p>	<p>2007 -10</p>	<p>New</p>
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<p>Management of Precursor Risk of Chronic Condition.</p> <p>Self-management</p> <p>Introduction of supportive management interventions will include</p> <ul style="list-style-type: none"> - Increasing the 'uptake' of evidence-based screening programmes such as Get Checked - Increased uptake of preventative immunisations such as flu and hepatitis vaccination - Improved self-recognition and self-management of modifiable risk factors - Access to evidence-base tools, skills & knowledge to aid self-detection of range of conditions. - Development of Kaupapa Maori Nurse Navigator services - Introduction of point of consultation testing - Improved community access to diagnostics 	<p><i>Decision support</i></p> <p>Effective management of chronic conditions precursor populations is reliant on effective primary care recall systems, and the use of an agreed tool that identifies the common handful of modifiable risk factors¹</p> <p><i>Clinical information</i></p> <p>Clinical information support will require information at two levels Population level information around risk status from regular updates of PHO enrolled population Individual patient information from integration of a number of clinical systems such as PACS and laboratory reporting.</p>	<p>2007/08</p>	<p>New and Existing</p>
<p>Early Chronic Condition Management</p> <p>Early Chronic Condition Management is a comprehensive package delivered by primary healthcare providers that will ensure continuity and care management for the population with early conditions. It will utilise a range of evidence-based and best-practice protocols, procedures, and tools and care pathways for a variety of early conditions including diabetes, cardiovascular, respiratory disease, cancer, and mental illness.</p> <p>Self-Management interventions will include</p> <ul style="list-style-type: none"> ▪ Targeted group and individual education programmes for people with specific disease 	<p>Introduction of the Chronic Conditions PHO based continuity of care services based on multidisciplinary teams including social worker roles and the development of a Primary Care Advisor Role will also assist in improving communication and integration</p>	<p>2007/08</p>	<p>New and Existing</p>

¹ Tobacco, body weight, nutrition and diet, physical activity, alcohol, substance use, psychosocial stress

<ul style="list-style-type: none"> ▪ Utilising an identified health education management plan, including nurse navigators and peer educator/supporters ▪ Behaviour modification using brief opportunistic interventions ▪ Access to programmes to sustain improved healthy behaviours such as green prescriptions 			
<p>Advanced Chronic Conditions Management</p> <p>Advanced Chronic Condition management is a comprehensive generalist/specialist care package designed to ensure continuity and care management for people with more advanced complex chronic conditions.</p> <p>Advanced chronic condition management will build on the existing chronic condition management infrastructure to:</p> <ol style="list-style-type: none"> 1. Deliver continuity management (refers to continuity of information, people and care) organised within a primary/secondary network and delivered by the primary care team that coordinates: <ul style="list-style-type: none"> ▪ Consistently organised access to 'specialist care' programmes (community and in-patient) to assist in stabilising co-morbidities and planned specialist care provided through community outpatient interventions for early detection ▪ Specialist support services such as community pharmacy medicines management ▪ Structured programmes that maximise independence, functional autonomy and quality of life, predominantly delivered in clinical settings such as slow stream rehabilitation ▪ Uniform access to appropriate diagnostic tools and effective therapeutic interventions <p>New services will include</p> <ul style="list-style-type: none"> ○ Primary care based nurse led care continuity management ○ Primary care managed acute response service ○ Establishment of new models of specialist care available in the community and delivered in the home (Virtual wards). 	<p>Delivering this level of care continuity will require the development of new infrastructure including:</p> <ul style="list-style-type: none"> • Creation of primary/secondary healthcare multidisciplinary networks • Primary/secondary/ tertiary interface processes • Electronic referral and discharge summaries • Individualised discharge planning • Specialist roles including General Practitioners with a Special Interest (GPSI), Nurse practitioners, and continuity of care • Uniform access to diagnostic services particularly for people who live in isolated rural communities 	2008/09	New and Existing

<p>This model draws on both primary and secondary care expertise and would form part of a care continuity management response</p> <ul style="list-style-type: none"> ○ Development of slow stream rehabilitation services within the community to support the return or maintenance of independence ○ Development of sub acute step down services, such as short stay admission to NGO residential care ○ Development of new social worker roles in primary care as part of care continuity team ○ Expansion of home based support services ○ Provision of rapid response services such as specialist chronic conditions nurses in ED, and the provision of out reach services in community as part of the virtual ward system ○ Development of virtual First Specialist Assessment services and acute outpatient clinics for the timely provision of specialist clinician advice and support to general practitioners ○ Development of the nurse navigator role to guide and support patients requiring intensive management and to ensure patients complete a treatment round eg cancer care ○ Development of sub acute step down services/ transition beds in residential care ○ Introduction of Community Pharmacist medicines management to support people with complex pharmacological treatments 			
<p>Investigate the devolvement of Secondary care contracted Home based support services and Community Services Personal Care to primary and community sector</p>	<p>This will allow better alignment with current service provision</p>	<p>2007/08</p>	<p>Existing</p>
<p>Introduce CarePlus Community Pharmacy medicines management</p>	<p>This is a core component to support care for people</p>	<p>2007/08</p>	<p>Existing</p>

	with Advanced Chronic Conditions		
Evaluation of the Discharge Transition Funding pilot will provide more information to support any redesign of this funding stream.	Identified as an action to address Grafton report	2007/08	Existing
Cancer			
Participate in the Midland Region Cancer Network	Attendance at Midland Region Cancer Network.	2007 -2010	Existing
Continue implementation of BOPDHB Smokefree Policy <ul style="list-style-type: none"> ▪ Use data to target effective smoking cessation 	Identified in the BOPDHB Cancer Action Plan	2007-2010	
Strengthen multidisciplinary care for cancer patients <ul style="list-style-type: none"> • Encourage primary healthcare participation in a district cancer technical advisory group (CTAG) • Review care co-ordination & options identified for improving links with community services and provider arm services (linked with patient mapping) • Development of care co-coordinators to facilitate the delivery of appropriate services • Continue Cancer Support and Advocacy specialised service for Maori (covers full spectrum of needs of the patient and whanau including rehabilitation and palliative care) • Apply the BOPDHB chronic progressive conditions model to provide and organising framework 	Identified in the BOPDHB Cancer Action Plan	2007-2010	New and Existing
Implement the recommendations of the evaluation of the BOPDHB Palliative Care Strategy	Identified in the BOPDHB Cancer Action Plan	2007/08	Existing
Continue to develop a workforce consistent with the Midland Regional Cancer Network endorsed approach of localized service provision.	Initial funding premiums may need to be considered for start-up services (Haematology/Oncology for example).	2007-2010	
Cardiac			
Ensure equity of access to cardiac rehabilitation services for all patients by participating in the development of a regional coordination model for the delivery of CR services.	Midland regional model of care developed which recognises different sectors of community Patient pathway mapping may be appropriate in	2007/08	Existing

Palliative Care

Context

In 2003 the Bay of Plenty District Health Board developed a Palliative care strategy. This strategy focused on:

- Developing a consistent palliative care approach
- Establishing a district palliative care network
- Organising a single point of co-ordination
- Building provider capacity and capability
- Developing a comprehensive continuum of care

The implementation of this strategy has been recently evaluated. This report has yet to be finalised however the preliminary recommendations endorse the original strategy and identify key actions to progress the development of palliative care services.

Actions	Comments	Timeframe	Revenue
<p>Recommendations from the evaluation of the Implementation of the BOPDHB Palliative Care Strategy May 2007, may include</p> <ul style="list-style-type: none"> • Re establishment of the Palliative Care Network • Introduction of the Liverpool care pathway • Progress the development of a district wide specialist palliative care service comprising Palliative Physician, Nurse Practitioner, Pain Management and social worker service. This service will work across hospital, hospice and community for both EBOP and WBOP • Introduction of an independent service providing a single point of needs assessment and care co-ordination/ case management • Development of a district secondary care inpatient service based on the Liverpool Care Pathway • Review and alignment of provision of palliative care respite beds • Development of primary care based palliative care services for Maori • Participation in Midland Regional Palliative care planning and service alignment. 	<p>This service development will required new resourcing for:</p> <ul style="list-style-type: none"> • Network activity support • Project funding to introduce the Liverpool Care Pathway • Approximately 3.5 FTE's for the District Specialist Service • Approximately 2 FTE per hospital • Expansion of palliative care services, training and workforce in primary care for Maori <p>Redesign of the existing services will allow for reinvestment of resources into a single pt of need assessment and care co-ordination (new RFP'd provider) Review current volumes and utilisation of respite beds/ carer respite including geographic access. This review may need to consider the current service specification for palliative respite and consider the introduction of level 5+ hospital care for end of life services</p>	2007/08	New and Existing

Health of Older People

Context:

A major principle of the Programme of Care for Older People is “adding functional life to years-lived for older people in the BOPDHB’s population”. This principle underlines the direction the BOPDHB is taking to reduce and prevent in some cases, the incidence of moderate and severe incapacity amongst our older population.

The focus of BOPDHB PoC activities are to

- Develop of environments that support older people to self manage.
- Enhance services and appropriate care options including:
 - improved co-ordination and connection of services and processes
 - home care, community support and residential care
 - interventions which enable older people to remain in their homes
 - services to assist formal and informal care givers
- Enhanced availability, flexibility, delivery, management and location of specialist geriatric and psycho geriatric services and improved information provision about care options for frail older people.

Actions	Comment	Timeframe	Revenue
As part of the redesign of secondary care Specialist Health Services for Older People (SHSOP) identify for primary and community services: <ul style="list-style-type: none"> • preferred best practice model of care • key service dependencies & structure, including <ul style="list-style-type: none"> ○ primary care referral ○ ED presentation ○ Geriatric Orthopaedics ○ Community Psychogeriatric ○ Early rehab intervention ○ Virtual consultations ○ Health access resource teams –(HART) rapid response early assessment and intervention team ○ Nurse Practitioner Community/Residential Support roles 	Implementation will address capacity, capability, patient pathways and care options for older people	Model fully implemented 2010	Existing

<ul style="list-style-type: none"> Implement the district wide rollout of the evaluated InteRAI tool 		2007/08	Existing
Develop a sub project to identify and scope integrated solutions to psycho geriatric/ mental health/ disability issues for older people	An interface project between Health of Older peoples services and Mental Health	2007/08	Existing
Develop appropriate services for Older Maori, which may include <ul style="list-style-type: none"> Kaupapa maori respite and residential services Expansion of the Enliven, supported living programme Identify and address gaps in Kaumatua services 	Identified as an action to address Grafton report	2007/ 10	Existing and New
Investigate the ongoing viability of residential care for the older population in Mt Maunganui, Papamoa, Omokoroa, and Waihi beach	Utilise information from the review of population need for community based secondary services in the Western Bay of Plenty to be completed 2007/08	2007/08	
Expand and strengthen development of slow stream rehabilitation services within the community to support the return to or maintenance of independence	Interface service between Chronic Conditions and Health of Older People	2007/ 10	Existing and New
Continue to develop the Enliven, supported living programme		2007/ 10	Existing and New
Supported living <ul style="list-style-type: none"> Visitor services Respite Home based support 	PoC activities	2007/ 10	Existing and New
Establish a technical advisory group to provide advice on positive ageing (PATAG)	Work is currently underway to establish the shared development of this group with SmartGrowth	2007/08	New
Utilise the findings of the innovations funded research project around establishing in the Western Bay of Plenty a One stop shop for older people to access information and services	Project established under innovations funding	2007/ 10	New

Child and Youth Health

Context

A Child and Youth Programme of Care will be developed during 2007/0. This programme of care will include a Health Needs Assessment (HNA). The programme of care will include current service developments and will also identify new service models for primary and community based care for children and young people. Key themes have already been identified including:

- Increased access to prevention and screening services and well child checks
- Increased access to specialist care in the community
- Improving the quality safety and accessibility of services such as oral health, ante natal and parenting services and the provision of obstetric care

Actions	Comments	Timeframe	Revenue
<p>Strengthen multidisciplinary care for children and young people including:</p> <ul style="list-style-type: none"> • Introduction of HIV screening of pregnant women • Continue roll out of Family violence initiatives • Introduction of community dentist service • Introduction of agreed services identified in the oral health business case • Introduce neonatal hearing screening • HEHA • Introduce opportunistic immunisation screening • Nurse Led Kaupapa Maori Community Based Services <p>Scope a service redesign to increase community delivery of specialist paediatric services, particularly for rural communities</p>	PoC development	2008	New Existing New New New New New New Existing Existing
Implement service redesign to improve administrative coverage in In-patient Maternity Services Whakatane	Identified as an action to address Grafton report	2008	Existing
Scope the introduction of ante natal services and lactation services	Identified as an action to address Grafton report	2008	New
Continue to support the Child and Youth Technical Advisory Group Immunisation outreach programmes have been expanded to include an extra 3 PHO's delivering this service	Identified as an action to address Grafton report	2007 ongoing	Existing

Investigate the development or redesign of antenatal and parenting services for young parents particularly Maori with a focus on Healthy Starts and reducing the number of low birth weight babies.	Identified as an action to address Grafton report	2008	Existing and New
Implement the Oral health services agreed in the Oral Health Business Case	HEHA Ministry Approved Plan - Nutrition Fund	2007/08	New
Implementation of the new Mobile Community Dentist Service for the Eastern Bay.	Identified in the Oral HealthPoC	2007/08	Existing and New
Access to primary care services for adolescents in Murupara will need to be further considered. BOPDHB will work with the community, school and primary care providers to develop solutions	Identified as an action to address Grafton report	2007/08	Existing
BOPDHB will develop Maori peer counselling service to support the uptake of breastfeeding. Evaluation of the Kaupapa Maori antenatal classes and the peer counselling services will provide information to guide the development of further antenatal, birthing and parenting courses for Maori	Identified as an action to address Grafton report HEHA Ministry Approved Plan –Breastfeeding with evaluation of the breastfeeding component included	2007/08	New
Investigate the provision of primary birthing services across the district (Tauranga and Whakatane)		2008/09	Existing
Increase childhood vaccine preventable disease coverage rates through contractual arrangements to achieve 95% of 2 yr olds fully immunised	DAP action	2007/08	Existing
Implement Service Redesign identified in the BOPDHB Sexual and Reproductive Programmes of Care	Identified as an action to address Grafton report	2008	Existing and New

Maori Health

Context:

The BOPDHB Maori Health Strategic Plan Te kenga Hou 2006 – 2007 Strategy: –To improve M ori health through addressing inequalities and strengthening wh nau, hap and iwi, outline the approach the DHB will utilise to improve Maori health. The key themes of this strategy are:

TINO RANGATIRATANGA (*Maori Self Determination*)

- To acknowledge and actively support M ori aspirations for determination and greater control over their own health and well being
- acknowledge and actively support M ori aspirations for self-determination
- Facilitate inter-sectoral commitment and action to improve the broader health determinants more effectively
- Work towards a Maori co-purchasing organisation

TUITUINGA POU HAUORA (*Integrated Service Delivery*)

- Ensure active Maori participation at all levels of service planning, implementation, provision and monitoring
- Improve access by reducing barriers
- Ensure that resources targeted to M ori in mainstream services are designed to maximise Maori health outcomes

HE RANGA HUA HAUORA (*Building on existing gains*)

- Develop comprehensive sustainable approaches to M ori provider development including mental health
- Strengthen M ori population health strategies to shift the balance towards health (including mental health) improvement, illness/injury prevention, health promotion and self-management
- Expand and strengthen the M ori provider workforce across the continuum of care delivery including mental health
- Continue to invest in 'For M ori by M ori' services including mental health
- Work with M ori providers to develop procedures to ensure services including mental health are responsible and accountable to wh nau, hap and iwi)

Actions	Measures/Milestones	Timeframe	Revenue
H Ritenga completed to contracted level	DAP action Number of audits using He Ritenga	2008	Existing
Pilot the kaupapa primary and secondary care service 'Whanaungatanga' Model	DAP action	2008	Existing
Increase compliance with ethnicity data collection protocols	This will require work with providers to improve their systems for collecting and recording ethnicity	2008	Existing

Agree and implement Mai Ng Kur Wh rei ki Tihirau M ori Workforce Plan (MNKWKT)	Number of new initiatives developed and implemented each year Gaps, issues and opportunities identified.	2008	Existing
Introduce Nurse led (Nurse Practitioner) Kaupapa Community Based services, targeting <ul style="list-style-type: none"> ▪ High need populations ▪ Rural and isolated communities ▪ Chronic conditions ▪ Whanau ora ▪ Child and youth 		2007	
Introduce the He Ritenga Treaty of Waitangi Health audit framework to community providers based on the outcomes and learnings of the trial of the tool in the Provider Arm		2009	
Expand Mirimiri contracts to address waiting times. This service expansion will be dependant on the availability of appropriate mirimiri practitioners	Identified as an action to address Grafton report	2008	
Scope the development of kaupapa mentoring & counselling services for Adolescents	high need identified in rural isolated areas of EBOP	2008	New and Existing
Expand access to community transport for isolated rural communities	high need identified in rural isolated areas of EBOP	2008	New and Existing
Develop Kaupapa suicide prevention services	high need identified across BOP	2008	New and Existing
Extend primary care school based clinics		2008	New and Existing
Improve access to GP services for Tauranga/Opotiki/Murupara PHOs	identified need for permanent locum positions across BOP	2008	New and Existing
Introduce regional Kaupapa Maori IMAC co ordination	Regional IMAC has identified need for Regional Maori IMAC Co ordinator in rural EBOP	2008	New and Existing
Develop Regional Kaupapa Maori Primary Health co ordination	Identified need for co ordinated services for Maori primary health in rural EBOP	2008	New and Existing
Integrate regional Kaupapa Maori Chronic Conditions co ordination as part of the implementation of the Chronic Conditions management services	High need for service dedicated resource to address diabetes & chronic conditions across BOP	2008	New and Existing
Continue Maori Provider Development including: <ul style="list-style-type: none"> o The development of Iwi health plans o progress and prioritise initiatives as identified by: 		2009	New and Existing

<ul style="list-style-type: none">- M ori Nursing Forum- M ori Mental Health Provider Forum- M ori DSS Providerso Implement Kaupapa Maori Nurse Practitioner Service for Primary Careo Tuhoē Health plan			
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Health Equity

Context

Reducing inequalities is a priority for government and is a BOPDHB District Strategic Plan Priority Area. Health inequalities are evident between socioeconomic groups, ethnic groups, and people living in different geographical regions and males and females. Health inequalities result in some people having more illness disability and dying earlier than others in different social groups. BOPDHB action to address health inequalities is focused on two areas; access and provision of health care and those factors that influence or impact on the ability of people to keep them healthy. These factors include, housing, employment, education, participation in society, income and safety.

Actions	Measures/Milestones	Timeframe	Revenue
Maintain the current Tauranga City on its Feet project - until 2008. The project may then be integrated into routine programmes of primary and community providers.		2008/10	Existing
Continue to participate in and support COBOP – particularly actions identified in the three year work plans for Housing, Healthy Eating Healthy Action, and Safe Communities projects and <ul style="list-style-type: none"> ▪ Contribute to the development of the economic transformation, environment and culture and heritage work plans in 2007/08. ▪ Maintain the work on Housing to promote affordability of housing, housing for people with disabilities, healthy homes projects and universal housing design. 	HEHA Workplace Wellness	2007	Existing
Consolidation of Tauranga Safe City project coordinated programme initiatives	Identify new priority areas to address and future funding from DHB to ensure sustainability of project.	2007/08	Existing
Continuation of Tauranga Healthy Homes project into Phase 2 in association with other funders. Identifying smaller priority communities for DHB-led projects to impact on poor health status of people living in un-insulated houses.		2007 ongoing	Existing
Continue to support Active EBOP - programme to promote physical activity among Maori, families/whanau, and young and older people in the Opotiki, Whakatane and Kawerau District Councils.	This is a 3 year programme working collaboratively with the 3 councils, Sport BOP, Maatata Sports, SPARC and ACC.	2007 ongoing	Existing
Continuation of promotion of influenza vaccination.	Future work will look at under 65's with chronic	2007 ongoing	Existing

	conditions who may be unaware of their eligibility for the free vaccine. This will target Maori and people with respiratory conditions in particular. Also look to work closely with primary health on options for rapid diagnostic testing and use of anti-virals.		
Pandemic influenza and other emergency management projects to promote readiness in community and amongst primary and community providers	Seeking proposals from public health and emergency management personnel	2007 ongoing	Existing
Promote use of HIA tool amongst local authorities and other government agencies.	Support staff from those agencies to gain the expertise needed.	2007 ongoing	Existing
Toi Te Ora - seeking a closer working relationship between the public health intelligence part of the PHU, and P & F and Maori Health teams in the DHB, PHOs, LAs and other agencies.	Making better use of existing epidemiological and social data to inform health promotion programme development.	2007 ongoing	Existing
Continue to support Active Families - Supports families with overweight/obese children to make better food choices and improve physical activity.	New programme since January 2007 funded jointly by SPARC and DHB and delivered by Sport BOP in the eastern BOP.	2007 ongoing	Existing
Pacific Island Health – consider the findings of the PI Health Needs Assessment currently being conducted by Pacific Island Community (Tauranga) Trust	Developed as part of the Ministry of Health Pacific Island workforce development funding stream	2007 ongoing	Existing
He Ritenga Treaty of Waitangi Health Audit Framework to assess culturally appropriate services within the Provider Arm to include mainstream and Maori Provider	Continued role out of He Ritenga	2007 ongoing	Existing

Mental Health

Context:

A mental health Programme of Care will be developed during 2007/08. This programme of care will utilise the Health Needs Assessment HNA completed in 2005 and 2006. The programme of care will also include current Mental Health plans and may also identify new service models for primary care specifically for people with mild to moderate mental health need. Key themes have already been identified including:

- The need to redesign specialist inpatient services in the Eastern Bay of Plenty
- Increased support for community based living- particularly for people with serious and enduring mental illness,
- Support for increased employment opportunities
- Increased access to respite for child and young people

Actions	Comment	Timeframe	Revenue
Explore option for a graduate clinical service to meet the needs of people with mental health issues and chronic physical conditions		2008	Existing and New
Review methadone Service provision and volumes to ensure timely consumer access	DAP action	2007/08	Existing
Increase consumer employment opportunities	Patient need identified	2007/08	Existing and New
Further develop child mental health respite services <ul style="list-style-type: none"> ▪ Identify scope and quantum of need ▪ Work with the mental health sector to develop service design 	Identified as an action to address Grafton report	2007/08	Existing and New
Scope the redesign of specialist inpatient services in the Eastern Bay of Plenty as part of the Whakatane Hospital redevelopment	Identified in the Secondary Services Purchasing Intent	2008	Existing and New
Pilot community based services for people with high and complex need including: <ul style="list-style-type: none"> ▪ Outreach services ▪ Community delivered and home based clinical and social support ▪ Supported housing 	Highlighted by mental health sector	2008	New
Scope the need for mild to moderate mental health services and the development of services in Primary Care	Further work with the mental health sector and the Local Advisory Group will identify the quantum of need and potential options for service development	PoC developed 2007/08	Existing and New

Scope the need for counselling support to be focused on justice referrals and probation services and or general counselling.	Identified as an action to address Grafton report	2008	Existing and New
Scope the range of services and options for people requiring respite services <ul style="list-style-type: none"> • adult respite beds • child respite beds 	Identified as an action to address Grafton report	2008	Existing and New

Sector Development

Context:

The BOPDHB DAP 2007/2008 identified two priority actions to guide and frame activities at all levels, these actions are:

Community Responsibility

Infrastructure Development

Facilities Development

Workforce Development

Information Systems Development

This section outlines key sector developments for the next 3 years

Actions	Comments	Timeframe	Revenue
Improve access to health service information, including designing community provider contracts to package health service information, update it regularly and provide it to Citizens Advice outlets and local libraries. Updated information could be provided on the BOPDHB website	Identified as an action to address Grafton report	2008/09	Existing and New
Scope the options and infrastructure required to devolve D/N and community nursing services in the primary care sector.	Identified in the BOPDHB Review of District Nursing Services	2008/09	Existing
Agree a Non-Provider Arm workforce development strategy and explore resource implications	DAP action	2007/08	Existing

Primary Health

Context

Good primary healthcare services provide essential services to enable people to stay healthy and to access care when they need it. The key role of primary care is identifying illness and to provide treatment and condition management that will control and limit the condition and associated disability.

The BOPDHB PHO Concept Plan provided the framework for the development of the 5 local PHO's. This plan also set a framework for the enhancement of the primary healthcare sector. These enhancements include:

- Increase the focus on prevention, behaviour modification, early diagnosis and treatment, in order to prevent and limit the development of chronic conditions.
- Improve the access to and appropriateness of primary healthcare services for M ori
- Consistent and seamless access to services across the continuum of care, including:
 - Removing/ redesigning the barriers between community/primary care services and secondary care
 - Integrate community service provision and ensure there are a range of community service options available eg respite care, social support, rehabilitation
 - Develop new models of care and scopes of practice such as
 - mobile/outreach services using multidisciplinary teams, virtual wards
 - Kaupapa Maori models of care
 - primary care based mental health,
 - General Practitioners with a Special Interest (GPSI)
 - access to community based specialist services eg community paediatrician, community physician
 - nurse led continuity of care services, nurse navigators etc
 - developing new models of delivery and organisation of GP services to facilitate recruitment and retention of GP services in rural and isolated communities

Appropriate placement of services including the reassessment of some secondary services into primary care as appropriate eg skin lesion clinics

Develop appropriate infrastructure to support development and new models of care including:

- IT systems and electronic decision support systems
- Referred services
- Agreed patient pathways

Most of these developments will be focused around the implementation of the BOPDHB Chronic Conditions PoC

Actions	Comments	Timeframe	Revenue
Collaborate across the range of providers to agree the right place for right care for step down beds once acute phase has been stabilised As part of the SHSOP service redesign project identify a patient pathway around sub acute step down care	DAP action Patient pathway identified and appropriate services design to meet need described.	2009	Existing

Implement the Primary Care minor surgery project		2008/09	Existing
Ensure ongoing primary healthcare participation in the Primary Care Information Plan (PIP)		2007/08	Existing
BOPDHB will continue to offer support, advice tools and processes to assist PHO's to improve their understanding of the health needs of their enrolled populations and to develop formalised PHO HNA	Identified as an action to address Grafton report	2007/08	Existing
Afterhours care in Whakatane. Work with providers to scope the development of afterhours primary care facility as part of Whakatane hosp redevelopment see Acute care	Identified as an action to address Grafton report	2008/09	Existing
Continue to increase the number of PHOs delivering the packaged service of: - M ori Health Plans - Care Plans - Performance Management	DAP	2007/08	Existing

Aged Residential Care

Context

Aged residential care currently provides core health and disability support services to older people and people with severe disabilities. There is potential to increase the range of services available to the community and the health sector. In particular to build additional components into the continuum of care. These additional components may include the further development of short stay sub acute hospital level services, rehabilitation and convalescent care, and palliative care. These developments will build on the current transition service and the bed and breakfast options in the Community Primary Options programme piloted by the Western PHO.

Actions	Comments	Timeframe	Revenue
Phased reconfiguration of Aged Residential Care (ARC) bed numbers by service type to reflect disability need	DAP action	2007/08	Existing
Identify the range of competencies required for sustainable delivery of BOP Older People PoC & Prioritisation List'. This includes the development of nurse practitioners who can work within elder care	DAP action	2007/08	Existing
Expand and further develop subacute and transition step down services to provide short stay care, at a more appropriate level for people following an acute admission to secondary care.	As part of the Chronic conditions PoC implementation	2008 ongoing	New and Existing

Elective Services

Context:

Elective services are interventions and treatment (usually surgical) that the patient requires for a condition that is not life threatening and where admission can be delayed.
BOPDHB

Actions	Comments	Timeframe	Revenue
Utilise the findings of the BOPDHB Review of Population Need for Elective Services and Current Provision, to redesign the provision of elective services	This may result in a review of elective service volumes currently in place. Standard discharge ratios targets will help ensure appropriate resource allocation.	2008	Existing and New
Work with GP's to better manage the timely and appropriate access to elective secondary services	This will include work around quality improvement processes being address by the Primary Secondary interface group. Also included is the management of inappropriate referrals which slow the development of local capacity.	2009	Existing and New

Referred Services

Context:

Referred services in Primary Care includes:

- Diagnostic services such as laboratory and radiology
- Pharmaceuticals and services provided community pharmacy

Referred services are essential support services for the timely and appropriate diagnosis, treatment and management of conditions. Successful implementation of the primary care based components of the BOPDHB Chronic Conditions PoC will require improved access, particularly for rural and isolated communities to a range of diagnostic and condition management support services.

Actions	Comments	Timeframe	Revenue
Scope options to improve community and primary care access to diagnostic procedures to support the implementation of the BOPDHB Chronic Conditions Programme of Care particularly primary care based patient management interventions	In order for the successful implementation of the Chronic Conditions PoC easy access to diagnostics will be required this may include: <ul style="list-style-type: none"> ▪ Point of consultation testing ▪ Community radiology ▪ Electronic viewing and reporting (PACS) system 	2010	To be confirmed
Introduce first line medicines management (medicine use review) services into community pharmacy	Training is currently underway for 60 community pharmacists to develop skills in medicine use review	2008/09	New
Develop specialist medicines management (advanced level) services within PHO's to provide advice and support to GP's and primary care services	Negotiations are currently underway with PHO's	2008/09	Existing
Review subsidization of private specialist medical laboratory testing	The review should find that resources can be more appropriately allocated.	2008/2009	Existing
Ongoing promotion of lab testing best practice by the Laboratory Clinical Board.	Consensus amongst stakeholder groups on what constitutes clinical best practice should lead to optimal testing practices in the region.	2008-2010	Existing

Informatics

Context:

This section identifies how BOPDHB and community and primary care providers will work together to improve the provision of information and communications technology, tools and processes to gather appropriate data at an individual level, to track and manage patients and to stratify population groups by their level of risk and therefore inform prioritisation and targeting of intervention effort

Effective chronic conditions management requires that 4 key elements for in place, these elements include:

- Condition Management where patients and their family whānau are supported with knowledge and skills in order to self manage their chronic condition(s). This approach includes both general health care and a more disease specific focus, where necessary Health care providers have access to systems and tools that will enable them to support patients, families and whānau in this manner.
- Delivery systems designed so that services are patient /family/whānau centred and culturally acceptable, and delivered by multidisciplinary teams providing seamless self-management, care management and care coordination to the person and their family/whānau.
- Decision support includes provision of evidence based treatment and referral options and tools so that the right treatment at the right time is provided by the right level of healthcare. This may include electronic risk assessment and decision support tools that allow GP's to develop individualised patient risk management plans consistent with the most up to date evidence.
- Clinical Information will require access to clinical information between all healthcare services. This access will be supported by technology and will enable information to be used to support infrastructure and resource development including for example work force development planning.

Actions	Comments	Timeframe	Revenue
Support the completion of HNA by the PHO to enable improved understanding of population risk and allow for risk stratification		2008/09	Existing
Continue to support and participate in the primary secondary interface working group project on developing shared electronic systems to facilitate patient referral and discharge across and between providers and the timely transmission of test results		2007 ongoing	Existing
Introduce a primary care based electronic decision support tool <ul style="list-style-type: none"> ▪ Scope the options and confirm preferred system 		2009	New
Increase the use and reliability of patient recall and screening data bases		2007 ongoing	Existing
Develop the use of electronic support for virtual clinics		2007/08	Existing