Bay of Plenty District Health Board
Annual Plan 2011/12
Statement of Intent 2013/14
Ms Sally Webb  
Chair  
Bay of Plenty District Health Board  
Private Bag 12 024  
TAURANGA 3143

Dear Ms Webb and team,

Bay of Plenty District Health Board 2011/12 Annual Plan

This letter is to advise you I have approved and signed Bay of Plenty District Health Board’s (DHB) 2011/12 Annual Plan for three years.

This year has seen significant change to the accountability framework for all DHBs with the introduction of annual Regional Service Plans to replace District Strategic Plans and one Annual Plan that incorporates the Statement of Intent. These changes are designed to help improve the way we plan service delivery by setting a long term direction and clear pathways to get there, through an integrated approach linking the different levels of health care.

I want to thank you for your cooperation as we transition to this new way of thinking and look forward to your continued support as we strive for improved health services for all New Zealanders.

Clinical and financial sustainability

All DHBs are expected to budget and operate within allocated funding and identify specific actions to improve financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB’s operation and service delivery.

I am pleased to see your DHB is planning to breakeven for the three planning years and that your plan notes a focus on identifying actions to ensure you continue to live within your means.

Primary Care

Delivering better, sooner and more convenient services closer to home has been a priority for the Government and DHBs for a number of years. Closer integration of services across primary and secondary care and a greater range of services being delivered in the community should not only reduce pressure on hospitals but also improve the patient experience. It is important that you collaborate with your regional DHB colleagues to develop this integration effectively.

I am pleased to see an enhanced commitment to achieving this priority area in your Annual Plan including more tangible actions and deliverables to show how you will achieve the objectives of your business case. I expect you to be active in advancing these improvements to the way primary care services are delivered in the community.
Regional Collaboration

Greater regional collaboration is a key aspect of the new accountability arrangements and supports more effective use of clinical and financial resources. Better collaboration amongst DHBs is essential to address priority vulnerable services and has the potential to maximise efficiencies through shared back office functions, as well as IT, workforce support and development and capital investment. As core elements of the National Health Board’s work, I look forward to seeing the benefits of collaborative partnership with your fellow DHBs as these important regional initiatives are implemented.

Your Annual Plan incorporates a strong regional flavour. It is evident that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning.

I expect to see delivery on your agreed Regional Service Plan actions as detailed in your Annual Plan and look forward to seeing greater ongoing support for the work of Health Benefits Limited in developing shared back office functions where appropriate. I also thank you for your continued commitment to work with the Health Quality and Safety Commission.

Health of Older People

The prioritisation of investment in services to ensure the health and support needs of older people are met is important. An ongoing programme will be required to manage the impact of our ageing population on health services and support the provision of high quality and sustainable services in this area.

I am pleased to see more detail in your Annual Plan on how you are planning to deliver health services for older people. I am especially interested to follow your progress in relation to addressing the respite care needs of your community and the effective use of recent additional funding for this service.

How you will provide new and expanded services for people with dementia is of importance to me as is your DHB’s continued application of the comprehensive clinical assessment tool (interRAI) currently being rolled out nationally. Better articulation of how improvements are being sought in this priority area will be expected from all DHBs in next year’s Annual Plan.

Clinical Leadership

Clinical leadership is fundamental to improving patient care and has an important role in supporting overall service delivery in a number of ways. Engagement with clinical leaders aids job satisfaction for health care professionals and improves delivery of workforce initiatives. The success of clinical networks is based on clinical input working across regions and nationally to assist with overall service delivery. Clinical leadership also plays an important part in the integration of service delivery closer to home.

I expect to see clinical leadership embedded as a way of working within your DHB and the ways in which you seek engagement with your clinicians continue to expand over coming years.

Health Targets

New Zealanders have high expectations that they will have access to quality health care services when they need them. The Government’s Health Targets are selected to drive ongoing improvements in specific priority areas in order to meet the growing expectations of the public.
I appreciate Bay of Plenty DHB's efforts to deliver on the Health Targets and overall I am satisfied with your progress in delivering on these. However, I ask you to continue to seek improvements and clearer identification of specific actions your DHB can take to accelerate performance across the six Health Targets.

The Ministry of Health has advised it considers there are risks to your DHB's ability to achieve the agreed targets for increased immunisation, better help for smokers to quit and better diabetes/CVD services. I expect you to remain focused on improving your performance in these areas and to work with the Ministry of Health, especially with the Health Target Champions to lift your performance on these targets in particular.

**Mental Health Ringfence**

I am approving your plan with the expectation that your DHB will work closely with the National Health Board to agree and ensure appropriate use of any currently unallocated mental health ringfence funding in line with policy.

**Annual Plan Approval**

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. All service change or service reconfigurations must comply with the requirements of the Operational Policy Framework and you will need to advise the National Health Board of any proposals that may require my approval.

Additionally, my acceptance of your Annual Plan does not indicate support for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependant on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round.

I acknowledge that the impacts for DHBs of the earthquakes in Christchurch over the last year are difficult to determine and that these have not been taken into account in producing Annual Plans. The impacts of these events are ongoing for the health sector and will need to be managed beyond what is included in your Annual Plan.

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2011/12 Annual Plan.

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

Yours sincerely

[Signature]

Hon Tony Ryall
Minister of Health
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The Midland Region DHBs

<table>
<thead>
<tr>
<th></th>
<th>Bay of Plenty</th>
<th><a href="http://www.bopdhb.govt.nz">www.bopdhb.govt.nz</a></th>
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<tbody>
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Note:
This plan should be read in conjunction with the draft Bay of Plenty District Health Board Māori Health Plan and the draft Midland Region Clinical Services Implementation Plan.
1 Executive summary

He aha te mea nui o te a? He tangata. He tangata. He tangata.

What is the most important thing in the world? It is people. It is people. It is people.

Health is very much about people – the people we are serving and the teams providing those services. This document, which for the first time is a combination of the District Annual Plan and the Statement of Intent, describes our short-term actions and goals as well as the measures we will use to gauge our success for the 2011/2012 year. Additionally, you will find within this report, our Statement of Forecast Performance for the three-year period 2011/12 to 2013/14.

In addition and complementary to the Government’s Expectations the Board have identified five key strategic priorities to be given increased focus during their three year term:

- Health Targets
- Māori Health/ Disparities
- Health of Older People
- Primary Health
- Wellness/Chronic conditions.

For each priority the Board identified the rationale for why each is important for the Bay of Plenty population and what they want to achieve in each area.

Health Targets

The Health Targets provide clear and specific focus for action to improve patient care and therefore better outcomes for our population.

Māori Health /Disparities

The long-term goal is for Māori within the Bay of Plenty to have the same level of wellness as non-Māori. The lack of Māori wellness is a burden on the community that must be addressed.

Health of Older People

BOPB DHB will be proactive in the management of services for the impending population increase in older people, given the associated high cost of care for this population. An emphasis will be on wellness, encouraging healthy independent living with good access to quality services and when eventually required palliative care.

Primary Health

BOP DHB will take a whole of sector approach, working in partnership to achieve wellness improvement and Better Sooner More Convenient services. This approach will see reduced reliance on hospitals and increased access to primary care services.

Wellness/Chronic conditions

BOP DHB will support services that enable people to become healthier and therefore reduce the need for treatment. This will include reduced obesity, stopping smoking, and high immunisation rates.
The drive to provide better, sooner, more convenient health care for the people of our community is at the forefront of our minds as we move into the 2011/12 year. Every member of society wants and expects access to good quality health care whenever they need it, whether it is at the birth of a child, during an acute midlife illness or at the end of life. Ensuring we understand and manage the tensions between cost, expectation and change will be fundamental in the coming years.

As a District Health Board we agree with the Government that innovation in service delivery is required to ensure the sustainability of public health services in a fiscally constrained environment. Procedures, medicines and medical interventions in general are improving rapidly in this ever-advancing technological era, but each carry an increasing cost.

The Bay of Plenty District Health Board is a complex organisation receiving annual Government funding of some $620M to provide and fund a full range of health and disability support services in the most efficient and effective way possible. Efficiency in the coming years will require innovation to continue to provide a high level of service within financial constraints.

Already we are starting to see the effects of innovation and transformational change on our services. Most recently the three original Eastern Bay of Plenty Primary Health organisations have merged into one regional Primary Health Alliance; implementation has commenced with Te Whiringa Ora (Integrated Family Health Network); a Whānau Ora provider has been formed in Opotiki; initial consultation and scoping of the Integrated Family Health Centre concept for Whakatane and Kawerau has commenced; and the Bay Navigator initiative across the Bay of Plenty has begun.

As a District Health Board we are committed to improving the health outcomes for our community not only through the evolution of services, but also through the achievement of the Minister’s priorities for 2011/2012. These include:

**Improving service and reducing waiting times**

In addition to meeting Elective Services and Emergency Department waiting time and delivery targets, we will develop strategies to assist in ensuring patients can be cared for as much as possible in a community setting, reducing the number of patients that require specialist care and referral to secondary services.

**Clinical leadership, networks and engagements**

Through the Midland Regional Clinical Services Plan, we will strengthen clinical networks and use these for service improvement and development at a local and regional level. Our focus for 2011/12 will be on ensuring senior clinicians and emerging leaders are supported to attend leadership programmes, ensuring that clinicians are involved in local and regional planning processes, and actively supporting national and regional initiatives related to enhancing clinical leadership, clinical engagement and the development of clinical networks.

**Closer integration of services**

Through Bay Navigator, the Integrated Family Health Network and Whānau Ora, we will work with community and hospital-based clinicians on long term conditions management, the frail elderly and appropriate services to assist in supporting patients to remain in their own homes, be cared for in the community where possible, and reduce unplanned admissions to hospital.
**The ageing population**

We will reduce hospital admissions through the provision of services in community settings and by ensuring access to respite care, day programmes and other social supports to appropriately support patients and their family/Whānau. We will ensure appropriate monitoring and audit to improve quality across home-care and aged residential care services.

**Regional collaboration**

Regional and national planning has become central to the DHBs planning process. We will place a strong focus on implementation of the Midland Regional Clinical Services Plan and work to develop shared functions across DHBs. In 2011/12 we will focus on six key service areas and three infrastructure areas these include Renal, Cardiology/Cardiac, Maternity, Primary Care, Mental Health and Cancer services and Information for Clinicians, Workforce and Māori Health infrastructure.

Multidisciplinary clinical networks will be established for each of these priority areas to ensure the development of sustainable regional models of care, each sitting under a common regional governance structure.

The Midland DHBs have been considering a range of options for consolidating back office functions across the Midland region, as a further action to improve cost efficiencies and drive infrastructure developments. Final decisions have yet to be made, but a range of functions are to be considered on a business case basis, to be provided through the vehicle of the Midland Region’s shared services agency HealthShare. That agency will also be responsible for supporting a strengthened regional planning function, ensuring that the Midland Regional Clinical Services Plan is implemented, and further built on in future iterations. The governance arrangements for overseeing the collaborative model will be based on equal shareholding between the five Midland DHBs.

**Deliver agreed financial results**

We will work with our staff and stakeholders to implement productivity and efficiency initiatives that will see real benefit to our community and ensure financial and clinical sustainability. The challenges for the sector and for us as a DHB are considerable and complex, made more so by restricted access to increases in funding. We have no option but to continue to do things in different, innovative and more effective ways if we aim to balance our budget and continue to provide the level of service required for improving the health outcomes of Bay of Plenty people.

If we are to successfully deliver on the priorities identified within this annual plan, we need to engage and support people at all levels, people delivering services and people receiving services, so that they have an understanding of the environment in which we operate.

We need to be clear about what we are hoping to achieve, how we are going to achieve it and how we will know if we have been successful. Now, more than ever, we need to be explicit about our priorities, our targets and the measures we will use whilst remaining flexible and responsive in an environment of change and uncertainty. We have been successful in creating innovations within our services in the past year and will continue to evolve with the changing environment.

Thank you to all those who have worked with us and alongside us in the past year, we hope you will continue to support us as we continue to strive towards healthy, thriving communities within the Bay of Plenty.
The Annual Plan of the Bay of Plenty District Health Board is signed for and on behalf of the DHB by:

<table>
<thead>
<tr>
<th>Sally Webb</th>
<th>Jeff Williams</th>
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<tbody>
<tr>
<td>Chair, Bay of Plenty District Health Board</td>
<td>Deputy Chair, Bay of Plenty District Health Board</td>
</tr>
<tr>
<td>Date: 24 June 2011</td>
<td>Date: 24 June 2011</td>
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</tbody>
</table>

The Annual Plan of the Bay of Plenty District Health Board is signed for and on behalf of the Crown by:

<table>
<thead>
<tr>
<th>Phil Cammish</th>
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<tr>
<td>CEO, Bay of Plenty District Health Board</td>
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<td>Date: 24 June 2011</td>
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The Honourable Tony Ryall

Minister of Health

Date:
2 Introduction

2.1 Context

2.1.1 Background

Bay of Plenty District Health Board (BOPDHB) is one of 20 District Health Boards (DHBs) established on 1 January 2001 by the New Zealand Public Health and Disability Act 2000 (the NZPHD Act). DHBs were established in respect of specified geographically defined populations as vehicles for the public funding and provision of personal health services, public health services, and disability support services. Each DHB is a Crown Entity, owned by the Crown for the purposes of section 7 of the Crown Entities Act 2004 and is accountable to the Minister of Health.

This Annual Plan (the Plan) has been prepared to meet the requirements of both section 39(1) of the NZPHD Act and section 139(1) of the Crown Entities Act 2004. It sets out our DHB’s objectives and goals against our strategic priorities and national expectations and describes to Parliament and to the general public what we intend to achieve in 2011/12 to improve the health and well being of our community. This Plan also contains non-financial and financial forecast information for 2012/13 and 2013/14.

As a public accountability document, this Plan will be used at the end of the year by auditors working on behalf of the Office of the Auditor-General to compare our planned performance with actual performance delivered and will be reported in our Annual Report.
2.1.2 Health Sector Context

This Plan has been prepared within a wider strategic context for health care set by Government. The Government wants all New Zealanders to lead longer, healthier and more independent lives. DHBs, as a significant part of the health system are expected to contribute by ensuring that service delivery is better, sooner and more convenient and that the health system is adaptive, innovative and continually improving.

The New Zealand Health Strategy, the New Zealand Disability Strategy and other strategies listed below provide the context and guidance for policy and planning and national, regional and local levels.

The New Zealand Health Strategy sets the strategic direction for all health services in New Zealand. It establishes a vision for health services, principles for planning and provision of services and it outlines objectives for the health of the population. In particular it focuses on tackling inequalities in health. The five priority service delivery areas included in the New Zealand Health Strategy are:

- Public health
- Primary health care
- Reducing waiting times for public hospital elective services
- Improving the responsiveness of mental health services
- Accessible and appropriate services for people living in rural areas.

The New Zealand Disability Strategy aims to improve the ability of people experiencing disability to participate in community life. The Strategy supports the underlying philosophy of valuing every individual and is intended to move New Zealand towards becoming an inclusive society.

The Māori Health Strategy (He Korowai Oranga) supports Māori aspirations to take control of their own health. It upholds the structures based around Whānau, Hapū and Iwi. It recognises that there is a range of community groups in Māori society which make valuable contributions to the advancement of Whānau health. He Korowai Oranga contributes to improving the socio-economic and health status of Māori. It also calls for reforms that will serve to value Māori solutions and integrate the delivery of health services that underpin the broader population health goals of Māori.

The Primary Health Care Strategy aims to see local populations enrolled in a primary health care service that improves health, keeps people well and is accessible.

The Treaty of Waitangi is New Zealand’s constitutional document. The Government is committed to fulfilling its role as a Treaty partner. Central to the Treaty relationship and implementation of Treaty principles is a shared understanding that health is a ‘taonga’ (treasure). Based on this understanding, Māori and the Crown (including Crown Entities such as District Health Boards) will have a shared role in implementing health strategies for Māori, and will relate to each other in good faith, with mutual respect, co-operation and trust.

The National Long Term Health Sector Plan (the LTHS Plan) represents an important step in developing a more integrated health and disability support system as collectively envisaged by the national strategies described above. The LTHS Plan provides a high level direction over a very long term (20 years), and describes the challenges the system faces, options for
models of care that offer solutions and implications for the way services are configured in the future. The LTHS Plan guides future decisions regarding service configuration and investment at all levels of the system and supports DHBs in their regional and local planning.

Regional Clinical Services Plans (RCSP) are central to DHBs delivery of health and disability services and drive increased collaboration to plan services. RCSPs describe the service strategy for the region and what services over time will be implemented collaboratively. More specifically the Midland RCSP outlines where the region aims to be in 5 to 10 years. It includes current and future population characteristics and plans the models of care and configuration of services across the region that will best ensure service viability and financial affordability. It guides resource allocation and service provision decisions at the regional and district level.

2.1.3 Population and Health Profile

Covering 9,666 square kilometres, our District Health Board serves a population of 202,193 and stretches from Waihi Beach in the North West to Waikato Bay on the East Cape and inland to the Kaimai and Mamaku ranges. These boundaries take in the major population centres of Tauranga, Katikati, Te Puke, Whakatane, Kawerau and Opotiki. Eighteen Iwi are located within the Bay of Plenty District Health Board area.

Population

Our population has the second fastest growth rate of all New Zealand’s District Health Boards. Total population growth in the planning period 2006 to 2026 is forecast to be 25.5% higher than that for New Zealand as a whole.

The majority of the growth is expected to be in the Western Bay of Plenty region (particularly Tauranga City) with the Eastern Bay of Plenty expected to experience a static or declining population. In this regard, 77% of our population resides in the Western Bay of Plenty.

These tables summarise the current demographic characteristics and future projections for the Bay of Plenty DHB area. The Census 2006 data provide the most recent accurate estimates describing the current population structure.

<table>
<thead>
<tr>
<th>Age group</th>
<th>BOPDHB 2006 (% of Total)</th>
<th>2006 – 26 (% Growth)</th>
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</thead>
<tbody>
<tr>
<td>0 - 14</td>
<td>22.4</td>
<td>6.4</td>
</tr>
<tr>
<td>15 - 24</td>
<td>11.6</td>
<td></td>
</tr>
<tr>
<td>25 - 44</td>
<td>25.1</td>
<td>17.3</td>
</tr>
<tr>
<td>45 - 64</td>
<td>25.1</td>
<td></td>
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<tr>
<td>65 - 74</td>
<td>8.5</td>
<td>84.3</td>
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<tr>
<td>75+</td>
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<td></td>
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<tr>
<td>Total</td>
<td>100</td>
<td>25.5</td>
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<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>BOPDHB 2006 (% of Total)</th>
<th>2006 – 26 (% Growth)</th>
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<tr>
<td>Māori</td>
<td>24.4</td>
<td>38.5</td>
</tr>
<tr>
<td>Pacific</td>
<td>11.1</td>
<td>83.4</td>
</tr>
<tr>
<td>Asian</td>
<td>2.4</td>
<td>21.5</td>
</tr>
<tr>
<td>European / Other</td>
<td>73.1</td>
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<table>
<thead>
<tr>
<th>Territorial Authority</th>
<th>BOPDHB 2006 (% of Total)</th>
<th>2006 – 26 (% Growth)</th>
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<tbody>
<tr>
<td>Western BiOP District</td>
<td>21.5</td>
<td>24.2</td>
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<tr>
<td>Tauranga City</td>
<td>53.4</td>
<td>36.4</td>
</tr>
<tr>
<td>Whakatane City</td>
<td>17.1</td>
<td>0.9</td>
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<tr>
<td>Kawerau District</td>
<td>3.5</td>
<td>-17.3</td>
</tr>
<tr>
<td>Opotiki District</td>
<td>4.6</td>
<td>-3.7</td>
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Compared to the national population, the proportion of Bay of Plenty DHB population that:

- Is 65 years and over is 29% larger than that for New Zealand as a whole.
- Identify as Māori is 67% larger than that for New Zealand as a whole.
- Live in rural areas is 49% larger than that for New Zealand as a whole.
In terms of projected future growth (2006 – 2026), for Bay of Plenty DHB area:

- Total population growth is higher (25.5 %) compared to that for New Zealand overall (18.1%).
- The 65 year and over age group is projected to grow the most (84.3% increase in 20 years).
- Growth in the 65 year and over population is very similar (84.3%) to that for all New Zealand (85.2%).
- Growth in the 0 – 14 year population is higher (6.4%) compared to that for all New Zealand (1.1%).
- The Māori population has a higher growth rate than the ‘European/Other’ population.
- While the Pacific Islander population is projected to have the highest growth rate, this is starting from a very small baseline currently representing 1.1% of the total Bay of Plenty DHB population.
- The majority of the growth is expected to be in the Western Bay of Plenty region, particularly Tauranga city, with the Eastern Bay of Plenty region being static or experiencing population decline.

Like the national population, our population is ageing, with the highest percentage increase occurring in the 65+ years compared with New Zealand as a whole. Our ageing population has obvious and very serious implications for health services into the future, particularly in terms of workforce sustainability and demand on services.
2006 Census

2006 Census - Sub Regional Age Profile

The significant number of over 65’s can be attributed to:

- The region is a desirable retirement destination.
- We start from an older base (current).
- We lose many of the 18-30 age groups (tertiary study, jobs).

Unlike the Western Bay of Plenty, the Eastern Bay of Plenty has a relatively youthful population with a third of the population under 30 years compared to a national average of 28%.

About a quarter of our population live in areas with high NZDep 06 scores (which are associated with poorer health). About one in seven people live in areas with low scores (associated with better health).

Health Profile
Our health profile is generated through a comprehensive Health Needs Assessment (HNA) that describes our population and their health status. The health and disability status of the population in our district, together with input from the community and stakeholders, help ensure that we select long-term strategic outcomes to meet the health needs of our population.

Analysis of the health needs of people of the Bay of Plenty has indicated the following priorities:

- Avoidable hospitalisation.
- Disease of the respiratory system, bronchitis and asthma amongst infants and young children, adults and older people.
- Children and youth have significantly higher rates of hospitalisation and death due to accidental injuries. These include burns (more than double national rates), falls, accidental poisoning and road traffic accidents.
- Chronic obstructive airways disease amongst adults that is 10% higher than national rates.
- Whooping cough and acute bronchitis amongst infants and young children (especially amongst Māori infants).
- Cellulitis amongst adults (45-64 years).
- Diabetes and chronic renal disease (including diabetes renal failure).
- Cardiovascular disease, including ischaemic heart disease and strokes disproportionately affects Māori.
- Gastroenteritis for infants and young children.
- Skin conditions for youth and adults.
- Otitis media for infants, young children, younger adults and older people.
- Schizophrenic disorders for youth and young adults.
- Unstable angina for older adults.

Māori children and youth in the Bay of Plenty also have substantially worse indicators for asthma, oral health, teenage pregnancy and acute rheumatic fever (and chronic rheumatic heart disease) that are amongst the highest in the world.

Social and economic characteristics of populations are recognised as key determinants of health outcomes and health inequalities and are therefore important considerations in assessing health needs and determining interventions to improve health.

Key socio-economic indicators include:

- Approximately 50,000 people in Bay of Plenty DHB area live in NZDep 9 and 10 areas (most deprived) – approximately 50% of this population are Māori
- Approximately 50% of the total Māori population lives in NZDep 9 and 10 areas while approximately 25% of all non-Māori are in NZDep 9 and 10 area
• In general, compared to the Western Bay of Plenty the population in the Eastern Bay of Plenty is younger, has higher levels of unemployment, and higher levels of socio-economic deprivation as estimated by NZDep score
• Overall, Bay of Plenty DHB population is over-represented in high deprivation score categories and under-represented in low deprivation categories compared to New Zealand as a whole

![Distribution of NZDep in BOPDHB and New Zealand (2006)](image)

The following panel is a summary of key socio-economic indicators for the Bay of Plenty DHB population, compared with New Zealand rates:

<table>
<thead>
<tr>
<th>BOP DHB rate same as NZ rate</th>
<th>BOP DHB rate higher than NZ rate</th>
<th>BOP DHB rate lower than NZ rate</th>
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<td>Low income**</td>
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<tr>
<td>Overcrowding (all)</td>
<td>Unemployment (1.2)</td>
<td>No car access (0.8)</td>
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<tr>
<td>Overcrowding (0 – 24 years)</td>
<td>No telephone access (1.5)</td>
<td></td>
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<td></td>
<td>One-parent households (1.1)*</td>
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<thead>
<tr>
<th>BOP DHB Māori rate higher than NZ Māori rate</th>
<th>BOP DHB Māori rate higher than BOP DHB European rate</th>
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</thead>
<tbody>
<tr>
<td>Not NCEA Level 2 or higher**</td>
<td>Not NCEA Level 2 or higher (1.5)</td>
</tr>
<tr>
<td>Low income (1.1)</td>
<td>Low income (1.3)</td>
</tr>
<tr>
<td>Unemployment (1.2)</td>
<td>Not owning home (1.3)</td>
</tr>
<tr>
<td>No telephone access (1.3)</td>
<td>Unemployment (2.4)</td>
</tr>
<tr>
<td>Overcrowding (all)(1.1)</td>
<td>No telephone access (4.7)</td>
</tr>
<tr>
<td>Overcrowding (0 – 24 years)(1.1)</td>
<td>No car access (3.5)</td>
</tr>
<tr>
<td></td>
<td>Overcrowding (all)(4.1)</td>
</tr>
<tr>
<td></td>
<td>Overcrowding (0 – 24 years)(5.8)*</td>
</tr>
<tr>
<td></td>
<td>One-parent households (2.2)*</td>
</tr>
</tbody>
</table>

*Statistical significance not defined.

** Difference is statistically significant but less than 5% in magnitude.

Of note:
• There are clear ethnicity-related differences in social and economic health determinants
• Compared to Māori in New Zealand as a whole, Bay of Plenty Māori have less income, more unemployment, lower telephone access and experience greater levels of household crowding
Within the Bay of Plenty DHB area, Māori experience worse rates than the European population for all nine indicators summarised. For some of these the difference is large—for example, Māori 0–24 year olds are 5.8 times more likely to live in overcrowded housing conditions.

### 2.1.4 Operating Environment

This section provides a summary of the key factors that impact on our DHB and influence the decisions we make.

**Health Sector Wide Factors**

**The population is changing**

Population growth, diversity and redistribution is creating a variety of pressures. Population growth to 2026 is expected to be concentrated on urban centres and there will be much less growth in smaller centres and rural areas and in some cases the population will decline. The population is ageing, as a result of rising life expectancy and lower birth rates.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban growth</td>
<td>Requirement for ongoing investment in services, workforce and facility development in urban centres</td>
</tr>
<tr>
<td>Provincial and rural decline</td>
<td>Increasing pressure on clinical sustainability due to declining patient numbers and workforce supply</td>
</tr>
<tr>
<td>Increasing ethnic diversity</td>
<td>Demand for greater flexibility and a range of culturally responsive services</td>
</tr>
<tr>
<td>Evolving family structure</td>
<td>Decreased access to informal care and increased demand for support services</td>
</tr>
<tr>
<td>Ageing population</td>
<td>The nature of required services is likely to shift toward an emphasis on long-term conditions and toward increasing complexity</td>
</tr>
</tbody>
</table>

**Increasing prevalence of long term conditions**

A growing proportion of the population, particularly amongst the adult population, is living with a long-term condition e.g. diabetes, heart disease, cancer or chronic respiratory disease. Long-term conditions tend to be long in duration and slow to progress. The growth in these conditions is largely attributable to changes in people’s lifestyles and behaviours.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growth in the number of people living with long-term conditions</td>
<td>Acute services will increasingly accommodate patients whose needs are more complicated.</td>
</tr>
<tr>
<td></td>
<td>New models of care to focus on managing conditions and preventing acute exacerbations through the use of more proactively planned care in a primary/community based setting and the promotion of Whānau led care.</td>
</tr>
<tr>
<td></td>
<td>Increase focus on supported patient self management.</td>
</tr>
<tr>
<td></td>
<td>This will mean impacts on workforce availability, investment in information technology and primary/community infrastructures.</td>
</tr>
<tr>
<td>Increased incidence of multiple complex symptoms and co-morbidities</td>
<td>Care is likely to require greater use of interconnected multidisciplinary teams.</td>
</tr>
<tr>
<td></td>
<td>Providers will need to co-ordinate services and communicate more efficiently with each other.</td>
</tr>
</tbody>
</table>
Greater chance of long-term conditions linked to lifestyle choices | National decisions will have to be made on the appropriate levels of investment into interventions which help prevent the onset and progression of these conditions as well as interventions which promote healthier lifestyles.

Decrease in the rate of funding growth

The Government has identified that the rate of growth in funding of the public health and disability sector is unsustainable.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ageing population</td>
<td>Funding will need to increase, or be redistributed between service areas. The health care expenditure on services for those aged 65 years and over will increase.</td>
</tr>
<tr>
<td>New technologies and models of care</td>
<td>People will expect access to new technologies. This will require new funding or robust prioritisation processes (including disinvestment and reallocation decisions) or current services may need to be reconfigured. New technologies and models of care may be more efficient, but their introduction usually requires upfront investment in infrastructure and development.</td>
</tr>
<tr>
<td>Global demand for health workers</td>
<td>There is international competition for health workers. This places increasing pressure on organisations to offer competitive wages and conditions and to consider alternative approaches in their use of technology and the make-up of their workforce.</td>
</tr>
<tr>
<td>A decrease in the rate of funding growth (after a recent period of increases)</td>
<td>There will be a need to: - Increase efficiencies within existing services - Redistribute existing funding - Find ways to leverage resources and staff with other sectors e.g. through engagement with Technical Advisory Groups - Find better ways of prioritising resources and providing care for those who need it most.</td>
</tr>
</tbody>
</table>

Health inequalities persist

The benefits of an improvement in health status are not equitably shared across population groups. Good health relies on the determinants of health as well as health services.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inequalities in health status continue, with potential for disparities to worsen</td>
<td>There will be a need to: - Effectively and appropriately design services - Maintain an appropriate skill set within the workforce, and ensure a focus on cultural responsiveness - Determine the most appropriate resource distribution within the health sector and across Government</td>
</tr>
<tr>
<td>Long-term and intergenerational inequalities</td>
<td>Long-term planning and commitment required with emphasis on ‘joined up’ approaches across sectors (health, housing, education and social services). Improved access to health services (from prevention to cure) will be a priority.</td>
</tr>
</tbody>
</table>

Health workforce shortages are worsening
Workforce shortages are a key challenge to the health system’s ability to provide a full range of accessible, high-quality health services. This presents an even more significant challenge in rural areas where recruitment and retention of health professionals can be comparatively more difficult than it is in urban areas.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Implications</th>
</tr>
</thead>
</table>
| International demand and an ageing workforce | There will be a need to make better use of the workforce we have available and look for alternatives such as:  
  - Invest in technology to support new ways of working (e.g. telemedicine)  
  - Regional and national collaboration  
  - Employment of supervised but unregulated staff  
  Making greater use of patients’ own personal resources (i.e. self-management, expert/lay support and Whānau/family care). |
| Scarcity of support from informal carers | Alternative support networks need to be created or developed.                                                                                     |
| Super-specialisation of some medical professions | The pool of generalist professionals will become smaller, at a time when demands for general skills will be increasing. Staff development will be affected (i.e. training). |
| Rural workforce shortages | There will be a need to consider reconfiguration or clustering of services to provide clinical sustainability. Investment in telemedicine, information technology and cross-organisational arrangements will be required. |

New technologies are being developed

In the past 60 years, medical technology has advanced in ways unimaginable to previous generations. Technological advances have expanded the capabilities of medical care, but they have also been a key cause of rising health costs.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing introduction of new diagnostic tools/tests and new therapeutics</td>
<td>Initial and ongoing costs are often high. Some of these are necessary to support strategic priorities. Improved access for evaluation will be required.</td>
</tr>
<tr>
<td>More accessible information for patients and clinicians</td>
<td>The way information is accessed will change for both patients and health workers.</td>
</tr>
<tr>
<td>Increased communication options and speed for patients and clinicians</td>
<td>The way patients and health workers communicate will change particularly with the increasing use of secure electronic interactions (voice, video or email).</td>
</tr>
<tr>
<td>Continued growth in research and knowledge</td>
<td>Ongoing need for guidelines and decision support for clinicians to assist the assimilation of research into practice.</td>
</tr>
<tr>
<td>Increased understanding of</td>
<td>Analysis of appropriate information will be necessary to identify the people most in need as well as to support quality improvement and research.</td>
</tr>
</tbody>
</table>
Public expectations rising

People are taking a more active interest in their health, are better informed about their conditions and are more aware of options for treatment than in the past.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients will be better informed</td>
<td>Patients will have higher expectations of health professionals. They will be better placed to take more of a lead in their own care.</td>
</tr>
<tr>
<td>Ongoing expectations of highly personalised services</td>
<td>There must be a balance between the needs of the individual and the needs of the broader population.</td>
</tr>
<tr>
<td>Availability of new technologies</td>
<td>There are likely to be increased disparities between publicly funded services and those funded by private insurance or directly by patients in terms of which new technologies are more likely to be available.</td>
</tr>
<tr>
<td>Ongoing expectations of health as a 'civil right'</td>
<td>Health is likely to remain high on the political agenda. There will be implications for the workforce (likely to require greater regulation to ensure safe services).</td>
</tr>
<tr>
<td>Increased diversity in expectations</td>
<td>There will be an increasing need for more culturally responsive and diverse services.</td>
</tr>
</tbody>
</table>

2.1.5 Nature and Scope of Functions – Our Role and Purpose

We collaborate with other health and disability organisations, stakeholders and our community to identify what health and disability services are needed and how to best use the funding we receive from Government to improve, promote and protect the health and wellbeing of our population.

Through this collaboration, we ensure that services are well coordinated and cover the full continuum of care, with the patient at the centre. These collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the whole of the health system to achieve the best health outcomes for our community.

We are socially responsible and uphold the ethical and quality standards commonly expected of providers of services and public sector organisations. We need to consider all needs and services including prevention, early intervention, treatment and support services, and how these services can be provided to best meet the needs of the population within the funding provided. We are responsible for monitoring and evaluating service delivery, including audits of the services we fund.

As a District Health Board we will:

- **Plan** in partnership with key stakeholders (i.e. clinical leaders, Iwi, Primary Health Organisations and non-Government organisations), the strategic direction for health and disability services.

- **Plan** in collaboration with other DHBs and the National Health Board, regional and national work.
• **Fund** the provision of the majority of the public health and disability services in our district, through the contracts we have with providers.

• **Provide** hospital and specialist services primarily for our population of 202,193 people but also for people referred from other DHBs.

• **Promote, protect and improve** our population’s health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health initiatives.

We receive funding from Government to undertake our role. The amount of funding is determined by the size of our population, as well as the populations’ age, gender, ethnicity and socio-economic status characteristics. The National Health Board also has a role in the planning and funding of some services¹.

**Planning and Funding Health and Disability Services**

The Planning and Funding Division of our DHB is responsible to the Chief Executive Officer for planning and funding health and disability services across the Bay of Plenty district and determining how best to invest the funding we receive from Government to meet the health needs of our population.

The core responsibilities of the Planning and Funding Division are:

• Assessing our population’s current and future health needs;

• Determining the best mix and range of services to be purchased;

• Building partnerships with service providers, Government agencies and other DHBs;

• Engaging with our stakeholders and community;

• Leading the development of new service plans and strategies in health priority areas;

• Prioritising and implementing national health and disability policies and strategies in relation to local need;

• Undertaking and managing contractual agreements with service providers; and

• Monitoring, auditing and evaluating service delivery.

Through our Planning and Funding Division, we enter into service agreements or arrangements with the organisations or individuals who can best provide the health and disability services required to meet the needs of our population, achieve the objectives of the DHB and enhance efficiencies across the whole of the health system.

**Providing Health and Disability Services**

As well as being responsible for planning and funding the health and disability services that will be delivered in the Bay of Plenty district, we also provide a significant share of those services as the ‘owner’ of hospital and specialist services.

These services are provided through our Provider Arm Division from two key facilities being Tauranga Hospital and Whakatane Hospital.

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¹ Particularly for public health and disability support services.
Tauranga Hospital is a level 4/5 facility, providing a full range of services medical, surgical, paediatrics, obstetrics, gynaecology and mental health. Tauranga Hospital is also a base for a range of associated clinical support services and allied health such as rehabilitation, speech therapy, physiotherapy, stroke and cardiac support, district nursing and drug and alcohol programmes.

Whakatane Hospital is a level 3/4 facility providing medical, surgical, paediatrics, obstetrics, gynaecology and mental health services. Like Tauranga Hospital, Whakatane Hospital is also a base for a range of associated clinical support services and allied health such as rehabilitation, speech therapy, physiotherapy, stroke and cardiac support, district nursing and drug and alcohol programmes.

There are 349 beds at Tauranga Hospital, including the Special Care Baby Unit, Maternity and Mental Health. Approximately 224 beds are available for medical and surgical patients (including critical care and coronary care) with a further 58 for children and older people and 17 for medical day stay. Twenty-four beds are designated for mental health patients and 10 for Mental Health for older people. There are 43 beds available for maternity including 12 for the special care baby unit.

Tauranga Hospital serves one of the fastest growing populations in the country and the campus has undergone significant development in recent years to enable the DHB to grow health services to match. Project LEO has seen the construction of a new wing of high quality which includes theatres, outpatients department, radiology, emergency department expansion and the maternity unit.

The DHB has recently completed the Tauranga Hospital ‘East Wing’ development which houses the Intensive Care, Cardiac Care and High Dependency units. The total number of beds within these units will accordingly increase from 10 to 20. Three further 28 bed wards have been completed to allow for future expansion to keep pace with population growth across the district. A new endoscopy suite has also been completed.

Tauranga Hospital is the base for clinical and medical trainees with the establishment of the Clinical School. Training and placement programmes have been implemented with clinical trainees reporting positively on the quality of their placement.

Whakatane Hospital is a Level 3/4 facility, providing medical, surgical, paediatrics, obstetrics, gynaecology and mental health services. Like Tauranga Hospital, Whakatane Hospital is also a base for a range of associated clinical support services and allied health such as rehabilitation, speech therapy, physiotherapy, stroke and cardiac support, district nursing and drug and alcohol programmes.

There are 123 beds at Whakatane Hospital, including the Special Care Baby Unit, Maternity and Mental Health. Approximately 67 beds are available for medical and surgical patients with a further 14 designated for children and elderly patients.

Whakatane Hospital services a population that has a large proportion of lower socio-economic communities many of which are rural and isolated. Campus redevelopment is scheduled to occur commencing 2011 to 2014.

It is envisaged that Whakatane Hospital will be a key base for clinical and medical trainees in the future, as the Clinical School becomes more established. Some training and placement programmes are already underway.

The costs of providing services to people living outside of the Bay of Plenty district are met by the DHB of domicile and are referred to as ‘inter‐district’ services or Inter‐District Flows (IDFs). Likewise, where services cannot be provided by our DHB, we have funding
arrangements in place enabling Bay of Plenty district residents to travel outside the district. We also have service delivery contracts with external funders, such as the Accident Compensation Corporation (ACC). We closely monitor IDF and ACC volumes to ensure our ability to provide for our own population is not adversely affected by demand from outside the district.

**Promoting Community Health and Wellbeing**

Good health is determined by many factors, or social determinants of health, which sit outside of the traditional health system (e.g. education, housing and income). Our partnerships with other agencies; including local and regional councils, Mental Health Commission, Child Youth and Family, Police, Housing NZ, the Ministries of Education and Social Development and ACC are vital in creating and supporting social and physical environments that prevent illness and reduce the risk of ill health.

Toi Te Ora, our regional Public Health Unit, provides public and population health services on behalf of the Bay of Plenty and Lakes DHBs.

Through Toi Te Ora we support collaborative ventures and initiatives that focus on the reduction of behavioural and environmental risk factors to reduce long-term conditions and injury. This includes improving nutrition, increasing physical activity and reducing tobacco smoking, alcohol consumption and other risk behaviours. Working collaboratively to provide ‘safe’ social and physical environments for our younger populations is a focus. In order to gain maximum benefit our strategies to reduce inequalities in health outcomes is focused on working in areas of high need, such as education settings, workplaces and Māori communities.

Toi Te Ora also delivers population and public health services and supports the development of healthy and safe physical and social environments through healthy housing, smokefree environments and encouraging physical activity. Toi Te Ora leads collaboration on safeguarding water quality, biosecurity (protecting people from disease-carrying insects and other pests) and the control of communicable diseases and emergency planning to ensure preparedness for a natural or biological emergency.
3 Strategic Direction

3.1 Our Vision

Our vision
Healthy, thriving communities. Kia Momoho Te Hapori Oranga

Our mission
Enabling communities to achieve good health, independence and access to quality services.

Our values
Cultural – we will acknowledge, preserve and promote mana atua, mana tūpuna, mana whenua and mana tangata
Accountability – we are accountable to our communities and the Government
Collaboration – we will work with others and value the contribution we will make
Flexibility – we will allow for the variation in needs and solutions required for different communities
Integrity – we will be honest, forthright and open in our transactions, planning and deliberations
Good employer – we will be a good employer by building relationships of mutual trust and respect with staff. We will strive to become an employer of choice

3.2 National, regional and local context

3.2.1 National Context

This section outlines what the Government and the health and disability system want to achieve in the longer term, and explains how the Government’s shorter-term priorities and targets connect with these strategic outcomes. The table in section 3.3.1 shows the value chain of how the outputs we deliver (what we do) impacts the health of our population and results in achievement of the long-term outcomes and priorities of our DHB and ultimately delivers on the Ministry of Health’s vision: “All New Zealanders lead longer, healthier and more independent lives”.

Ensuring people can live longer, healthier and more independent lives is a core objective of society. Good physical and mental health provides people with the security and comfort needed to enjoy their lives and take advantage of all the opportunities available to them. Good health and the ability to live independently are also important drivers of socioeconomic success and provide a powerful means of eliminating social disadvantage and inequality by enabling people to realise their full potential.
The wellbeing of New Zealanders in a high-quality, patient centred health system is the focus of the Government’s policy for ensuring all New Zealanders have the same opportunities for good health. Our challenge is to enhance the quality of services and realise efficiencies so that more of our resources are devoted to patient care.

3.2.2 National Service Planning

The New Zealand Public Health and Disability Act 2000 requires that, ‘the Crown and DHBs must endeavour to provide for health services to be organised at either a local, regional or national level depending on the optimum arrangement for the most effective delivery of properly co-ordinated health services’ (section 3(5)). The Government aims to enhance regional and national cooperation through planning and funding designated specialist services that are of national significance to ensure the sustainability of the health and disability system into the future.

Services should be planned, funded and provided at the national, regional or district level based on the size of the population best able to ensure the future clinical and financial viability of a safe, quality public health and disability service. Services currently most vulnerable to service disruption are considered first for national or regional planning guided by the following principles to determine service planning location:

1. Provision of a unified service with effective service integration across all providers, especially community, primary and secondary.
2. Best use of workforce and capital, planning and funding capability to minimise administrative and contracting overhead.
3. Minimise risk and disruption and provide for longer-term service continuity.
4. Be responsive to distinctive local needs.

During 2011/12 five initial candidate services will be developed as National Services. These services are: Clinical Genetics, Paediatric Pathology, Paediatric Metabolic Services, Paediatric Cardiology and Paediatric Cardiac Surgery. A further five services will be the recipients of National Service Improvement Programmes. These services are: Cardiac Surgery, Paediatric Oncology, Paediatric Gastroenterology, Neurosurgery and Major Trauma.

The Midland DHBs will, as appropriate, work with the National Health Board to develop contract specifications and arrangements for the services to be planned and funded nationally, identify the funding methodology for providers, negotiate terms with selected provider(s); and develop national clinical network arrangements for both National Services and National Service Improvement Programmes.

3.2.3 Regional Service Planning

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

In the Midland region these challenges impact in ways that reflect the unique characteristics of our DHBs and our region as explored in greater depth in the Midland Regional Clinical Services plan (MRCSP). As such, our DHBs face a range of common problems for which we are all seeking solutions.

By actively participating in planning across the Midland Region we will reduce the duplication of effort and enable the five Midland DHBs to collectively develop more
sustainable solutions. Regional planning can help identify efficiencies, and a planned approach helps to ensure that specialist skills and input remain available at a local level. Collectively, working as a strong group of DHBs we are in a better position to respond to the challenges facing our region’s health care system.

However in some circumstances, close collaboration around specific clinical services may be more appropriate between a subset of our five DHBs; in some cases, there are already historical alignments with DHBs from outside of the Midland region. Hence, we need to build an approach to collaboration that enables flexibility and that does not attempt to stamp one-size-fits-all solutions.

The regional implementation plan which was developed from the MRCSP outlines the activities to be undertaken for each of the priority service areas, being: Maternity, Cardiac/Cardiology, Renal, Primary/Rural, Cancer and Mental Health.

Each of the action groups for the services priority areas identified in our Regional Implementation Plan will be tasked with developing service specific performance measures as an early deliverable of the programme in 2011/12. Planned dates for this work being completed are outlined in the regional implementation plan. This process will be led by the clinicians in each service area and will be informed by and aligned with any national initiatives. This will ensure that no duplication occurs and the measures developed are fit for purpose. There will be representatives from each Midland DHB on each action group to ensure appropriate representation, but it is the clinicians as a group, not individual DHBs that are leading the process. Where these groups are already formed, the clinical leader has been identified in the action plan. For some services the clinical lead is a generalist such as a Chief Medical Advisor; the intention is to pass leadership onto specialists for each service wherever this is possible as the network develops. Further services will be considered for development during the course of 2011/12 and these will be incorporated into future regional planning activity.

**Improving service sustainability**

The draft MRCSP submitted to the NHB describes a vision for the future of health services in the Midland Region and provides a framework for DHB planning and acting collaboratively on a regional basis. It does not prescribe radical changes in current patient flows or existing configuration of hospital services. Rather, it focuses on how the region can work together to support vulnerable services, to improve equity of access to regional services and to improve health outcomes across the region as a whole.

**Clinical networks and models of care**

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

**Regional service priorities**

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

**Renal Services:** Disparate access issues and workforce vulnerabilities exist. Focus will be on finalising, then implementing, new models of care to strengthen the services regionally. However it should be noted that the growth path for renal dialysis is unsustainable and the region will need to manage this growth through prioritisation and agreed access criteria in the future.

**Cardiology/cardiac services:** Disparate access issues and workforce vulnerabilities exist, with a poor interface across the continuum. The opportunity exists to make a difference to population health outcomes and inequalities through a cardiology pathway that is strongly rooted across the continuum of care from prevention through to specialist care, and cardiac rehabilitation. This is a combination of existing regional work on cardiology/cardiac services, additional development in new initiatives such as HeartHealth, and Better, Sooner, More Convenient Care cardiac service improvement programmes. Again the affordability of ever emerging new technologies will require focussed attention to prioritisation in the future.

**Maternity Services:** Maternity services are the lynchpin of acute services in provincial areas, and obstetrics was clearly identified as a vulnerable service early in the development of the MRSCP. There are workforce issues across maternity services, and opportunities to strengthen quality improvement activities regionally.

**Primary Care Services:** Because of the current transformational changes occurring in community services, and the greater focus on integration with specialist services, primary care was identified as an earlier priority area for regional action with a particular focus on rural health. There is a significant role for the sector to address issues of acute demand, improved access to chronic care services, seamless care across community services, and a greater choice for patients in how they access their health care.

**Mental Health Services:** A three-tiered structure has the Chief Executives, GMs Planning and Funding and GMs Māori Health providing the corporate and strategic leadership to the Midland Regional Network. The shared goals and an agreed common purpose are:

- Effective governance and decision making processes.
- Mechanisms for stakeholder input at a district and regional level aligned to national imperatives.

**Cancer Services:** The Midland Cancer Network involves cancer continuum stakeholders working across organisational and service boundaries to reduce the incidence; reduce the impact of cancer; address inequalities with respect to cancer and improve the experience and outcomes for people with cancer. The Midland Cancer Network Strategic Plan 2009-2014 guides implementation of the following strategic directions:

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

Each of these areas has varying vulnerabilities which the Midland region believes can best be approached and supported through regional collaboration. Each of the Service Priorities would be supported by a strong multidisciplinary clinical network with a focus on integrated
patient pathways, common clinical policies, a potential shared workforce, and shared clinical audit programmes.

**Regional infrastructure priorities**

To improve financial and clinical sustainability, the Midland region has chosen four infrastructure areas to focus on. Each of these areas will have its own work programme.

These are:

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

**Workforce** – This workstream will address the changing models of care required to meet increasing demand for health services, and address the most commonly raised issues across the region relating to recruitment, retention and future sustainability of the workforce. Workforce development activity underpins the collective response required to ensure access to quality, sustainable services across the whole region, and Midland DHBs share responsibility for planning and undertaking forward-looking action on workforce development that minimises duplication.

**Māori Health** – A reduction in health inequalities must remain a core focus of regional work, ensuring that DHBs pool their resources and understanding of how to reduce health inequalities, and implement a monitoring plan to ensure health inequalities are addressed at all organisational levels.

Each of these priorities has stand-alone work programmes that both inter-face with the Service Priorities but also set a broader plan of action for improving regional infrastructure. These actions are outlined in the Midland Regional Implementation Plan for 2011/12 which should be reviewed in conjunction with this document.

In addition to these Services areas, there is another regional activity being progressed in 2011/12:

**Elective Services** – Where there is a natural flow of service provision, the Midland region is moving towards greater integration of each DHBs elective services. Purchasing appropriate regional volumes will allow sustainable service improvement. Service improvement will be supported by regional referral pathways, clinical networks and consistently applied access criteria. Appropriate levels of service delivery will be supported in each DHB. Individual DHBs will monitor the level of service provision delivered to their population. Both DHB of domicile (where people live) and DHB of service (where people access services) will work together to manage referrals.

**What we will contribute to regional planned service delivery in 2011/12**

Bay of Plenty DHB shares with the other Midland DHBs, the following areas of focus:

- Child and Youth Health Services
- Older People’s Health Services
- Mental Health and Addiction Services
• Hospital and Specialist Services
• Primary and Community Health Services.

Local actions in relation to these services are recorded along with deliverables and timing in section 4 of this document. In the following chapter, the Statement of Forecast Service Performance, we will group the services according to the output classes of:
• Prevention
• Early Detection and Management
• Intensive Assessment and Treatment Services
• Rehabilitation and Support
detailing the measures and targets of output delivery performance.

3.3 Improving Outcomes for Our Population – What we are trying to achieve

In line with the functions and responsibilities of a DHB, our vision is *Healthy, Thriving Communities*. In achieving our vision, we will deliver on the Ministry of Health’s vision: “*All New Zealander’s lead longer, healthier and more independent lives.*”

Four strategic goals guide us in achieving our vision.

• **Strategic Goal 1: People are healthier, able to self-manage and live longer**

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

• **Strategic Goal 2: People are able to participate more in society and retain their independence for longer**

  There is a growing acceptance for a system that maximises client independence through person-centered and capacity-building approaches to service delivery, with outcomes that:

  1. Change the perception of communities, the workforce and the clients themselves as to the functional capacity of older people and those affected by mental illness or addiction;
  2. Improves or maintains client’s functional capabilities, so that their need for long term support is delayed or reduced;
  3. Improves or maintains a client’s quality of life by maximising their capacity to interact with the wider community.

• **Strategic Goal 3: People receive timely and appropriate complex care**

  Driven by a patient centred approach, our DHB will continue its commitment and dedication to improving hospital productivity, service quality and overall patient experience.
• **Strategic Goal 4: Health inequalities between population groups in our community will reduce**

We are committed to moderating the effects of disparity through funding and providing programmes that target inequalities, improve access to services and information.

The current strategic document for addressing Māori Health for Bay of Plenty DHB is Te Ekenga Hou (TEH).

Since the creation of TEH in 2007 there have been a number of changes in the strategic environment. The key changes for Māori Health at a national level have been development, and implementation, of Whānau Ora and the establishment of a consistent Māori Health Plan for District Health Boards. At a local level Bay of Plenty DHB has undertaken a restructure and regionalisation of Mai i ngā Kuri a Wharei ki Tihirau within the Provider Arm.

It is timely to review TEH in line with these strategic developments. Te Ekenga Hou is the Bay of Plenty DHB’s Strategic Plan to improve health outcomes for Māori and reduce health inequalities experienced by Māori. It incorporates the strategic direction for both Māori Health Planning and Funding and Mai i Nga Kuri a Wharei ki Tihirau (Regional Māori Health services). The revised TEH continues to adhere to the New Zealand Public Health and Disability Services Act 2000 and aligns to He Korowai Oranga, Whānau Ora and the BOP DHB’s Māori Health Plan.

The Bay of Plenty DHB Māori Health Plan prioritises and focuses planning for Māori Health Planning and Funding to concentrate efforts on improving Māori health and reducing Māori health outcome disparities by focusing on the key indicators where the health inequalities experienced are the greatest between Māori and non-Māori. The DHB Māori Health Plan strongly aligns to TEH.

The BOPDHB’s Māori Health Plan is informed by:

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

• The DHB’s strategic objectives from its Regional Services Plan and Annual Plan.

The plan describes Bay of Plenty District Health Board’s Māori health focus areas during 2011-12.

The plan is made up of three parts:

• A brief profile of the BOPDHB population.

• A collection of national-level Māori health indicators.

• A collection of Regional Māori health indicators.

• A collection of local-level Māori health indicators.

To chart our progress, we have identified a number of outcomes for each strategic goal. These outcome measures are long-term (5-10 years) and as such we aim to see an improvement over time.

Our Statement of Forecast Service Performance (see chapter 5) describes our medium term performance targets in the form of impacts and impact measures. Our outcomes framework in the appendices describes in detail the links between the outcomes, impacts and outputs for the strategic priorities identified.
### 3.3.1 Bay of Plenty DHB Performance Framework

All New Zealanders lead longer, healthier and more independent lives

<table>
<thead>
<tr>
<th>Government Goals</th>
<th>Ministry of Health Outcomes</th>
<th>Midland CSP</th>
<th>Goals</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good health and independence are protected and promoted</td>
<td>A more unified and improved health and disability system</td>
<td>People receive better health and disability services</td>
<td>The health and disability system and services are trusted and can be used with confidence</td>
<td>MOH SOI</td>
</tr>
</tbody>
</table>

#### Midland Region Agreed Outcomes

- **BAY OF PLENTY DHB Strategic Goals – Healthy Thriving Communities**
  - People are healthier, able to self-manage and live longer
  - People are able to participate more in society, and retain their independence for longer
  - People receive timely and appropriate complex care
  - Health inequalities between population groups in our community will reduce

#### Focus Areas

- Child and Youth Health Services
- Older People’s Health Services
- Mental Health and Addiction Services
- Primary and Community Health Care Services
- Long Term Condition Health Services

### 5-10 Year Outcomes

#### Impacts

- Prevention Services
  - Reduction in smoking
  - Better oral health
  - Reduction in ASH and acute admissions
  - Healthier weights
  - Home based support for elderly
  - Less family violence

- Early Detection and Management Services
  - Reduced acute admissions
  - Diabetes is better managed
  - ASH admissions reduced
  - Screening is increased
  - Long term conditions reduce

- Intensive Assessment and Treatment Services
  - ED presentations are seen promptly
  - Improved care
  - Fewer acute admissions
  - Reduced ‘did not attend’ for specialist assessments
  - Reduced length of stay in hospital
  - Waiting time for elective services are reduced

- Rehabilitation and Support Services
  - More appropriate end of life care
  - Reduced entry to aged residential care
  - Clients with complex needs access home based support services
  - Increased number of clients access restorative models of care

#### Resources

- Health Professionals and Competencies
- DHB Owned Providers and NGO Providers
- Clinical Leadership and Clinical Networks and Relationships
- Quality Systems and Processes – Assurance and Improvement
- Information Services and Technology
- Financial Resources
- Governance DHB Leadership and Corporate Support
- Clinical and Non-Clinical Assets and Infrastructure
Strategic Goal 1: People are healthier, able to self-manage and live longer

Expectation
Bay of Plenty DHB will deliver programmes which support people to identify and reduce their risk factors, and to make healthy choices so that a discernable difference can be made in enabling people to attain the highest possible quality of life and to avoid, delay or reduce the impact of long-term conditions.

Current smoking rates in New Zealand are continuing to decline. However smoking related disease accounts for a large proportion of the health dollar. In addition there is significant evidence to support the negative and long-term consequences of smoking in pregnancy. The age-standardised prevalence of current smoking in 15–64-year-olds fell significantly between 2006 (24.4%) and 2009 (21.8%). The 2006 Census BOPDHB smoking prevalence rate of 22.3% is relatively similar to the National figures. However, smoking rates for Māori (48%) and Pacific peoples (30.1%) residing in the BOPDHB district are significantly higher.

With the right support, people will become more health conscious and their level of health literacy will improve. Many people can learn to be active participants in their own care, living with and managing their conditions. This can help them to avoid complications, slow down deterioration and avoid further co-morbidity. The majority of people with long-term conditions fall into this category, so even small improvements can have a significant impact.

We expect declines in smoking prevalence across all our populations, and anticipate that people will reduce their risk factors and make healthy choices so as to make a real difference in attaining the highest possible quality of life and avoid, delay or reduce the impact of long-term illness.

Why is this goal a priority?
Health services for people with long term conditions are a priority for Bay of Plenty DHB because long term conditions account for a significant proportion of health inequalities, and come at a significant personal and system cost.

Long term conditions, such as cardiovascular disease, diabetes, respiratory disease and cancers are a priority because they impose a significant additional burden on disadvantaged and disenfranchised populations as well as health services. As the population ages and lifestyles change these conditions are likely to increase significantly. Nationally the prevalence rates of most long-term conditions are increasing. The emphasis must be on better prevention of smoking, obesity and cancer, and how and where patients with long-term conditions are managed. Prevention services will be in primary and community settings.

Outcome measures - We will know we are succeeding when there is:

Reduced complication rates related to long term conditions, specifically the following, will be seen:
A reduction in smoking rates for the Bay of Plenty population
- Tobacco smoking kills an estimated 5,000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions. It is a major cause of lung and a variety of other cancers, as well as chronic obstructive pulmonary disease, heart disease and strokes.
- In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say no to tobacco smoking is our foremost opportunity to target improvements in the health of populations with high need and to improve Māori health status.

New Zealand Tobacco Use Survey 2007- DHB Estimates

<table>
<thead>
<tr>
<th>Age</th>
<th>Females</th>
<th>Males</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bay of Plenty</td>
<td>15-19 years</td>
<td>25.5%</td>
<td>20.5%</td>
</tr>
<tr>
<td></td>
<td>20-24 years</td>
<td>39.5%</td>
<td>38.2%</td>
</tr>
<tr>
<td></td>
<td>25-29 years</td>
<td>35.1%</td>
<td>36.1%</td>
</tr>
<tr>
<td></td>
<td>30-39 years</td>
<td>30.1%</td>
<td>31.0%</td>
</tr>
</tbody>
</table>
Long-term Outcome measure: The proportion of the Bay of Plenty population who smoke (15+ years)

Daily smoking among those aged 15–64 years, 1997–2009 (age-standardised prevalence)

Annual number of deaths attributed to smoking (all causes), among those aged 35+ years,2 by sex, 1950–2005

Source: Tobacco Use in New Zealand Key findings from the 2009 New Zealand Tobacco Use Survey, MOH

A reduction in the proportion of young people who take up tobacco smoking.

- In New Zealand during 1999-2009, ASH Survey data suggested that daily smoking rates among Year 10 students were highest for females, those attending schools in the most deprived areas, and those for whom one or both parents smoked. In the Bay of Plenty during 1999-2009, the proportion of Year 10 students who had never smoked increased significantly from 29.3% in 1999 to 61.6% in 2009. During this period, daily smoking rates in the Bay of Plenty were similar to/higher than the NZ average, while the proportion who had never smoked was lower.

- Data from the 2006 Census demonstrated a similar picture with 26.6% of Bay of Plenty young people aged 15-24 years

2 In considering TAM, the lower age group for inclusion is 35 years, reflecting the time that elapses between exposure (tobacco) and the development of diseases for which tobacco is a risk factor, and that lead to deaths that can be attributed to tobacco exposure (TAM).
being regular smokers, as compared to 21.8% nationally. Smoking rates were higher for Māori than for Pakeha-New Zealander young people and for those living in the most deprived areas. Such disparities are of concern, as if left unaddressed they potentially signal ongoing disparities in later adult health outcomes, as well in-utero and early childhood exposures as the current generation of Bay of Plenty young people begin their own families.

<table>
<thead>
<tr>
<th>The proportion of ‘never smokers’ among Year 10 students</th>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>2% annual increase in the number of Year 10 students in the Bay of Plenty schools identifying as never-smokers</td>
<td>61.6%</td>
<td>64%</td>
<td>66%</td>
<td>68%</td>
</tr>
</tbody>
</table>

An increase in the number of smokefree pregnancies

The estimated percentage of all pregnant women who smoke in New Zealand is 22% (for the year ended September 2005). It is estimated that 43% of women who smoke during pregnancy are Māori. The proportion of pregnant women who smoke in Bay of Plenty would significantly exceed the national average. Approximately three-quarters of pregnant women who smoke aged 15 to 24 years and one-third aged 25 to 34 years are Māori.

There has been a consistent upward trend in the Bay of Plenty from 2000 to 2008 in smokefree pregnancies across maternal age and ethnicity; however, there are significant disparities between Māori and non-Māori.

The data continues to highlight that the gaps between district and national rates are closing.

Data sourced from the National Minimum Dataset

Craig, Elizabeth., McDonald, Gabrielle., Reddington, Anne and Wicken, Andrew. (2009) The Determinants of Health for Children and Young people in the Bay of Plenty University of Otago

The proportion of women who smoke during pregnancy

<table>
<thead>
<tr>
<th></th>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>Not currently available</td>
<td>30% 10%</td>
<td>29% 9%</td>
<td>28% 8%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A reduction in obesity rates for the Bay of Plenty population

- A healthy body size is increasingly recognised as important for good health and wellbeing, as the evidence grows that obese children and adults are at greater risk of short-term and long-term health consequences.
- Obesity is associated with a long list of adult health conditions, including: cardiovascular disease (ischaemic heart disease, high blood pressure and stroke), various types of cancer, type 2 diabetes, kidney disease, fatty liver disease, osteoarthritis, pulmonary embolism, polycystic ovarian syndrome, gout, gallstones, reproductive disorders, sleep apnoea, complications in pregnancy, complications in surgery, and psychological and social problems. In addition, obese people are more likely to experience personal, social and professional difficulties.

Long-term Outcome measure: The proportion of the Bay of Plenty population who are obese (15 years+) is reduced

(Bay of Plenty / Taranaki / MidCentral)

Children aged 2-14 (% obese with 95% Confidence Intervals) 5.2 (3.1–7.3)
Number of obese children = 4,400

Adults aged 15+ (% obese with 95% Confidence Intervals) 27.5 (24.5–30.5)
Number of obese adults = 96,600

3 World Health Organisation 2000

4 World Cancer Research Fund and American Institute for Cancer Research 2007
An increase in life expectancy for the Bay of Plenty population

- Life expectancy at birth indicates the total number of years a person could expect to live, based on the mortality rates of population at each age in a given year or period
- Good health has two core dimensions: how long people live and the quality of their lives

Long-term Outcome Measure: Life expectancy at birth

People are able to participate more in society and retain their independence for longer

Expectation
Primary and community services support people to recognise signs and symptoms and to self manage where appropriate or seek help early to better manage their illness or long-term condition. Consequently, people are able to retain their independence for longer and continue to participate meaningfully in society.

Why is this goal a priority?
There is a growing recognition that population ageing is a dynamic factor influencing the nature of the Bay of Plenty community and there is significant risk for health services in managing the demand and cost that this population will require. The region experiences one of the highest proportions of older people in New Zealand (MOH 2007). There is a significant ‘baby-boomer’ cohort. Factors affecting the increased numbers of older people globally, in New Zealand, and this region include:

- Increased longevity
- Declining birthrate
- Migration
- Tangata Whenua ageing dynamics

The Western Bay of Plenty’s warm sunny climate and pleasant coastal geography have provided an attractive retirement destination for many decades. In contrast, ageing in Tangata Whenua communities is ‘in situ’ within long established communities. Recent trends show increasing numbers of families moving to the region as a lifestyle choice. The proportion of people aged 50+ indicates that a significant proportion of people will reach retirement age in the next five years, exacerbating labour force issues and health and care service demand by 2026 and beyond. It is estimated that the numbers of 80+ will grow from less than 3,000 in 2006 to 35,000 in 2050.
The Bay of Plenty is experiencing growth in demand for acute (emergency or urgent) services. There will be over 65,000 presentations at Tauranga and Whakatane Hospital Emergency Departments this year. Population growth and the increasing age of our population are driving much of this increased demand.

For most people, their GP is their first point of contact with health services. Primary care can deliver services faster and closer to home. It is also one of the most effective ways to prevent disease through early detection and screening, as well as through encouraging people to take responsibility for their own health. Primary care is also vital for the effective coordination of care across the continuum of care and for improving the management of care for people with long-term conditions.

**Outcome measures:** We will know we are succeeding when there is:

**A reduction in ‘avoidable’ presentations to hospital Emergency Departments (ED)**
- Supporting people to self manage their long-term conditions or seek intervention early will result in a reduction in the proportion of the population seeking urgent care or requiring acute admission to hospital.
- With increasing population growth, the number of people presenting to ED is increasing year on year – reducing current acute demand growth will be a challenge. Our first focus is on reducing the number of people presenting in lower triage levels who do not need hospital or specialist level intervention and could be better managed in more appropriate locations such as general practice.
- Improving access to alternative pathways of care will ensure people are being given the right treatment in the right place; improving health outcomes, reducing pressure on hospital resources and enabling investment in other priority areas.
- The goal is to reduce the number of ED attendances in the “non-urgent” and “semi-urgent” categories as this is a good indicator of effective primary care services, early intervention and self-management.

**Long-term Outcome Measure – Average Emergency Department Attendances**
A reduction in acute admissions to hospital

- The impact of long-term conditions in terms of quality of life and cost to the health system is significant. Early diagnosis and intervention and improved disease management provide major opportunities for improving health outcomes; particularly for Māori who have disproportionately higher rates of many long-term conditions.
- Improving the management of long-term conditions will reduce acute admissions to hospital and specialist services and will enable the DHB to redirect resources and avoided costs into more effective prevention and early intervention services.

In 2009 it is estimated that the following percentage of New Zealanders attended an emergency department and were admitted to hospital (note some people may present in ED or be admitted more than once)

- Estimated % of NZ population who attended ED 21.2%
- Estimated % of NZ population who attended ED and were admitted 9.3%
- Estimated % of NZ population who were acute admissions to hospital 12%

There is an increase in the proportion of the population over 65 years supported to live well, in their own homes

- Living in Aged Residential Care (ARC) is appropriate for a small proportion of our population. When people receive adequate support for their needs to be managed, remaining in their own homes is considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities.
- Living in ARC facilities can be associated with a more rapid functional decline than ‘ageing in place’. It is also a more expensive option, and resources could be better spent providing appropriate levels of support to people in their own homes. The aim is to support older people to stay at home as long as possible rather than entering ARC facilities.

Long-term Outcome Measure – The percentage of the population 65+ living in ARC and those receiving Home Based Support Services

The following table indicates the number of over 65’s currently living in aged residential care or receiving home based support.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Volume</th>
<th>% of the population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Care beds per annum</td>
<td>30,154</td>
<td>5%</td>
</tr>
<tr>
<td>Home based support</td>
<td>75,000</td>
<td>13%</td>
</tr>
<tr>
<td>Population over 65</td>
<td>569,560</td>
<td></td>
</tr>
</tbody>
</table>

Please note around 95% of the Residential Care are people over 75 years of age, i.e.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Volume</th>
<th>% of the population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Care beds per annum</td>
<td>28,646</td>
<td>11%</td>
</tr>
<tr>
<td>Population over 75</td>
<td>256,760</td>
<td></td>
</tr>
</tbody>
</table>

There is a decrease in the proportion of the population aged over 65 who are assessed to live in residential rest home level care

<table>
<thead>
<tr>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>4.8%</td>
<td>4.7%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

Long-term Outcome Measure – The average length of stay (ALOS) will reduce

People who require specialist or secondary services will be discharged from hospital as early as possible and receive post discharge care in a primary or community setting.

<table>
<thead>
<tr>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.62</td>
<td>3.69</td>
<td>3.96</td>
<td>3.96</td>
</tr>
</tbody>
</table>
People receive timely and appropriate complex care

Expectation
Driven by a patient centred approach, we will deliver timely and appropriate complex care, emphasising service quality and hospital productivity to improve patient health outcomes and experience.

Why is this goal a priority?
Our Government is concerned that patients wait too long for hospital diagnostic tests, for cancer treatment and for elective surgery. Bay of Plenty DHB is committed to meeting the Minister’s expectations and the national, regional and local health targets so as to ensure optimal outcomes for Bay of Plenty DHB residents. There is good evidence to suggest that early diagnosis, intervention and treatment yields improved long term outcomes, improved health status, and reduces the burden on health services.

Outcome measures: We will know we are succeeding when there is:

A reduction in the rate of acute readmissions to hospital
Acute readmission rates are a well-established measure of quality care, efficiency and appropriateness of discharge for hospital patients particularly as a counter-measure to average length of stay. International experience is that shorter lengths of stay are correlated with higher rates of acute readmissions.

Long-term Outcome Measure – Acute Readmission Rate.

An improvement in clinical quality and patient safety in hospital and specialist services
- Mortality rates are a well-established measure of clinical outcomes for hospital patients, due to the fact that mortality is an explicit and readily available measure related to the safety and efficacy of treatment. Maintaining or improving mortality rates will accordingly ensure maintenance of clinical quality standards without precluding productivity gains in other areas such as, length of stay.

- Overseas experience shows that systemic changes to the way care is offered to patients can lead to measureable changes in patient morbidity and mortality. Examples are changes intended to reduce incidences of falls, pressure ulcers, pneumonia, and hospital acquired infections in patients.
Long-term Outcome Measure – 30 Day Mortality Rate

<table>
<thead>
<tr>
<th>DHB</th>
<th>Standardised mortality rate</th>
<th>Average</th>
<th>Unstandardised mortality rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>MidCentral</td>
<td>1.50</td>
<td>1.50</td>
<td>1.50</td>
</tr>
<tr>
<td>Auckland</td>
<td>1.40</td>
<td>1.40</td>
<td>1.40</td>
</tr>
<tr>
<td>Waitemata</td>
<td>1.35</td>
<td>1.35</td>
<td>1.35</td>
</tr>
<tr>
<td>Waikato</td>
<td>1.30</td>
<td>1.30</td>
<td>1.30</td>
</tr>
<tr>
<td>Taranaki</td>
<td>1.25</td>
<td>1.25</td>
<td>1.25</td>
</tr>
<tr>
<td>Nelson</td>
<td>1.20</td>
<td>1.20</td>
<td>1.20</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>1.15</td>
<td>1.15</td>
<td>1.15</td>
</tr>
<tr>
<td>Bay of Plenty</td>
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<td>1.10</td>
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<td>Hutt Valley</td>
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<tr>
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</tr>
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<td>Nelson Marlborough</td>
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<td>0.65</td>
<td>0.65</td>
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<tr>
<td>Northland</td>
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<td>Wellington</td>
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<td>Hutt Valley</td>
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<td>0.05</td>
</tr>
<tr>
<td>Taranaki</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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</tbody>
</table>

Reduce the 30 day mortality rate

<table>
<thead>
<tr>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.40</td>
<td>0.35</td>
<td>0.30</td>
<td>0.25</td>
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</table>

Health inequalities between population groups in Bay of Plenty DHB’s community will reduce

Expectation: Reducing health inequalities is at the centre of New Zealand’s public health agenda and is an expectation articulated in the New Zealand Public Health and Disability Act 2000. There is a growing awareness that average health status alone is not a sufficient indicator of health system performance and that the distribution of health within a population is just as important. Equally patterns of difference in health outcomes that are based on ethnicity are unacceptable – this is a health justice and social justice issue. Whilst solutions to health inequalities are largely related to health determinants, it is nonetheless the responsibility of health (particularly funders, primary and community health services) to moderate the effects of disparity through funding, providing programmes that target inequalities, improve access to services and information and build levels of health literacy.

Why is this goal a priority?

A baby boy born in New Zealand today to non-Māori parents can expect to live 79 years. If his parents are Māori he can expect to live 70 years. A baby girl born in New Zealand today to non-Māori parents can expect to live to 83 years. If her parents are Māori she can expect to live 75 years. It is Bay of Plenty DHB’s belief that all children born in the Bay of Plenty district should have the same life expectancy regardless of ethnicity or place of residence.

Systemic disparities in health outcomes between Māori and Pakeha New Zealanders have persisted for decades. Inequalities in health status are reflected in the patterns of access to health services, chronic disease rates; admission rates to secondary hospitals (in particular in the area of ambulatory sensitive hospitalisations), mental health admissions and admissions to forensic units and of course in morbidity and amenable mortality rates. There is growing evidence that inequalities are bad for all of us (even the wealthier populations) as a society characterised by social inequalities and injustice is a society where discord prevails.
The Public Health Intelligence Unit’s Occasional Bulletin No 28, *Monitoring Health Inequality Through Neighbourhood Life Expectancy (2005)* indicates that the Bay of Plenty district population is about midway in terms of level of health (health outcomes) and midway for distribution of health. We’re not significantly better than the average DHB for either of these variables indicating that there remains a significant way to go. Of significance are the inequalities that exist within the Bay of Plenty DHB region.

Outcomes - We will know we are succeeding when there is:

A continuing closing of the life expectancy gap between Māori and non-Māori

All children born in the Bay of Plenty district have the same life expectancy regardless of ethnicity or place of residence.

Long-term Outcome Measure:
Māori/non-Māori life expectancy

![NZ LIFE EXPECTANCY AT BIRTH BY ETHNICITY AND GENDER](image)

Ethnic differences in amenable mortality reduce

Amenable mortality is mortality that can theoretically be averted by good health care. If all people have the ability to access health care appropriately and easily then amenable mortality rates will not display ethnic differences. Good access includes being able to physically access appropriate services in a timely way; it also includes having a level of health literacy that ensures people are able to make informed judgments around the appropriateness of seeking health care.

The estimated rates of amenable mortality per 100,000 population for New Zealanders under 75 years is:

- Māori male – 320.5
- Māori female – 189.6
- Non-Māori male – 113.6
- Non-Māori female – 63.1

(2006, age adjusted)

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5 These two measures are not dissimilar; however it should be noted life expectancy is an aggregate indicator of all factors affecting mortality (including genetic/familial factors). Amenable, mortality on the other hand, can be seen as a proxy for access to appropriate health interventions.
Long-term Outcome Measure:
Amenable mortality rates by ethnicity

This graph plots a rate ratio for Māori females (red line) and Māori Males (blue line) - i.e. the lines show how many times higher the Māori rates are than the non-Māori rates. Of concern is the rise for Māori males from 2.2 times higher in 1996 to 2.8 times higher in 2006.
4 Delivering on Priorities and Targets

4.1 The Minister of Health’s Expectations

The Minister of Health has outlined his expectations for 2011/12 which enables us to plan and prioritise activity for the coming year. National health targets have also been set by the Minister.

The Minister’s expectations together with the national health targets reinforce the Government’s commitment to a public health system that delivers better, sooner, more convenient health care for all New Zealanders by focusing on enhancing performance, increasing outputs, improving quality and effectively managing resources. There is also a strong focus on improving front line services and operating within approved financial budgets.

In setting expectations for 2011, a clear signal has been given that DHBs must deliver services and achieve national health targets within existing resources and within budget.

For the 2011/12 year, the Minister’s expectations and priorities for District Health Boards include:

- Improve service and reduce waiting times through the achievement of health targets within agreed timeframes.

- Strengthen clinical leadership, networks and engagements.

- Closer integration of services across the care continuum to improve convenience for patients and reduce pressure on hospitals. Specifically:
  - Reducing unplanned admissions through working with community and hospital-based clinicians on: long term disease management, the frail elderly, after-hours services.
  - Ensuring community and hospital-based clinicians are at the forefront of development, supported by management, and enabled to provide services more effectively.
  - Developing efficient and effective integrated family health centres.
  - Supporting the Whānau Ora initiative.

- Plan for the impact of our ageing population on health services with a specific focus on:
  - Mental health (dementia), disease and injury prevention.
  - Building better systems both in terms of monitoring and audit to improve quality across home-care and aged residential care.
  - Avoiding hospital admissions through new and expanded services particularly in community settings.
  - Improving access to respite care, day programmes and other social supports to appropriately support family/Whānau.
  - Engaging in the next steps of work on the aged residential care review.

- Regional collaboration – accelerated collaboration between DHBs to maximise clinical and financial resources and evidence of real gains from this collaborative endeavour particularly as it relates to:
- Regional plans focus on high priority and vulnerable services and implementation plans to sustainably secure these services.
- Developing shared back-office functions across DHBs.
- Regionalisation of IT platforms, IT support and workforce development.

- Deliver on agreed financial results through an ongoing commitment to efficiency gains and productivity improvements.

Our DHB’s plans for 2011/12 incorporate Government’s priorities and the table below references where each Government priority is more specifically discussed within this Plan:

<table>
<thead>
<tr>
<th>Minister’s Expectations</th>
<th>Annual Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen clinical leadership, networks and engagement</td>
<td>See table 4.1.1</td>
</tr>
<tr>
<td>Closer integration of services across the care continuum to improve convenience for patients and reduce pressure on hospitals</td>
<td>See table 4.1.2</td>
</tr>
<tr>
<td>Plan for the impact of our ageing population on health services</td>
<td>See table 4.1.3</td>
</tr>
<tr>
<td>Deliver on agreed financial results through an ongoing commitment to efficiency gains and productivity improvements</td>
<td>See Section 9</td>
</tr>
<tr>
<td>Improve service and reduce waiting times through the achievement of health targets within agreed timeframes</td>
<td>See section 4.2</td>
</tr>
<tr>
<td>Regional collaboration – accelerated collaboration between neighbouring DHBs to maximise clinical and financial resources and evidence of real gains from this collaborative endeavour</td>
<td>See section 4.3</td>
</tr>
</tbody>
</table>

4.1.1 Government Priority: Strengthen clinical leadership, networks and engagement

Bay of Plenty DHB’s comprehensive senior medical, nursing and allied health leadership structure is integral to, and active in clinical governance activities. Senior physicians, nurses and allied health professionals engage in leadership training.

Regionally Bay of Plenty has been active in the development of the Midland Regional Clinical Services Plan and will continue to take a leadership role in the implementation of regional initiatives, ensuring involvement of clinicians from the primary and secondary settings.

BOP DHB sees clinical leadership as being fundamental to achievement of our four strategic goals:

- Strategic Goal 1: People are healthier, able to self-manage and live longer
- Strategic Goal 2: People are able to participate more in society and retain their independence for longer
- Strategic Goal 3: People receive timely and appropriate complex care
- Strategic Goal 4: Health inequalities between population groups in our community will reduce
The involvement of and leadership provided by clinicians will ensure that we focus on areas that will achieve the most gain for our populations most at risk and in doing so ensure that we continue to develop and deliver services that are both efficient and effective.

<table>
<thead>
<tr>
<th>We will undertake these initiatives/activities and actions</th>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| **We will ensure that clinicians are involved in local and regional planning processes** | • Clinicians will take a lead role in all MRCSP action groups  
• Clinicians are involved in all existing Midland Regional Clinical Networks  
• Clinicians take a lead role in Bay Navigator | Ongoing | Midland Region Programme Manager  
Midland Region Programme Directors  
Bay Navigator Governance Group |
| **We will actively support leadership training and development for clinicians** | Attendance at:  
• Leadership in Practice Programme  
• Health Leaders Advanced Programme  
• Coach U Programme  
• Kaupapa Māori Clinical Support Service (Mental Health) | Ongoing | BOP DHB Clinical School/General Manager  
Human resources  
Poutiri Trust |
| **We will actively support national initiatives related to enhancing clinical leadership, clinical engagement and the development of clinical networks** | Development, implementation and ongoing management of:  
• Midland Regional Training Network  
• Career planning for all clinicians | December 2011 | BOP DHB Clinical School/General Manager  
Human resources |
| **Strengthen and support nursing leadership capacity in collaboration with the Midland Directors of Nursing through nursing leadership networks.** | Provide quarterly senior nursing leadership forums to develop clinical networks across the primary and secondary settings. | Quarterly | Regional Directors of Nursing |
| **Midland Allied Health Network will focus on supporting allied health clinical leadership and networks.** | • Establish a regional profile  
• Develop resources collaboratively to support new graduates into practice. | Ongoing | Regional Directors of Allied Health |
4.1.2 Government Priority: Closer integration of services across the care continuum to improve convenience for patients and reduce pressure on hospitals

Bay of Plenty DHB has been working on improving the interface between the primary/community and secondary settings for some time now. Significant progress has already been achieved with the launch of the Bay Navigator. Bay Navigator provides a mechanism for re-design across the health system in the Bay of Plenty. It includes the development of a website as a key access point for clinical staff across the Bay to access and find the best treatment pathways for particular conditions.

In essence the Bay of Plenty District Health Board’s Bay Navigator, is a project to develop care pathways for the improvement of the patients overall journey, and the continuity of care across different disciplines and sectors, with the aim of reducing duplication and improving the efficiency of resources within a constrained financial setting and medical workforce. The pathways propose to deliver devolution of appropriate care to the patient at the right time, in the right place, thus facilitating better sooner more convenient care. There are a number of services that are already being delivered in the primary care setting that have been previously hospital based services, these include community primary options, intravenous rehydration, deep vein thrombosis management, pneumonia management, cellulitis management, community podiatry, and minor skin surgery.

The DHB will continue to work with its major primary care partners to identify areas which can more efficiently be provided within the community setting. The primary care sector in Bay of Plenty has been working closely with the DHB on improving services which align to the health targets and this focus will continue over the coming year. Included in this approach are monthly health target meetings between the PHOs and the DHB with a focus on improved activity in the primary sector.

Within the Eastern Bay PHO, the business case, Te Whiringa Ora, complex chronic condition care coordination/case management will deliver a web based patient care management tool to allow multiple providers to contribute to a central care plan. This is to be linked with the work of the Bay Navigator and associate clinical pathways. Te Whiringa Ora has case managers attending medical ward discharge planning rounds for identification of highly complex patients for enrolment on to the programme. Referrals have already been accepted on to the programme from hospital, primary care, and the community respiratory nursing service.

The initiatives outlined below will assist us to work towards achievement of the following strategic goals:

- **Strategic Goal 1**: People are healthier, able to self-manage and live longer
- **Strategic Goal 2**: People are able to participate more in society and retain their independence for longer
- **Strategic Goal 3**: People receive timely and appropriate complex care
- **Strategic Goal 4**: Health inequalities between population groups in our community will reduce

by ensuring that people regardless of their needs receive the right care, at the right time, in the right place, by the right people. Where possible people will receive care when they need
it, as close to home as possible with a focus on early intervention and reducing the need for hospital care, allowing greater independence and ongoing contribution to society.

The following actions have been developed as a result of integrated planning across the PHOs and DHB, and include the Eastern Bay of Plenty business case objectives and the Bay Navigator objectives. Integration and cross reference at a governance level occurs through inclusion of primary care representatives and senior DHB personnel, including clinicians on the Alliance Leadership Team (ALT) and Bay Navigator Governance Group. At an operational level there are links through the Bay Navigator Action Groups and the Service Alliance Leadership Teams (SALT) in terms of representation and the reporting processes through to the Governance groups.

On a regional basis the organisations involved in the BSMC business cases have been formally invited to contribute to the Regional Steering Group which is the regional planning governance group, this will ensure alignment between local and regional primary care developments. On an operational level hospital and primary care clinicians are involved in a variety of action groups including primary care, maternity, information technology, and the regional training network.

The governance and operational groups for Bay Navigator and the Eastern Bay Business Case have detailed action plans for the 2011/12 year that will be worked through and monitored. Reporting to the Board will occur via CEO monthly reports, health target reporting, IDP Reporting, and regular reporting against the Annual Plan and Statement of Intent. In addition the Board has identified Primary Care as a strategic priority and this will be a focus over the 2011/12 year.
We will undertake these initiatives/activities and actions

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing unplanned admissions through working with community and hospital-based clinicians on long term disease management, the frail elderly, after-hours services through:</td>
<td></td>
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<tr>
<td>Frequent flier initiative EBPHA IFHN - assigning primary care case managers to patients who frequently require hospital admission.</td>
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<tr>
<td>Frequent flier initiative through Bay Navigator will identify WBOP initiatives and ensure alignment to EBOP IFHN developments</td>
<td></td>
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</tr>
<tr>
<td>Rapid response team in place and managing patients in the community – the focus of the rapid response team initially will be on chronic care management including those patients with COPD, diabetes and CVD.</td>
<td>May 2012</td>
<td>PHOs through After Hour services</td>
</tr>
<tr>
<td>Nurse case managers identify candidates for community based complex care programme</td>
<td></td>
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<tr>
<td>IT based referral and case management shared data system in place and being used by primary and secondary providers to support shared care planning</td>
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<tr>
<td>Provision of additional support to care homes to prevent resident admission to hospital</td>
<td></td>
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<tr>
<td>Explore options for the development of a model of care that includes specialist advice and support to rest homes</td>
<td>June 2012</td>
<td>Planning and funding</td>
</tr>
<tr>
<td>Implement the Mauao Clinic - coordinated GP and Pharmacy service aimed at improving the full spectrum of primary care including medication management in rest homes concept, this will focus on the WBOP with consideration of extension to EBOP once reviewed by providers</td>
<td></td>
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<tr>
<td>Community response team in the WBOP continues to deliver rest home based care and support (this service will be provided by the rapid response team in the EBOP)</td>
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<tr>
<td>“Yellow Envelope” initiative for improving information sharing between rest homes and secondary care continues to be effective.</td>
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<tr>
<td>Number of hospital admissions from rest homes to be aligned with national benchmarks</td>
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<tr>
<td>Implementation of the Bay Navigator initiative</td>
<td></td>
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<tr>
<td>All identified pathways complete and implemented</td>
<td>June 2012</td>
<td>Bay Navigator Governance Group</td>
</tr>
<tr>
<td>Primary Care Information Group working as an action/advisory Group to the Governance Group</td>
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<tr>
<td>Publication of the Bay Navigator Website</td>
<td></td>
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<tr>
<td>Website operational</td>
<td>June 2011</td>
<td>Bay Navigator Governance Group</td>
</tr>
<tr>
<td>Additional pathway information added to website as available</td>
<td>June 2012</td>
<td></td>
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<tr>
<td>Website marketing complete</td>
<td></td>
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<tr>
<td>Website hits monitored and reported on</td>
<td></td>
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<tr>
<td>We will undertake these initiatives/activities and actions</td>
<td>Deliverables</td>
<td>Timing</td>
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<tr>
<td>Links between Integrated Family Health Centre COPD initiative and Bay Navigator identified. Development of Care Pathway for respiratory</td>
<td>▪ To expand and implement the EBOP COPD pathway in WBOP including: investigating virtual FSA opportunities, Smoking Cessation pathway, Referral guidelines for FSA, and Spirometry education in the community Success measures include: ▪ Number of hits on Bay Navigator website ▪ FSA/Follow up ratio ▪ Reduction in wait lists ▪ Reduction in admissions (review rate) ▪ Track number of virtual FSA’s ▪ Improvement of health target for smoking cessation ▪ COPD patients confident to self manage their condition</td>
<td>January 2012</td>
</tr>
<tr>
<td>Development of Care Pathway for diabetes</td>
<td>▪ Develop and implement an education and self management pathway for newly diagnosed type 2 diabetes Success measures include: ▪ Number of hits on Bay Navigator website ▪ <strong>HBA1C after diagnosis compared with HBA1C after 12 months</strong> ▪ <strong>Number on pathway – measured by audit over number newly diagnosed</strong> ▪ <strong>Number at 12 months that attend retinal screening and 12 month check</strong> ▪ Weight, BP etc by comparison groups</td>
<td>January 2012</td>
</tr>
<tr>
<td>Development of Care Pathway for cardiology</td>
<td>▪ Six pathways to be developed and implemented: chest pain, undifferentiated dyspnoea, atrial fibrillation (including warfarinisation), palpitations, syncope, and asymptomatic murmur. Success measures include: ▪ Number of hits on Bay Navigator website ▪ % improvement of appropriate referrals ▪ Reduction in waiting times ▪ Reduction in number of acute admissions for those wait listed</td>
<td>November 2011</td>
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</table>
We will undertake these initiatives/activities and actions

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<tr>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
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<tbody>
<tr>
<td>Six child health pathways will be implemented: UTI Pathway, Asthma Pathway,</td>
<td>February 2012</td>
<td>Bay Navigator Child Health Action Group</td>
</tr>
<tr>
<td>Eczema Pathway, Gastro Pathway, Skin Sepsis Pathway, and Chronic OME Pathway.</td>
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<tr>
<td>Success measures include:</td>
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<tr>
<td>▪ Number of hits on Bay Navigator website</td>
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<tr>
<td>▪ Reduction in admissions</td>
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<tr>
<td>▪ Reduction in length of stay</td>
<td></td>
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<tr>
<td>Evaluation complete</td>
<td>March 2012</td>
<td>Planning and Funding</td>
</tr>
<tr>
<td>Recommendations aligned to EBPHA BSMC Business Case</td>
<td></td>
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<tr>
<td>Recommendations implemented</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation complete</td>
<td>March 2012</td>
<td>Planning and Funding</td>
</tr>
<tr>
<td>Recommendations implemented</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Each pathway has associated workforce analysis and action plan developed</td>
<td>June 2012</td>
<td>Bay Navigator Governance Group, ALT, DHB</td>
</tr>
<tr>
<td>Workforce plan developed in conjunction with EBPHA ALT to include workforce</td>
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<tr>
<td>development needs and activities to support development including links to</td>
<td></td>
<td></td>
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<tr>
<td>the BOP Clinical School, E-learning activities, and other educational</td>
<td></td>
<td></td>
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<tr>
<td>opportunities</td>
<td></td>
<td></td>
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<tr>
<td>Clinical training needs linked to Regional Training Network activity.</td>
<td></td>
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<tr>
<td>Development of models of care for primary care and Whakatane Hospital</td>
<td></td>
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<tr>
<td>redevelopment</td>
<td></td>
<td></td>
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<tr>
<td>Planning and Funding</td>
<td></td>
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<tr>
<td>We will undertake these initiatives/activities and actions</td>
<td>Deliverables</td>
<td>Timing</td>
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<td>------------------------------------------------------------</td>
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</tbody>
</table>
| Ensuring community and hospital-based clinicians are at the forefront of development, supported by management, and enabled to provide services more effectively | • Support the continuation of Bay Navigator (integrated care pathway) development which includes the full multidisciplinary team across primary and secondary services using a GP-SMO Co-leadership model.  
• Ensure alignment of Bay Navigator and EBPHA Business Case through linkages between Governance and operational groups.  
• Ensure alignment of Bay Navigator EBPHA Business Case, and Whakatane redevelopment  
• Technical Advisory Groups (TAGs) continue to provide Planning & Funding with advice on opportunities for development and/or remodelling of services.  
• Continue the hospital provider representation on Primary Care Governance structures: ALT, Clinical Leadership Team, and SALTs in Eastern Bay business Case | Ongoing | Bay Navigator Governance Group, ALT, Whakatane Redevelopment Steering Group |
<p>| | | Ongoing | TAGs |
| | | Ongoing | DHB, EBHA ALT |</p>
<table>
<thead>
<tr>
<th>We will undertake these initiatives/activities and actions</th>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| Developing efficient and effective integrated family health centres and supporting the Whānau Ora initiative. | • Whānau Ora Centre opening in Tauranga  
• Active participation in the Midland ALT  
• Active participation in the Eastern Bay of Plenty PHA ALT  
• Planning to implement High Trust and Integrated Contracts  
• Align contracts to outcomes in line with Results Based Accountability to facilitate the delivery of Whānau outcomes  
• IFH centre/system development in Whakatane currently scoped and stakeholders engaged - completion of Phase 3 of the Business case to occur by December 2011. (Phase 3 Business Case to include financial planning, models of care, and service framework) | July 2011  
Ongoing  
Ongoing  
July 2011  
Ongoing  
December 2011 | PHO  
DHB  
DHB  
DHB  
DHB |
4.1.3 Government Priority: Plan for the impact of our ageing population on health services

Bay of Plenty DHB has a strong focus on population ageing given the large number of 65+ currently in our community and the forecast growth in this group. We know that the 65+ age group are the largest consumers of health care and thus of the health care dollar. Bay of Plenty DHB’s involvement in the Population Aging Technical Advisory Group (PATAG) is a key mechanism for identifying the issues and needs for the aging population. PATAG is a partnership between Bay of Plenty DHB and Smart Growth, which is a collaborative venture between the three BOP Councils and The Combined Tangata Whenua Forum to consider the 50-year population growth and its impacts.

The initiatives outlined below will assist us to work towards achievement of the following strategic goals:

- **Strategic Goal 1:** People are healthier, able to self-manage and live longer
- **Strategic Goal 2:** People are able to participate more in society and retain their independence for longer
- **Strategic Goal 3:** People receive timely and appropriate complex care

by ensuring our older people receive appropriate care supporting independent living and contribution to society for as long as possible.
<table>
<thead>
<tr>
<th>We will undertake these initiatives/activities and actions</th>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health (dementia), disease and injury prevention</td>
<td>Increased provision of secure dementia beds in Aged Residential Care facilities</td>
<td>On-going</td>
<td>GM Planning &amp; Funding</td>
</tr>
<tr>
<td></td>
<td>Improve education around dementia and develop and trial a dementia-specific care plan for clients of Mental health Services for Older Persons</td>
<td>Ongoing</td>
<td>Regional Dementia Support &amp; Advisory Service Coordinator</td>
</tr>
<tr>
<td></td>
<td>Utilise statistical data gathered from Memory Service pilot to inform the development of an ongoing Memory Service</td>
<td>30 June 2012</td>
<td>Mental Health Services for Older People</td>
</tr>
<tr>
<td></td>
<td>People with dementia and their families are supported to remain independent for as long as possible in the community through timely access to support and information</td>
<td>On going</td>
<td>GM Planning and Funding</td>
</tr>
<tr>
<td>Building better systems both in terms of monitoring and audit to improve quality across home-care and aged residential care</td>
<td>Integration of contract and Certification audits for Aged Residential Care with Ministry of Health (HealthCERT)</td>
<td>On-going</td>
<td>GM Planning &amp; Funding</td>
</tr>
<tr>
<td></td>
<td>Implementation of interRAI in Aged Residential Care facilities supported (pending outcome of business case)</td>
<td>30 June 2012</td>
<td>GM Planning &amp; Funding</td>
</tr>
<tr>
<td>Avoiding hospital admissions through new and expanded services particularly in community settings</td>
<td>Expansion of residential care provision by approval of 2 new residential care providers</td>
<td>30 June 2012</td>
<td>GM Planning and Funding</td>
</tr>
<tr>
<td></td>
<td>Medication reviews take place in residential care</td>
<td>30 June 2012</td>
<td>Medwise</td>
</tr>
<tr>
<td></td>
<td>Provision of targeted education</td>
<td>30 June 2012</td>
<td>Primary Care Nurse Liaison</td>
</tr>
</tbody>
</table>
### Improving access to respite care, day programmes and other social supports to appropriately support family/Whānau

- Ongoing provision of flexible options to support carers to take a break through the provision of respite options including dedicated beds in aged residential care facilities and top up to Carer Support for residential care pursuant to Ministerial initiative.
  - Ongoing Provision of Kaupapa Māori Flexi Respite Care and Kaupapa Māori residential respite to ensure culturally appropriate service provision

### Engaging in the next steps of work on the aged residential care (ARC) review

- Active participation in national process
- Encouraging investment in the sector through approval of 2 new ARC providers in Western Bay of Plenty

<table>
<thead>
<tr>
<th>Deliverables</th>
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<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing provision of flexible options to support carers to take a break</td>
<td>On-going</td>
<td>GM Planning &amp; Funding</td>
</tr>
<tr>
<td>through the provision of respite options including dedicated beds in aged</td>
<td></td>
<td>GM Planning and Funding Māori Health</td>
</tr>
<tr>
<td>residential care facilities and top up to Carer Support for residential care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pursuant to Ministerial initiative.</td>
<td></td>
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</tr>
<tr>
<td>Ongoing Provision of Kaupapa Māori Flexi Respite Care and Kaupapa Māori</td>
<td></td>
<td></td>
</tr>
<tr>
<td>residential respite to ensure culturally appropriate service provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On-going</td>
<td>1 July 2011</td>
<td>GM Planning &amp; Funding</td>
</tr>
</tbody>
</table>

### 4.2 Achieving National Health Targets

To measure progress against national priorities and the Minister of Health’s expectations, a set of national health targets has been established, with the anticipation that collaborative focus will drive performance improvement across the sector.

Our DHB is committed to making continued progress towards achieving the national health targets, and the goals we intend to reach over the coming year are set out in the table below. The activity planned to deliver on these health targets is outlined below.
<table>
<thead>
<tr>
<th>Health target</th>
<th>Long term target</th>
<th>Local target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shorter stays in Emergency Departments</strong></td>
<td>95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours</td>
<td>95% Of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours</td>
</tr>
<tr>
<td><strong>Improved access to Elective Surgery</strong></td>
<td>The volume of elective surgery will be increased by an average of 4,000 discharges per year (compared with the recent average increase of 1,400 per year)</td>
<td>Bay of Plenty District Health Board agrees to a minimum of 8,357 total elective surgical discharges in 2011/12 (excluding cardiology and dental)</td>
</tr>
<tr>
<td><strong>Shorter waits for Cancer Treatment Radiotherapy</strong></td>
<td>Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010</td>
<td>100% Of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).</td>
</tr>
<tr>
<td><strong>Increased Immunisation</strong></td>
<td>85 percent of two year olds are fully immunised by July 2010; 90 percent by July 2011; and 95 percent by July 2012.</td>
<td>95% Of two year olds (all ethnicities) are fully immunized by July 2012.</td>
</tr>
<tr>
<td><strong>Better help for Smokers to Quit</strong></td>
<td>80 percent of hospitalised smokers are provided with advice and help to quit by July 2010; 90 percent by July 2011; and 95% by July 2012. Similar target for primary care will be introduced from July 2010 or earlier, through the PHO Performance Programme.</td>
<td>95% Of hospitalised smokers are provided with advice and help to quit by July 2012.</td>
</tr>
<tr>
<td><strong>Better Diabetes and Cardiovascular Services</strong></td>
<td>Increased percent of the eligible adult population have had their CVD risk assessed in the last five years.</td>
<td>90% Increased percent of the eligible adult population (Māori) have had their CVD risk assessed in the last five years.</td>
</tr>
<tr>
<td></td>
<td>90% Increased percent of the eligible adult population (Pacific) have had their CVD risk assessed in the last five years</td>
<td>90% Increased percent of the eligible adult population (other ethnicity) have had their CVD risk assessed in the last five years</td>
</tr>
<tr>
<td></td>
<td>90% Increased percent of the eligible adult population (all ethnicities) have had their CVD risk assessed in the last five years</td>
<td>90% Increased percent of the eligible adult population (all ethnicities) have had their CVD risk assessed in the last five years</td>
</tr>
<tr>
<td></td>
<td>Increased percent of people with diabetes attend free annual checks</td>
<td>75% Increased percent of people with diabetes (Māori) attend free annual checks</td>
</tr>
</tbody>
</table>
### Health Target: Shorter Stays in Emergency Departments

The initiatives outlined below will assist us to work towards achievement of the following strategic goal:

- **Strategic Goal 3:** People receive timely and appropriate complex care

by ensuring that appropriate community services are in place so that only those people who need to attend ED do so, and when there they receive timely and appropriate care by appropriately skilled staff.

<table>
<thead>
<tr>
<th>We will undertake these initiatives/activities and actions</th>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved information on alternate appropriate health care provision available to patients presenting to ED</td>
<td>Develop strategy for patient information on discharge from ED – personalised patient information.</td>
<td>Dec 2011</td>
<td>Cluster Leadership</td>
</tr>
<tr>
<td>Foster relationships between hospital doctors, GPs and the wider multidisciplinary team through the establishment of integrated clinical care pathways</td>
<td>Bay Navigator - A web facilitated reference source providing pathway information, referral criteria and long-term disease management resources. This is to be delivered through the Bay Navigator project. Identified pathways (see below) to be developed and implemented.</td>
<td>Dec 2011</td>
<td>Bay Navigator Governance Group</td>
</tr>
<tr>
<td>Develop integrated clinical care pathways</td>
<td>Bay Navigator – clinical care pathways for the following patient groups:</td>
<td>Dec 2011</td>
<td>Bay Navigator Governance Group</td>
</tr>
<tr>
<td></td>
<td>- Respiratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Child Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Cardiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthen arrangements for referral of walk-ins and non-registered patients to primary health care providers</td>
<td>Strategy development for engagement of non-enrolled patients. Providing information on GPs, and education on benefits of GP enrolment.</td>
<td>On going</td>
<td>ED Cluster Leadership</td>
</tr>
<tr>
<td>Task Description</td>
<td>Details</td>
<td>Target Date</td>
<td>Responsible Party</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
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<td>----------------------------------------</td>
</tr>
<tr>
<td>Develop frequent attender care plans with primary care</td>
<td>Identify the frequent attendees and in conjunction with hospital medical team and GP develop individualised care plans. Frequent attendees are identified through both ED and Ward reports. Engagement of specialist nursing and case management model in reducing readmissions for people with long term disease. EBOP – Te Whiringa Ora model for early supported discharge and readmission reduction.</td>
<td>On going</td>
<td>Provider Arm/PHO</td>
</tr>
<tr>
<td>Develop referral arrangements between ED and primary care</td>
<td>ED development for strategic plan on implementation of electronic referrals in conjunction with GP liaison.</td>
<td>June 2012</td>
<td>ED Cluster Leadership, GP Liaison, and Information Management</td>
</tr>
<tr>
<td>Improve referral rates to Coordinated Primary Options</td>
<td></td>
<td>Ongoing</td>
<td>Provider Arm/PHO</td>
</tr>
<tr>
<td>Explore options for acute clinics to be accessed by GPs</td>
<td>Bay Navigator – implement outcomes</td>
<td>May 2012</td>
<td>Provider Arm/PHO</td>
</tr>
<tr>
<td>Survey patients quarterly to ascertain reasons for presenting to ED and not GP</td>
<td>Template Development for survey. Implement interventions based on findings of patient survey</td>
<td>June 2012</td>
<td>ED Cluster Leadership</td>
</tr>
<tr>
<td>Review current variance response plan, aligning with Care Capacity Demand Management (CCDM) activity</td>
<td>Refer to variance response management above. Evaluate selected nursing division across both sites in conjunction with CCDM</td>
<td>On going</td>
<td>Nursing Leadership</td>
</tr>
<tr>
<td>Pilot Surgical Admission and Planning Unit</td>
<td>Pilot SAPU Full integration with APU</td>
<td>Complete</td>
<td>Surgical Cluster Leadership</td>
</tr>
<tr>
<td>Review Medical Assessment and Planning Unit to determine if efficiencies are being achieved</td>
<td>Monthly monitoring of % patients discharge/transferred from APU within 36 hours</td>
<td>On going</td>
<td>Medical/ED Cluster Leadership</td>
</tr>
<tr>
<td>Develop and signoff ED standard operating procedures, formalising responsibilities and implement ED streaming</td>
<td>Completed SOPs signed off by COO and MD</td>
<td>Complete</td>
<td>ED Clinical Director</td>
</tr>
<tr>
<td>Pilot ‘discharge by 11’ initiative and then roll out across all wards</td>
<td>Target reported through balance scorecard</td>
<td>On going</td>
<td>Cluster Leadership</td>
</tr>
<tr>
<td>‘Stranded Patient’ initiative</td>
<td>Patients with ALOS greater than DRG ALOS identified, reported, analysed, and monitored. Care plan developed for stranded patients as appropriate</td>
<td>On going</td>
<td>Cluster Leadership</td>
</tr>
<tr>
<td>Trial ‘discharge lounge’ in 1d composite ward, evaluate and consider rollout across other wards</td>
<td></td>
<td>June 2012</td>
<td>Provider Arm</td>
</tr>
</tbody>
</table>
4.2.2 Health Target: Improved Access to Elective Surgery

The initiatives outlined below will assist us to work towards achievement of the following strategic goals:

- **Strategic Goal 2:** People are able to participate more in society and retain their independence for longer
- **Strategic Goal 3:** People receive timely and appropriate complex care by ensuring that people gain timely access to elective services thus enabling early and ongoing contribution to society following surgery.

### We will undertake these initiatives/activities and actions

<table>
<thead>
<tr>
<th>We will undertake these initiatives/activities and actions</th>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planning and Process:</strong></td>
<td>Decrease cancellation rate (Target &lt; 5 per month)</td>
<td>17 Jan 2011 – 31 July 2012</td>
<td>Anaesthesia, Radiology &amp; Surgical Services in partnership with Service Improvement</td>
</tr>
<tr>
<td>Implement the Productive Operating Theatre Pilot</td>
<td>Surgical production plan will be met each month</td>
<td></td>
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</tr>
<tr>
<td>Implement of foundation modules followed by the enabling modules of:</td>
<td>ESPI compliance achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Teamworking</td>
<td>Meet or exceed Standardised Intervention Rates</td>
<td></td>
<td></td>
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<tr>
<td>- Scheduling</td>
<td></td>
<td></td>
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<tr>
<td>- Redesign of pre-assessment process (including greater primary sector involvement)</td>
<td></td>
<td></td>
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<tr>
<td>Defining acute and elective pathways</td>
<td></td>
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<tr>
<td><strong>Elective waiting times:</strong></td>
<td>Zero patients waiting for more than six months for either FSA or Treatment for all Surgical Specialties</td>
<td>Dec 2011</td>
<td>Anaesthesia, Radiology &amp; Surgical Services &amp; Women Family &amp; Child Services</td>
</tr>
<tr>
<td>All specialities to target a 6 month maximum waiting time between first specialist assessment (FSA) and treatment</td>
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<tr>
<td>Close monitoring of all referrals, FSA and treatment lists</td>
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<tr>
<td>Individualising SMO support to manage long waiting lists</td>
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<tr>
<td>Directing greater volume of elective surgery to Whakatane Hospital</td>
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<tr>
<td>Investigating opportunities to reduce follow-ups</td>
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</tbody>
</table>
**Capacity:**
- Utilising regional capacity
- Utilising private capacity
- Increasing theatre utilisation at Whakatane Hospital by:
  - Meet surgical production plan and implement productive theatre
- Reduce bed days for elective and arranged patients with specific project focusing on Early Recovery After Surgery (ERAS)
- Limiting the number of IDF’s to those services not provided locally
- Implement Care Capacity Demand Model
- Transfer to New ICU and staged commissioning of 5 additional Intensive care & 5 additional coronary care beds

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve day of surgery admission rate by 9% (target 90%)</td>
<td>June 2011-June 2012</td>
<td>Anaesthesia, Radiology &amp; Surgical Services</td>
</tr>
<tr>
<td>Increase day surgery rate from 57% to 61%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve theatre utilisation at both Tauranga and Whakatane Hospitals (from 82% to 85% at Tauranga Hospital) and (from 68% to 85% at Whakatane Hospital)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4.2.3 Health Target: Shorter Waits for Cancer Treatment Radiotherapy

The initiatives outlined below will assist us to work towards achievement of the following strategic goals:

- **Strategic Goal 2:** People are able to participate more in society and retain their independence for longer
- **Strategic Goal 3:** People receive timely and appropriate complex care

by ensuring that people with cancer receive timely and appropriate care supporting independent living and contribution to society for as long as possible.

<table>
<thead>
<tr>
<th>We will undertake these initiatives/activities and actions</th>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everyone needing radiation treatment will have this within four weeks. This is measured by the percentage of patients ready for treatment in category A, B and C waiting less than four weeks between first radiation oncology assessment and the start of radiation treatment</td>
<td>Work with Waikato DHB to ensure patients start treatment within 4 weeks from decision to treat. Develop robust contingency plans with Waikato DHB to be implemented when demand increases.</td>
<td>On going</td>
<td>Provider Arm, Waikato DHB</td>
</tr>
</tbody>
</table>
4.2.4 Health Target: Increased Immunisation

The initiatives outlined below will assist us to work towards achievement of the following strategic goals:

- Strategic Goal 1: People are healthier, able to self-manage and live longer
- Strategic Goal 4: Health inequalities between population groups in our community will reduce

By ensuring that children are immunised as recommended so as to reduce the risk of immunisation preventable disease and the associated impacts on the health system and society.

<table>
<thead>
<tr>
<th>We will undertake these initiatives/activities and actions</th>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| Develop and implement good systems for monitoring and recall of overdue immunisations | • Results of evaluation of remodelled immunisation service completed in October 2011 in both the east and Western Bay of Plenty are used to further refine the use of data from NIR and GP-based patient management systems.  
  • Information to be made available to individual GP practices monthly showing immunisation performance results in comparison with other practices within the Bay of Plenty. | October 2011                                      | Planning & Funding National Immunisation Register/PHOs                         |
| Social marketing programme – implement a programme of awareness amongst health care staff and the community of immunisation issues | • Recommendations from evaluation of outcomes of phases 1 and 2 of Parent Education Programme used to inform development of phase 3.  
  • BOPDHB Immunisation Parent Education programme – phase 3 - approved and completed. | August 2011                                      | Planning & Funding/Toi Te Ora                                    |
| Increase opportunistic immunisation in a wider range of venues (Child Assessment unit/Pediatric inpatient wards/outpatients/Emergency Departments/hauora clinics/GP clinics) | • Staff in different settings are fully trained to deliver opportunistic vaccinations using high quality systems including protection of the vaccine cold chain.  
  • Increased numbers of opportunistic immunisations in hospital and GP/community settings monitored by BOPDHB through quarterly PMRs. | September 2011                                      | Planning & Funding/Provider Arm                               |
| Investigate change to existing funding models to more incentivised arrangements (outcomes based funding model) Re-focus the outreach immunisation programme to focus on low uptake areas. | • As baseline levels of vaccination increase, funding is shifted to areas which will better reduce the gap between actual performance and target.  
  • Increased numbers of children from low uptake areas vaccinated. | September 2011                                      | Planning & Funding                                            |
|                                                             |                                                                                                                                          | June 2012                                   | PHOs                                                |
### We will undertake these initiatives/activities and actions

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decrease the number of declines by providing appropriate information to those parents who may vaccinate their children.</strong></td>
<td>• The two Lay Advocate roles employed in the Eastern and Western BOP link with Well Child Providers and parents to promote and educate the benefits of childhood immunisations.</td>
<td>August 2011</td>
</tr>
<tr>
<td></td>
<td>• Monitoring number of contacts with mothers prior to birth/no. of contacts with mothers after birth/referrals from and to GPs/contacts with providers to advise of benefits of immunisation.</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>• Continue to develop relationships with midwives and other providers that may assist in educating women and their families around immunisation.</td>
<td>Ongoing</td>
</tr>
<tr>
<td><strong>Achieve the immunisation Health Target and immunisation coverage rates at other ages</strong></td>
<td>• 95% of 2 year old children up to date with their age-appropriate vaccinations.</td>
<td>1 July 2012</td>
</tr>
<tr>
<td></td>
<td>• 95% of two year olds (Māori) are fully immunised.</td>
<td>1 July 2012</td>
</tr>
<tr>
<td></td>
<td>• Immunisation to occur in a timelier manner at all ages.</td>
<td></td>
</tr>
<tr>
<td><strong>Networking and collaboration between health providers within the BOPDHB and with other Midland DHBs are fostered to improve overall performance.</strong></td>
<td>• Eastern and Western BOP immunisation forums provide mechanisms and integrated service delivery models to improve vaccination performance.</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>• Midland DHBs provide mutual support and drive initiatives to increase vaccination rates to Midland immunisation target.</td>
<td>June 2012</td>
</tr>
</tbody>
</table>

### 4.2.5 Health Target: Better Help for Smokers to Quit

The initiatives outlined below will assist us to work towards achievement of the following strategic goals:

- **Strategic Goal 1:** People are healthier, able to self-manage and live longer
- **Strategic Goal 2:** People are able to participate more in society and retain their independence for longer

by reducing the impact of smoking related disease and the associated impacts on the health system and society.
<table>
<thead>
<tr>
<th>We will undertake these initiatives/activities and actions</th>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| **Data Capture**                                        | • 95% of hospitalised smokers will be provided with help to quit by July 2012  
• 90% of smoking patients attending primary care will be provided with help to quit by July 2012  
• 80% of nurses, doctors and allied staff will have received ABC smoking cessation training  
• 400-600 Māori, Pacific and pregnant women patients at Tauranga Hospital are given brief advice, NRT therapy and referred to a community quit agency | September 2011 | Smoke Free Coordinator and Clinical Lead |
| **Clinical Leadership**                                 | • 40-60 Māori and Pacific ex-smokers trained in Kaihautu Auahi Kore leadership-peer support roles in their whānau  
• 2% reduction in the number of Year 10 students in the Bay of Plenty schools identifying as non-smokers by 2011  
• 600 to 660 people domiciled within the district will have access to intensive smoking cessation services, the majority of which will be Māori  
• 120 controlled purchase operations carried out on tobacco retailers in the BOP district  
• One more district council in the Bay of Plenty will adopt a smoke-free public places policy | Ongoing | GP Smokefree Champion, Tobacco Control Project Manager, PHOs, GPs, LMCS, and Provider Arm |
| **Systems Improvements**                                | • Improve visibility of Smokefree Coordinators (SFCs) by being present at nursing handovers within Emergency Department and Admissions Planning Unit  
• Implement an Inreach Patient Smoking Cessation transition service that enables whānau self-management to quit targeting Māori, Pacific and pregnant women in hospital. | June 2012 | Smoke Free Coordinator |
| **Training**                                             | Ongoing ABC training of clinical staff by:  
• Compulsory training of new clinical staff during organisational induction programme  
• Training of existing clinical staff coordinated by Learning Plus and DHB Smokefree Coordinators  
• Utilising the DHB e-learning tool within primary health care setting (focusing particularly on Māori providers) | Ongoing | Smoke Free Coordinator |
### Primary/Secondary Integration

- GP Smokefree Champion to offer ongoing CME sessions to primary clinical staff (GP’s and practice nurses) regarding smoking cessation.
- Increase volume of electronic discharge summary referrals to GP’s to enable comprehensive smoking cessation support in the primary setting.
- Improved engagement with other primary health care providers (such as Lead Maternity Carers) for ABC training and induction in the use of hospital systems for accurately capturing/recording that ABCs given.
- Utilising the ‘Man Alive’ CVD risk assessment programme in the Eastern Bay of Plenty to deliver ABC’s and thereafter arrange comprehensive cessation support.
- Primary and secondary clinicians linked through quarterly meetings of the Tobacco Control Steering Group led by the Tobacco Control Project Manager.
- Close monitoring of primary care performance by Tobacco Control Project Manager.

<table>
<thead>
<tr>
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<th>→</th>
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</tr>
</thead>
</table>

### 4.2.6 Health Target: Better Diabetes and Cardiovascular Services

The initiatives outlined below will assist us to work towards achievement of the following strategic goals:

- **Strategic Goal 1:** People are healthier, able to self-manage and live longer
- **Strategic Goal 2:** People are able to participate more in society and retain their independence for longer
- **Strategic Goal 3:** People receive timely and appropriate complex care
- **Strategic Goal 4:** Health inequalities between population groups in our community will reduce

by reducing the burden of chronic disease and the associated impacts on the health system and society.
<table>
<thead>
<tr>
<th>We will undertake these initiatives/activities and actions</th>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| Diabetes Detection & Follow-up Achieve correct role delineation. Define core purpose of secondary care diabetes services | **Best practice guidelines for screening at risk groups:**  
- Develop health promotion options in conjunction with Toi Te Ora (Public Health Unit)  
- Review existing promotion/detection funding to ensure it effectively targets all at risk groups  
- Regular review of GP performance by practice | June 2012 | Toi Te Ora Funder PHO/Funder |
| Diabetes management | **Advance new evidence-based screening options:**  
- Link screening to enrolment process  
- Link screening for diabetes to other health initiatives such as cardiovascular disease (CVD) risk assessments  
- Annual recall IGT for testing  
- Use of patient questionnaires  

**Reduce Hba1c management disparities for Māori**  
- Provision of specific data on breakdown of Māori Hba1c achievement  
- Development of BoP wide education to reduce disparities  
- Focus on clinics with the most significant disparities  
- Introduction of insulin starts in EBPHA (already in place in WBPHO) | June 2012 | All PHOs All PHOs |
| Diabetes Management | **Development of Diabetes Care Pathway(s)**  
- Implement the Bay Navigator diabetes care pathway  
- Ensure local diabetes team is involved in the development, implementation and ongoing management of agreed outcomes  

**Development of an agreed BOP wide CVD management strategic plan**  
**Reduce CVD risk assessment target achievement disparities for Māori**  
- Provision of specific data on breakdown of Māori CVD risk completion  
- Development of BoP wide education to reduce disparities  
- Focus on clinics with the most significant disparities  
- EBPHA to extend its current CVD risk assessment programme from EBOP PHO practices and extend to whole district and include all risk cohorts. | December 2011 | Provider Arm/PHOs |
| Diabetes Management | **Development of Diabetes Care Pathway(s)**  
- Implement the Bay Navigator diabetes care pathway  
- Ensure local diabetes team is involved in the development, implementation and ongoing management of agreed outcomes | June 2012 | PHOs |
| Diabetes management | **Advance new evidence-based screening options:**  
- Link screening to enrolment process  
- Link screening for diabetes to other health initiatives such as cardiovascular disease (CVD) risk assessments  
- Annual recall IGT for testing  
- Use of patient questionnaires | March 2012 | Primary Nurse Liaison Primary Nurse liaison PHOs EBPHA |
| Diabetes Detection & Follow-up Achieve correct role delineation. Define core purpose of secondary care diabetes services | **Best practice guidelines for screening at risk groups:**  
- Develop health promotion options in conjunction with Toi Te Ora (Public Health Unit)  
- Review existing promotion/detection funding to ensure it effectively targets all at risk groups  
- Regular review of GP performance by practice | June 2012 | Toi Te Ora Funder PHO/Funder |
4.3  DHB regional, sub regional and local priorities

4.3.1  Regional initiatives progressing in 2011/12

The regional initiatives outlined below will assist us to work towards achievement of the following strategic goals:

- Strategic Goal 1: People are healthier, able to self-manage and live longer
- Strategic Goal 2: People are able to participate more in society and retain their independence for longer
- Strategic Goal 3: People receive timely and appropriate complex care
- Strategic Goal 4: Health inequalities between population groups in our community will reduce

by ensuring alignment between local and regional goals and activity.

<table>
<thead>
<tr>
<th>We will undertake these initiatives/activities and actions</th>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inter-Hospital Transfer Project</strong></td>
<td>Establish a standardised system of inter-hospital transfer (co-ordination and management)</td>
<td>June 2012</td>
<td>WDHB Programme office</td>
</tr>
<tr>
<td>Ensure timely inter-hospital transfer to appropriate services across the midland region</td>
<td></td>
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</tbody>
</table>
| **Improved inter-hospital transfer care pathways to ensure patients receive the right treatment at the right place across the midland region (more specifically for the pilot area Tairawhiti district health)** | Produce a Standard Operating Plan  
  - acute inter-hospital transfers  
  - elective inter-hospital transfers  
  Development of a communication strategy  
  Establish a sustainable change management and HR process to ensure the successful implementation of the project | June 2012 | WDHB Programme office        |
<p>| <strong>Midland Acute Coronary Syndrome Project</strong>                | Establishment of a coherent midland DHB regional clinical governance structure / process | February 2012 | Project Manager               |
| (Project over 3 years)                                     |              |             |                              |
| Better management of coronary care demand                  |              |             |                              |
| <strong>Timely access to interventional diagnostic services</strong>    | Develop communication and secondary care process pathways for inter regional patient transfer | July 2012 | Project Manager               |</p>
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| Improve the care pathways to ensure patients receive right treatment at the right place across the Midland Region. | • Development of protocols (for a selection of patients for referrals) for high quality and timely care  
• Undertake a needs analysis exploring:  
  • current utilisation and demand (scheduling / roster / sessions) throughput of cath labs  
  • LOS constraints for patients awaiting cath lab procedures  
  • identification of potential efficiencies  
  • Future models of care  
• Undertake a financial analysis to determine forecast cost implications  
• Identification of the cost and resource implications of future demand  
• Options analysis of financial incentives to support end project deliverables | July 2012 | Project Manager |

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| Midland DHB Regional Smokefree Initiative  
Implementation the Midland DHB Smokefree Programme Regional Action Plan 2011-2013 | 100% of targets are achieved for 2011/12 | June 2012 | Midland Smokefree Programme Director |
| Workforce Development  
Develop recruitment policies and processes that aim to:  
  • set targets to employ only non-smokers  
  • identify successful recruits who smoke and support with cessation options | Draft recruitment policies and processes are prepared for each of the Midland DHBs for consideration by individual Human Resource Departments. | September 2011 | Midland Smokefree Programme Director |
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| **Work with local DHB Iwi forums to:**                    | Secure commitment from Midland Iwi Relationship Boards via Memoranda of Understanding to proactively champion smokefree activities towards achieving the Smokefree Vision:  
• Te Arawa Health Roopu – Bay of Plenty DHB  
• Te Nohanga Kotahitanga o Tuwharetoa – Lakes DHB  
• Bay of Plenty Māori Health Runanga - BOP DHB  
• Te Waiora o Nukutaimemeha – Tairawhiti DHB  
• Waikato Iwi Māori Council – Waikato DHB  
• Te Whare Punanga Korero – Taranaki DHB | December 2011 | Midland Smokefree Programme Director |
| **Addictions Programme**                                   | At least one Midland DHB has agreed to fund an Integrated programme | April 2012 | Midland Smokefree Programme Director |
| Explore feasibility of developing an integrated addictions programme that seeks to empower Whānau affected by issues relating to smoking, gambling, drugs and alcohol | | | |
| **District Councils**                                      | Secure commitment from the following District Councils  
• Waikato  
• Gisborne | December 2011 | Midland Smokefree Programme Director |
| • Identify, target and work with key District Councils to develop and implement smokefree outdoor plans by utilising the learning processes from other successful projects, such as Rotorua and Opotiki District Councils  
• Develop regional awards and promotions that identify District Councils who demonstrate and implement smokefree outdoor plans  
• Continue to advocate at local and regional level for smokefree environments, parks, sporting venues, shopping complexes etc | | | |
4.3.2 Regional, sub regional and local actions to deliver on the Midland Regional Clinical Services Plan (MRCSP) sponsored/led by this DHB

The initial Implementation Action Plan focuses on areas where collaborative actions can lead to improved service delivery, quality and viability. This implementation Plan prioritises the work streams currently operating or to be established. It is first and foremost, a plan of action around specific areas that clinicians identified in the formulation of the MRCSP as priorities for action.

The initiatives outlined below will assist us to work towards achievement of the following strategic goals:

- **Strategic Goal 1:** People are healthier, able to self-manage and live longer
- **Strategic Goal 2:** People are able to participate more in society and retain their independence for longer
- **Strategic Goal 3:** People receive timely and appropriate complex care
- **Strategic Goal 4:** Health inequalities between population groups in our community will reduce

by ensuring alignment between local and regional goals and activity.

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<tbody>
<tr>
<td><strong>Area 1: Maternity Services</strong></td>
<td>• Establishment of a regional network including appropriate clinical representation for our DHB</td>
<td>July 2011</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td></td>
<td>• Prioritised list of actions with associated measures to assess clinical effectiveness and viability</td>
<td>September 2011</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td></td>
<td>• Detailed short, medium and long term activities with specific reference to this service with defined measures of effectiveness</td>
<td>March 2012</td>
<td>General Manager, Human Resources</td>
</tr>
<tr>
<td></td>
<td>• Develop, implement and monitor measures of service improvement</td>
<td>December 2011</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td></td>
<td>• Develop a Performance Framework to measure clinical network improvements</td>
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<tr>
<th>Area 2: Primary Care</th>
<th>Deliverables</th>
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| • Implementation of Better Sooner More Convenient Primary care business cases including implementation of Integrated Family Health centres, the development of new models of care to support improved child health, Whānau ora, chronic care management, community services, and primary mental health. | • Put in / reference your local BSMC plans here;  
• The MCRSP will reference the performance indicators you have agreed from your BSMC Business cases.  
• The DHB will host this forum (on a rotating basis with other DHBs) and will ensure clinical and managerial support to these sessions. | As agreed in BSMC cases but by 30 June 2012  
August 2011  
September 2011  
July 2012 | GM Planning and Funding  
GM Planning and Funding  
GM Planning and Funding  
Chief Information Officer |
| • Establish a Midland Community Services Leadership Forum twice yearly for clinicians and PHOs to share developments and innovations in the implementation of BSMC. | Completed milestones for:  
• Midland Connected Health  
• Midland Medication Management  
• Regional Clinical Data Repository | | |
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<td><strong>Area 3: Cardiac Services</strong></td>
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| Appointment of a regional clinical cardiac network and terms of reference to oversee the Implementation Plan Implement the recommendations of the BSMC business cases for improving the management of long term conditions, including cardiac disease that will focus on:  
  - Improve current best practice for screening, assessment, diagnosis and treatment services for people with Cardiovascular Disease  
  - Implement Clinical Guidelines for people with Cardiovascular Disease or at risk of developing Cardiovascular Disease  
  - Develop Clinical Pathways linking primary and secondary services for people with Cardiovascular Disease  
  - Develop service delivery alternatives and innovations for people who are at risk, disengaged or who have significant barriers to services  
Reduce inequity and improve access to tertiary coronary services through:  
  - Annual monitoring of intervention rates  
  - The implementation of regionally agreed protocols  
  - Increased funding to meet national equity targets  
Improve Equity of access to effective cardiac rehabilitation services  
Develop a Performance Framework to establish service improvements | Develop existing regional network arrangements to align with the expanded scope. Convene group and set work plan | July 2011 | Chief Operating Officer |
|                                                           | Reduce the incidence of Cardiovascular disease through Primary Prevention Reduce the incidence of Cardiovascular disease through Secondary Prevention Improve patient cardiac outcomes Reduce inequity of access to cardiac tertiary services Reduce premature deaths from coronary heart disease Ensure we can monitor our improvements both clinically and financially | June 2012 | General Manger, Planning and Funding |
|                                                           | Monitoring report, and actions identified Protocols agreed from a clinically led process Demonstrate the funding has increase in like for like services | June 2012 | Chief Operating Officer |
|                                                           | Services offered can demonstrate better access and this is measured | June 2012 |                                           |
|                                                           | Develop, implement and monitor measures of service improvement | December 2011 | General Manger, Planning and Funding |
|                                                           |                                                           |                | Chief Operating Officer |
**We will undertake these initiatives/activities and actions**

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<tr>
<th>Area 4: Renal</th>
<th>Deliverables</th>
<th>Timing</th>
<th>Responsibility</th>
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<tbody>
<tr>
<td>Appointment of a regional clinical renal network and terms of reference to oversee the Implementation Plan</td>
<td>Building on arrangements already in place, establishment of a regional network including appropriate clinical representation for our DHB</td>
<td>October 2011</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>Implement new Incentre dialysis services at Waikato and Whakatane hospitals</td>
<td>Commence the planned service</td>
<td>June 2012</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>Establishment of new Incentre dialysis service at Whakatane Hospital</td>
<td>6 additional Incentre dialysis beds operational</td>
<td>June 2012</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>Improve primary and secondary care interface with the management of renal patients through agreed clinical protocols and pathways</td>
<td>Approximately 1100 visits per annum</td>
<td>July 2012</td>
<td>General Manager planning and Funding</td>
</tr>
<tr>
<td>Develop a Performance Framework to establish clinical network gains</td>
<td>Develop and implement local Pathways projects for renal / diabetes</td>
<td>January 2012</td>
<td>Chief Operating Officer</td>
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<tr>
<td></td>
<td>Develop, implement and monitor measures of service improvement</td>
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We will undertake these initiatives/activities and actions

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<tr>
<td><strong>Area 5: Midland Cancer Network initiatives</strong></td>
<td></td>
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<tr>
<td>Implementation of the Midland Cancer Network Work Programme, with focus on the following priority areas:</td>
<td></td>
<td></td>
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<tr>
<td>100% of targets are achieved</td>
<td>June 2012</td>
<td>Midland Cancer Network Manager &amp; Clinical Director</td>
</tr>
<tr>
<td>Midland Cancer Network is the lead network to support the National Lung Cancer Work Group service objectives</td>
<td></td>
<td></td>
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<tr>
<td>100% of service objectives are achieved</td>
<td>June 2012</td>
<td>MCN Clinical Director &amp; Project Manager</td>
</tr>
<tr>
<td>Ensure timely access to radiotherapy treatment:</td>
<td></td>
<td></td>
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<tr>
<td>• Continue development and implementation of the Midland Radiation Oncology Services Plan</td>
<td></td>
<td></td>
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<tr>
<td>100% all patients receive radiotherapy treatment within 4 weeks</td>
<td>June 2012</td>
<td>Regional Cancer Centre</td>
</tr>
<tr>
<td>Improve access and wait times for the diagnosis and treatment of lung and/or bowel cancer Note: indicator targets still in development</td>
<td></td>
<td></td>
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<tr>
<td>% achieve two week wait from initial referral to FSA</td>
<td>June 2012</td>
<td>Midland Lung / Bowel Cancer Work Group</td>
</tr>
<tr>
<td>% achieve 62 day wait from initial referral to first anticancer treatment</td>
<td></td>
<td></td>
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<tr>
<td>% presented at multidisciplinary meeting</td>
<td></td>
<td></td>
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<tr>
<td>% of colonoscopy referral to procedure within the national wait time</td>
<td></td>
<td></td>
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<tr>
<td>% achieve the 28 day wait from diagnosis to first anticancer treatment</td>
<td></td>
<td></td>
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<tr>
<td>Improve access and wait times to medical oncology/chemotherapy treatment</td>
<td></td>
<td></td>
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<tr>
<td>100% all patients receive chemotherapy treatment must be treated within four weeks, baseline needs to be established</td>
<td>June 2012</td>
<td>Midland Non-Surgical Cancer Treatment Work Group</td>
</tr>
<tr>
<td>Improve access to palliative care services</td>
<td></td>
<td></td>
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<tr>
<td>Continue to facilitate implementation of Liverpool Care Pathway (LCP)</td>
<td></td>
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<tr>
<td>Report annually providers’ progress with implementation of the Liverpool Care Pathway (LCP). :</td>
<td>June 2012</td>
<td>Midland Palliative Care Work Group &amp; LCP facilitators</td>
</tr>
<tr>
<td><strong>Baseline</strong></td>
<td><strong>By July 2012</strong></td>
<td></td>
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<tr>
<td>Waikato 90%</td>
<td>100%</td>
<td></td>
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<tr>
<td>BOP 65%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Lakes 75%</td>
<td>85%</td>
<td></td>
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<tr>
<td>We will undertake these initiatives/activities and actions</td>
<td>Deliverables</td>
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| **Area 6: Midland Regional Mental Health Network** Continue to implement the Midland Regional Eating Disorders Strategic Plan 2009-2015 | Fully developed clinical pathways with the Auckland Regional Eating Disorders that are consulted and agreed that include the hub and spoke  
Fully developed clinical pathways with Starship Hospital that are consulted and agreed  
Fully developed clinical pathways with Thrive residential service that are consulted and agreed | 31/08/2011      | Midland Eating Disorder Steering Group                                        |
|                                                                                                                              |                                                                                                                                                                                                             | 30/08/2011      | Midland Eating Disorder Steering Group                                        |
|                                                                                                                              |                                                                                                                                                                                                             | 30/08/2011      | Midland Eating Disorder Steering Group                                        |
| Commence implementation of the Midland Co-existing Problems Strategic Plan 2010-2015                                          | Develop regional agreement re CEP levels of competencies  
National CEP training is co-ordinated, delivered and evaluated in each Midland district | 31/12/2011      | Midland Director and Portfolio Managers                                        |
|                                                                                                                              |                                                                                                                                                                                                             | 31/12/2011      | Midland Workforce Coordinator                                                  |
| Continue to progress the Midland Mental Health and Addictions Workforce Development Strategic Plan 2011-2014                 | 100% achievement of 2011 - 12 workforce development objectives  
100% achievement of “Lets Get Real” (LGR) presentations to the Midland provider arm services  
Takarangi Competency Framework Phase II project is completed and an Evaluation Report is developed. | Jul 2011 – Jun 2012 | Midland Workforce Coordinator                                                  |
|                                                                                                                              |                                                                                                                                                                                                             | 30/08/2011      | Midland Workforce Coordinator                                                  |
|                                                                                                                              |                                                                                                                                                                                                             | 30/08/2011      | Midland Workforce Coordinator                                                  |
| Child Youth Continuum of Care – Inpatient Services                                                                         | A Service Level Agreement and agreed Clinical Pathway is fully developed with the ADHB Child Family Unit.  
A project is undertaken to identify alternatives to Child Youth inpatient beds being provided out of area. | August 2011      | Midland Director and Regional Network                                           |
|                                                                                                                              |                                                                                                                                                                                                             | December 2011   | Midland Director and Regional Network                                           |
| Midland Mental Health and Addiction Needs Assessment                                                                        | Utilisation tables are refreshed to included NGO PRIMHD data  
Mental Health and Addiction Plan 2011/2012 is implemented | June 2012        | Midland Director                                                               |
|                                                                                                                              |                                                                                                                                                                                                             | June 2012        | Midland Director and Regional Network                                           |
4.4 Our local priorities

Bay of Plenty DHB shares with the other Midland DHBs, the following areas of focus:

- Child and Youth Health Services
- Older People’s Health Services
- Mental Health and Addiction Services
- Hospital and Specialist Services
- Primary and Community Health Services
- People with Long term Conditions

Local actions in relation to the services listed above are recorded along with deliverables and timing. In Chapter 5 - the Statement of Forecast Service Performance, we will group the service activity according to the output classes of:

- Prevention
- Early Detection and Management
- Intensive Assessment and Treatment Services
- Rehabilitation and Support

detailing the measures and targets of output delivery performance. This section identifies only actions that are specific to Bay of Plenty DHB in order to avoid duplication.

4.4.1 Child and Youth Health Services

Children and young people are a priority for Bay of Plenty DHB because they are our future adult population. Children and young people in the Bay of Plenty currently have poor outcomes in oral health, lower immunisation rates, and higher avoidable hospitalisations than is desirable.

In the coming year we wish to make the following impact:

1. Children and young people are well, remain in their communities and need less hospital care.
2. Young people reduce risk behaviours and adopt healthier lifestyles.
3. Young people are healthier, aware of signs and symptoms of illness and seek help earlier.
4. Parents/care givers support children to be healthier, are able to recognise signs and symptoms of illness in children and seek help earlier.

We will focus on the following local initiative in Child and Youth Health services which will assist us to work towards achievement of the following strategic goals:

- Strategic Goal 1: People are healthier, able to self-manage and live longer
- Strategic Goal 2: People are able to participate more in society and retain their independence for longer
- Strategic Goal 3: People receive timely and appropriate complex care
• Strategic Goal 4: Health inequalities between population groups in our community will reduce.

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| Implement initiatives to aid in the early diagnosis and management of Rheumatic Fever | 21 schools will be participating in a Rheumatic Fever prevention throat swabbing programme  
Consider options for improved diagnosis and management of Rheumatic fever by:  
- Reviewing and implementing successful models of care  
- Developing and implementing care pathways  
- Developing programmes which ensure case management is central  
- Developing and implementing training programmes for primary care staff | June 2012 | Toi Te Ora |

4.4.2 Older People’s Health Services

Older People’s Services are a priority for Bay of Plenty DHB because the number of older people is set to start to rise significantly within four years, because not only more people will reach the age of 65 but also because increasing longevity will mean there are more people over the age of 80. The majority of older people remain well and independent until the last few years of life and with ten year life expectancy gap between men and women this means men would be expected to need access to support and hospital services in their late 70s, whereas women may need additional care in their late 80s. In the Bay of Plenty, this pattern for Māori occurs approximately eight years earlier, with Māori men requiring support and care in their late 60s and Māori women in their late 70s.

The growing demand for aged care in the Bay of Plenty is evidenced by:

- demand exceeding budget provision in 2010/2011 for aged care services
- increase in higher (most expensive) levels of care e.g. hospital level ARC
- investment in home based support services to keep people independent and at home
- high proportion of elderly with little family support.

The majority of hospital admissions are for people who are over 65.

Keeping well and active are fundamental to delaying the effects of chronic medical conditions and frailty.

Within in 15 - 20 years the number of older people will be 25% of the population and the number of people in working age groups will have reduced, adding pressure on the need to support older people to remain as independent as possible and to develop their own networks for support.
Bay of Plenty DHB has been a lead DHB in the implementation of the InterRAI assessment tool, with 100% of home assessments being conducted using this tool. Bay of Plenty DHB has a well established programme to ensure access to respite care beds, a recent initiative to allow more flexibility in the in the use of additional respite funding will enable us to evaluate use of respite care beds and consider options such as day programmes and home based support for those patients that would gain greater benefit from this approach.

Our challenge is encouraging people to use the dedicated residential respite care services that have been purchased. We will review respite care provision and capacity purchased and consult with our community to find out what people want to ensure that we are providing services that are appropriate to meet the needs of elderly people, their carers and family/Whānau, and particularly for people with dementia, with a view to encouraging increased utilization of services purchased.

We will engage in the next steps of the Aged Care Services Review by contributing to the national work being conducted through the sector.

In the coming year we wish to make the following impact:

- Older people are well and able to self manage their conditions, reducing the need for hospital care.
- Older people have access to timely and quality coordinated care from a range of providers enabling them to remain independent and in their own homes and communities.
- Older people have their end stage needs met in a holistic way that providers dignity and respect.

To achieve this, and be better prepared for the long-term impacts and opportunities arising from an ageing population, we plan to review our long-term strategic approach to services for older people. Throughout the development of our Health of Older People Strategy, we propose to maximise the clinical expertise within our organisation, engage with our stakeholders, and where necessary engage with external expertise to ensure that we are developing a strategic approach that aligns with best practice both international and local.

### 4.4.3 Mental Health and Addiction Services

Mental Health and Addiction Services are a priority for Bay of Plenty DHB because people who experience positive mental health and live in environments free of drug, alcohol or problem gambling related harm, have improved opportunity to participate and contribute in meaningful ways to the broader community. They are also better able to meet the responsibilities associated with maintaining personal wellbeing and good health as well as the meeting the health needs of family/Whānau.

Bay of Plenty DHB recognises the implicit nature of mental wellbeing to making overall health gains for the whole of population.

Bay of Plenty DHB is also committed to implementation and delivery of Te Kokiri, mental health and addiction action plan.

In the coming year we wish to make the following impact:

- People experiencing mental illness or an addiction define their recovery and are supported toward health, wellbeing and participation in society.
There is greater recognition of the role of whānau/families as partners in protecting and preserving the mental health and wellbeing of the service.

People with mental illness and addiction experience trustworthy agencies working across boundaries.

**4.4.4 Hospital and Specialist Services**

Hospital and Specialist Health Services are a priority for Bay of Plenty DHB because we are responsible for the delivery of core specialist secondary hospital and community based health services to the people of the Bay of Plenty. These services are mainly delivered from hospitals based in Tauranga and Whakatane with a small number delivered from off site facilities.

The core clinical services include:

- Emergency services
- Surgical and elective services
- Medical and older persons services, including rehabilitation
- Paediatric services
- Maternity services
- Mental health services.

These core clinical services are supported by:

- Imaging and other diagnostic services
- Theatre and anaesthetic services
- Therapy services
- Critical care services
- Pharmacy services
- Specialist community and district nursing services
- 24-hour hospital support services.

In response to the Minister’s expectations the DHB Provider Arm has developed five strategic direction statements that describe ultimate outcomes in terms of the hospital and specialist services it provides. They are:

- Improving service and reducing waiting times.
- Strengthening clinical engagement both within the DHB and regionally. Clinicians will lead the development and operation of each of the priority services with the goal of closer of services to home.
- Strengthening integration of services across hospitals and community.
- Strengthen our service delivery and service capacity to improve the health of the people.
- Improve regional collaboration between DHBs.
In the coming year we wish to make the following impact:

- The patients’ health care experience will be positive as a result of support for patient safety, rights and quality of care.
- To continue to develop our services through professional leadership, clinical engagement and a culture of learning.
- To develop the skills and knowledge of our workforce and be an employer of choice.
- To provide high quality care and manage the growth in demand through innovation, interdepartmental, community and intersectoral collaboration; teamwork and fiscal accountability.

4.4.5 Primary and Community Health Services

Primary Care and Community Services are important for Bay of Plenty DHB as this is where our community have first contact with publicly funded health services. In addition, a well functioning primary health care sector means people can prevent and manage their health without the need for hospital-based services. The Government strategy is for Better, Sooner, More Convenient Health Services and we continue to work with our primary care partners to progress this as outlined throughout this plan.

There are a number of activities already occurring in the primary sector which support Better, Sooner, More convenient health care e.g. nurse led clinics in High Schools, Green prescriptions, physical activity promotion, the volunteer network also provides a huge amount of support to patients in the community. Other examples include cardiovascular screening in community centres such as WINZ offices; increasing utilization of support roles within mainstream health services that are more focused on the needs of Māori and high need groups through Kai Awhina and Kai Tautoko – these roles are providing better engagement, health service navigation, advocacy and education to build confidence and self-awareness about a person’s own condition and how their family can participate effectively.

Bay Navigator is the key mechanism through which we will identify service improvement and service reconfiguration opportunities, with the aim of achieving closer integration of services across hospital and community settings to improve convenience for patients and reduce pressure on hospitals. Many of the clinically led workstreams are in the establishment phase so it is not possible to pre-empt the outcome of the activities being undertaken.

Bay Navigator involves re-design across the health system in the Bay of Plenty. It includes the development of a website as a key access point for clinical staff across the Bay to find the best treatment path for particular issues.

Cross-functional teams of GPs and hospital clinicians will work together to initially develop care pathways for the following conditions:

- respiratory
- diabetes
- child health
- cardiology.

It is a partnership between all the PHOs and the DHB, and is designed to bring primary and secondary clinicians together to become a part of a new direction in health care for the Bay of Plenty.
A care pathway is an algorithm that offers a flowchart format of the decisions to be made and the care to be provided for a given patient, or patient group, for a given condition in a ‘step-wise’ sequence. The Bay of Plenty District Health Board’s Bay Navigator will develop care pathways for the improvement of the patient’s overall journey, and the continuity of care across different disciplines and sectors, with the aim of reducing duplication, eliminating waste and ensuring the best value is achieved within the available clinical and financial resource.

Each of the four workstreams will develop and implement at least one care pathway in the initial 18-week phase. Two workstreams (child health and cardiology) have commenced their work, identifying 6 pathways for development each and plan to complete these by 31st August 2011. The diabetes workstream has identified some preliminary opportunities for delivering services closer to home. The respiratory workstream will commence their work in mid May 2011 and complete it within 18 weeks of their inaugural workshop. After the 18 week cycles have been completed across the four workstreams a formal evaluation phase will occur, culminating in an evaluation report to the Governance Group including recommendations for future work.

The Child Health pathways are:
- Upper respiratory tract infection
- Asthma
- Eczema
- Gastroenteritis
- Skin Sepsis
- Chronic OME.

The Cardiology pathways are:
- Chest pain
- Undifferentiated dyspnoea
- Atrial fibrillation
- Palpitations
- Syncope
- Asymptomatic murmur.

Through the Diabetes workstream an opportunity to move Diabetes Community Support services closer to home has been identified. Funding allocations will be informed by the Diabetes Care Pathway. Putting in place supports for patients and clinicians to help improve diabetes management and get care delivered by the right person in the right place at the right time is the guiding the principle behind the Bay Navigator project and this Diabetes related initiative.

The development of an Integrated Family Health Centre (IFHC) in the Eastern Bay of Plenty has the potential to transform the way care is delivered and support the delivery of Better Sooner More Convenient Health Care. Models of integrated health care development have been identified in a workshop which included representatives from Whakatane Hospital, Community and Disability providers, Māori Health and Primary Care. These models provide
a roadmap for integration by avoiding duplication of services across hospital and community providers. Stage 1 of the scoping of an IFHC concept is nearing completion following further provider and community consultation. Stage 2 which more formally details the financial and infrastructure modeling will be completed by December 2011. The DHB is confident that this joint work will result in an innovative integrated health delivery system.

In the coming year we wish to make the following impacts:

1. Intervention occurs earlier to detect, manage and treat existing and potential health conditions.
2. People are able to self-manage their conditions and have access to quality care coordinated across a range of providers.
3. People are healthier, aware of signs and symptoms of illness, and seek help earlier.

### 4.4.6 Health services for people with long-term conditions

Health services for people with long-term conditions are a priority for Bay of Plenty DHB because long-term conditions contribute to health inequalities – i.e. they account for a significant proportion of health inequalities. Long-term conditions create a burden for the individuals who suffer them and for the health system that must meet the cost of financing them. Long-term conditions are an area where there is significant growth, so it is important for Bay of Plenty DHB to identify people in our community who have long-term conditions and manage those conditions energetically to minimise both personal complications and system cost.

In the coming year we wish to make the following impacts:

1. More people are able to self-manage their conditions and have access to quality care coordinated across a range of providers.
2. Intervention occurs earlier to detect, manage and treat existing health conditions.
3. People adopt healthier lifestyles and reduce risk behaviours.
5 Statement of Forecast Service Performance

5.1 Output Classes

Four Output Classes:

- Prevention
- Early Detection and Management
- Intensive Assessment and Treatment Services
- Rehabilitation and Support

allow DHBs to group services and demonstrate the population health ‘impacts’ of their PBF allocation decisions, Government priorities and national decision-making.

One of the functions of the Statement of Forecast Service Performance is to show how the Bay of Plenty DHB will evaluate and assess what services and products we deliver to others in 2011/12. The performance measures chosen are not a comprehensive list and do not cover all of the activity of the DHB, but they do reflect a picture of the major part of our activity against local, regional and national strategies and priorities. Where possible, we have included past performance (baseline data) along with each performance target to give the context of what we are trying to achieve and for us to better evaluate our performance as part of our accountabilities under the CE Act 2004. BOP DHB believes the outputs and measures as presented in this section provide a good representation of the full range of services that we provide.

5.2 Output Class 1: Prevention

Preventative services are publicly funded services that protect and promote health for the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.

Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services.

Preventative services will assist in achieving the following strategic goals:

- Strategic Goal 1: People are healthier, able to self-manage and live longer
- Strategic Goal 2: People are able to participate more in society and retain their independence for longer
- Strategic Goal 3: People receive timely and appropriate complex care
- Strategic Goal 4: Health inequalities between population groups in our community will reduce
by identifying and addressing preventable conditions across the population early.

On a continuum of care these services are public wide preventative services. Prevention strategies will be identified for each of our priority areas:

- Child and Youth Health Services
- Older People’s Health Services
- Hospital and Specialist Services
- Primary and Community Health Services
- People with Long term Conditions

### 5.2.1 Child and Youth Health Services Prevention strategies

**How we will measure our performance:**

<table>
<thead>
<tr>
<th>In Child and Youth Health Services our prevention activities will drive a reduction in the proportion of young people who take up tobacco smoking</th>
<th>The proportion of ‘never smokers’ among Year 10 students</th>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>61.6%</td>
<td>64%</td>
<td>66%</td>
</tr>
</tbody>
</table>

The proportion of ‘daily smokers’ among Year 10 students

![Graph showing smoking rates over years](image)
An increase in the proportion of children who have good oral health

- Children and adolescents are a key priority group in the New Zealand oral health vision, and are eligible to receive free, publicly funded oral health services up until the age of 18 years.

- Regular dental care has life-long benefits for improved health. While water fluoridation can significantly reduce tooth decay across all population groups, variable access to fluoridated water supplies across the Bay of Plenty district means that prevention and education initiatives are essential to good oral health.

- Significant disparities still exist in oral health status and access to services for children and adolescents, particularly for those of Māori and/or Pacific ethnicity.7

Oral health outcomes are a good proxy measure of early contact with effective health promotion and prevention services and an indicator of reduced risk factors, such as poor diet, which has other benefits in terms of improved nutrition and healthier body weights.

### An increase in the proportion of children are caries free (no holes or fillings) at age 5

<table>
<thead>
<tr>
<th></th>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>25%</td>
<td>40%</td>
<td>35%</td>
<td>40%</td>
</tr>
<tr>
<td>Pacific</td>
<td>47%</td>
<td>52%</td>
<td>57%</td>
<td>62%</td>
</tr>
<tr>
<td>Total</td>
<td>47%</td>
<td>61%</td>
<td>57%</td>
<td>62%</td>
</tr>
</tbody>
</table>

7 Data source: New Zealand Oral Health Survey 2009
Oral Health DMFT Score at year 8 – a reduction in the number permanent teeth of children in school Year 8 (12/13-year olds) that are decayed, missing, and filled

<table>
<thead>
<tr>
<th></th>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>3.7</td>
<td>2.8</td>
<td>2.05</td>
<td>2.0</td>
</tr>
<tr>
<td>Pacific</td>
<td>3.43</td>
<td>3.0</td>
<td>1.73</td>
<td>1.7</td>
</tr>
<tr>
<td>Total</td>
<td>2.24</td>
<td>2.0</td>
<td>1.56</td>
<td>1.35</td>
</tr>
</tbody>
</table>

The impact of the child and youth health prevention services we fund will be determined from the following measures:

To achieve our desired Outcomes we will focus on the following Outputs:

Note: immunisation is included in primary and community prevention strategies

**Aim: More children and young people stay well**

How we will measure our performance:

<table>
<thead>
<tr>
<th>Quantity:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11 YTD</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people attending Pregnancy &amp; Parenting courses</td>
<td>900</td>
<td>297</td>
<td>956</td>
</tr>
<tr>
<td>Number of children who receive a B4 School Check (report by total eligible population and high deprivation)</td>
<td>2411</td>
<td>1552</td>
<td>1939</td>
</tr>
<tr>
<td>Number of children enrolled in a Tamariki Ora well child service</td>
<td>1742</td>
<td>1546</td>
<td>1266</td>
</tr>
</tbody>
</table>

Quality:

- National standards met for all programmes
Effectiveness:
- The percentage of infants fully breastfeeding at 6 weeks: 74% (Actual 09/10: 57%), Not yet available (69%)
- The percentage of infants fully breastfeeding at 3 months: 57% (Actual 09/10: 32%) (Target 11/12: 69%)
- The percentage of infants fully breastfeeding at 6 months: 32% (Actual 09/10: 30%) (Target 11/12: 56%)

5.2.2 Older Peoples Health Services Prevention strategies

The impact of the prevention services we fund for older people will be an increase in the proportion of people over 65 who are provided with appropriate levels of care and intervention to support their needs.

Appropriate support and care will allow ‘ageing in place’, maintaining a higher quality of life until ARC is functionally or clinically indicated.

How we will measure our performance:

An increase in the proportion of people over 65 who are supported to remain in their own homes and communities

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a decrease in the proportion of the population aged over 65 who are assessed to live in residential rest home level care</td>
<td>5%</td>
<td>4.8%</td>
<td>4.7%</td>
<td>4.6%</td>
</tr>
<tr>
<td>The average age of entry into Aged Residential Care increases</td>
<td>84 yrs 4 mths</td>
<td>84 yrs 5 mths</td>
<td>84 yrs 6 mths</td>
<td>84 yrs 7 mths</td>
</tr>
</tbody>
</table>

The impact of the older people’s health prevention services we fund will be determined from the following measures:

These prevention services we provide aim to focus on improving older people’s underlying health and wellbeing, in particular, preventing disease and injury

How we will measure our performance:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Target 2011/12</th>
<th>Actual 2010/11 YTD</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantity:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of residents in ARC services receiving Vitamin D supplements</td>
<td>75%</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Number of people visited by the accredited visitor services</td>
<td>40</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Effectiveness/Timeliness:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in the proportion of people 65+ receiving seasonal influenza vaccinations</td>
<td>70%</td>
<td>75%</td>
<td>68.92%</td>
</tr>
<tr>
<td>Increase in proportion of ARC residents receiving Vitamin D</td>
<td>75%</td>
<td>75%</td>
<td>65%</td>
</tr>
</tbody>
</table>
5.2.3 Primary and Community Health Services Prevention strategies

The impact of the primary care prevention services we fund will be determined from the following measures:

<table>
<thead>
<tr>
<th>A reduction in the proportion of the population admitted to hospital with conditions considered ‘avoidable’ or ‘preventable’</th>
<th>ASH rates improve – 0-74yrs</th>
<th>Actual as at Sept 10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>109</td>
<td>106</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>113</td>
<td>108</td>
<td>104</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

ASH Indirectly Standardised Discharge Ratios for Top Six Conditions for the Bay of Plenty DHB of Domicile 00-74 Agegroup

![ASH Indirectly Standardised Discharge Ratios for Top Six Conditions for the Bay of Plenty DHB of Domicile 00-74 Agegroup](image)

How we will measure our performance:

<table>
<thead>
<tr>
<th>More of our population are enrolled with a primary care provider</th>
<th>The percentage of our population enrolled with a GP</th>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>WBOP</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>EBOP</td>
<td>90%</td>
<td>92%</td>
<td>94%</td>
<td>96%</td>
<td></td>
</tr>
</tbody>
</table>

To achieve our desired Outcomes we will focus on the following Primary Prevention Outputs:

**Aim: People stay well**

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11 YTD</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantity:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% children fully immunised at two years</td>
<td>95%</td>
<td>78%</td>
<td>78%</td>
</tr>
<tr>
<td>Number of eligible adult population who have had a cardio-vascular risk assessment recorded in the last 5 years</td>
<td>52,566</td>
<td>47,579</td>
<td>44,909</td>
</tr>
</tbody>
</table>
- Number of eligible population who have had a HPV vaccination
- Number of eligible population who have had a cervical smear within the 3 year cycle
- Number of eligible population who have had breast screening within the 2 year cycle
- Number of eligible population who have had diabetes screening

<table>
<thead>
<tr>
<th></th>
<th>Target 2011/12</th>
<th>Actual from 01/09/2008 - 01/03/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6,945</td>
<td></td>
<td>2677</td>
</tr>
<tr>
<td>54,028</td>
<td></td>
<td>41,264 (3yrs)</td>
</tr>
<tr>
<td>19,412</td>
<td></td>
<td>11,147 (2yrs)</td>
</tr>
<tr>
<td>7,559</td>
<td>6,942</td>
<td>5,168</td>
</tr>
</tbody>
</table>

Achieve national targets for HPV vaccination


<table>
<thead>
<tr>
<th></th>
<th>1990 cohort</th>
<th>1991 cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 1</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Dose 2</td>
<td>45%</td>
<td>45%</td>
</tr>
<tr>
<td>Dose 3</td>
<td>40%</td>
<td>40%</td>
</tr>
</tbody>
</table>

(This programme ceases on 31 December 2011).

- For girls born in 1992-96

<table>
<thead>
<tr>
<th></th>
<th>1992-96 cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 1</td>
<td>65%</td>
</tr>
<tr>
<td>Dose 2</td>
<td>60%</td>
</tr>
<tr>
<td>Dose 3</td>
<td>55%</td>
</tr>
</tbody>
</table>

(This programme ceases when a young woman reaches her 20th birthday).

Quality:
- All programmes are delivered consistent with national standards

Effectiveness/Timeliness:
- The proportion of smokers identified in primary care and provided with help/advice to quit

<table>
<thead>
<tr>
<th></th>
<th>Target 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90%</td>
</tr>
</tbody>
</table>
5.2.4 Public Health Services Prevention Strategies

To achieve our desired Outcomes we will focus on the following Public Health Prevention Outputs:

<table>
<thead>
<tr>
<th>Aim: People stay well</th>
</tr>
</thead>
<tbody>
<tr>
<td>How we will measure our performance:</td>
</tr>
<tr>
<td><strong>Quantity:</strong></td>
</tr>
<tr>
<td>• Number of schools participating in the Health Promoting Schools programme</td>
</tr>
<tr>
<td>• Number of families participating in the Active Families programme (BOPDHB)</td>
</tr>
<tr>
<td><strong>Quality:</strong></td>
</tr>
<tr>
<td>• Increasing the proportion of schools participating in the Health Promoting Schools programme</td>
</tr>
<tr>
<td>• Improve the audit scores for partner abuse and child abuse and neglect programme components of the Family Violence Prevention Programme. The score in 2009/10 was 174/200</td>
</tr>
</tbody>
</table>

5.3 Output Class 2: Early Detection and Management

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings, including general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

These services will assist in achieving the following strategic goals:

- Strategic Goal 1: People are healthier, able to self-manage and live longer
- Strategic Goal 2: People are able to participate more in society and retain their independence for longer
- Strategic Goal 3: People receive timely and appropriate complex care
- Strategic Goal 4: Health inequalities between population groups in our community will reduce

By detecting health needs and implementing management strategies across the population before acute or chronic disease occurs.

Early Detection and Management Prevention strategies will be identified for each of our priority areas:

- Child and Youth Health Services
- Older People’s Health Services
- Hospital and Specialist Services
- Primary and Community Health Services
• People with Long term Conditions
• Mental Health Services

5.3.1 Child and Youth Health Services Early Detection and Management

_Aim: Children and young people are seen and treated early_

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quantity:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of pre-school children enrolled with Bay of Plenty DHB funded oral health services</td>
<td>8,184</td>
<td>6,857</td>
<td>6,005</td>
</tr>
<tr>
<td>Number of primary school children enrolled with DHB funded oral health services</td>
<td>24,000</td>
<td>23,317</td>
<td>22,623</td>
</tr>
<tr>
<td>Number of children caries free at 5 years of age⁸</td>
<td>61% 9,943</td>
<td>8,570</td>
<td>7,878</td>
</tr>
<tr>
<td>Number of adolescents provided with oral health services</td>
<td>8,184</td>
<td>Not yet available</td>
<td>22mths</td>
</tr>
<tr>
<td><strong>Quality:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A reduction in the number of enrolled pre-school and primary school children overdue for their scheduled examination⁹</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midland Oral Health Coordination and Audit services confirm that oral health service standards are being met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An increasing number of General Practices adopt and then maintain a recognised quality accreditation programme (e.g. Cornerstone)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An increasing number of Primary Health Organisations implement Māori Health Plans</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effectiveness:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting times for scheduled oral health examinations</td>
<td>≤ 12mths</td>
<td>Not yet available</td>
<td>22mths</td>
</tr>
</tbody>
</table>

5.3.2 Older People’s Health Services Early Detection and Management Strategies

_Aim: Early Detection and Management will ensure Older people are seen and treated early_

• Refocus resources towards delivery services in local community settings closer to people
• Develop range of services to support people with dementia and their carers / family / Whānau
• Ensure comprehensive standardised assessment and care planning is based on InterRAI

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quantity:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The number of needs assessments undertaken</td>
<td>4,330 325</td>
<td>4,689 325</td>
<td>4,330 325</td>
</tr>
<tr>
<td>The number of hours of support provided to people with dementia and their families by the Alzheimer’s Society</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Quality:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All NASC assessments are based on InterRAI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People with dementia are supported to remain living in their homes for longer</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

⁸ See table % DHB Caries Free at 5 years

⁹ There are expectations this will be reduced, however it is unlikely to reduce in the first 12 months of moving to a mobile service due to necessary shift in time frames at each school (from late 2013)
5.3.3 Primary and Community Health Services Early Detection and Management Strategies

Aim: Primary Care Early Detection & Management will ensure that health conditions are detected early to allow effective assessment, intervention and management of the conditions as early as possible.

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11 YTD</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quantity:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Number of people enrolled with a primary health organisations (PHO)</td>
<td>200,846</td>
<td>197,101</td>
<td></td>
</tr>
<tr>
<td>• Number of eligible patients enrolled in Care Plus</td>
<td>55%</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>• Number of dispensed items expenditure on Community Pharmaceuticals per enrolled population</td>
<td>3,663,192</td>
<td>3,478,573</td>
<td></td>
</tr>
<tr>
<td>• Number of tests – community laboratory</td>
<td>835,000</td>
<td>349,573</td>
<td>818,186</td>
</tr>
<tr>
<td><strong>Quality:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• General Practices have a quality accreditation programme in place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Effectiveness/Timeliness:</strong></td>
<td>Target 2011/12</td>
<td>Actual 2009/10</td>
<td></td>
</tr>
<tr>
<td>• There is a greater proportion of the high needs population enrolled with a PHO (Māori, above decile 5)</td>
<td>Increase by 2%</td>
<td>66,983</td>
<td></td>
</tr>
<tr>
<td>• The ratio of GPs to enrolled population</td>
<td>887:1</td>
<td>887:1</td>
<td></td>
</tr>
</tbody>
</table>

5.3.4 Health Services for people with Long Term Conditions Early Detection and Management Strategies

Aim: To facilitate self management and community based management strategies for people with long term conditions

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11 YTD</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quantity:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Number of patients enrolled in Care Plus</td>
<td>3,959</td>
<td>3,959</td>
<td></td>
</tr>
<tr>
<td>• Number of skin lesions removed</td>
<td>1,119</td>
<td>1,119</td>
<td></td>
</tr>
<tr>
<td>• An increase in the percentage of people in all population groups estimated to have diabetes accessing free annual checks</td>
<td>75%</td>
<td>66%</td>
<td>54.1%</td>
</tr>
</tbody>
</table>

---

10 This output measure is also included within section 5.x Primary & Community Health Care Services
The impact of the services we fund will be determined from the following measures:

<table>
<thead>
<tr>
<th>An increase in the proportion of people identified with diabetes who have improved management of their conditions</th>
<th>The percentage of people with diabetes who have satisfactory or better diabetes management (HbA1c≤8%)</th>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>57%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>77%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>72%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td></td>
</tr>
</tbody>
</table>

A reduction in the proportion of the population admitted to hospital with conditions considered 'avoidable' or 'preventable' where a long term condition is the primary diagnosis

5.3.5 Primary Mental Health Services Early Detection and Management Strategies

**Aim:** Early Detection and Management will ensure people with a mental health condition are seen and treated early

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11 YTD</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All providers report FTE and service utilization data</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>• There is a completed pre &amp; post Kessler 10 scores for each client seen</td>
<td></td>
<td>New Measure</td>
<td></td>
</tr>
</tbody>
</table>

5.4 Output Class 3: Intensive Assessment and Treatment Services

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a ‘hospital’. These services are generally complex and provided by health care professionals that work closely together.

They include:

- Ambulatory services (including outpatient, district nursing and day services across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services.

- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services.

- Emergency Department services including triage, diagnostic, therapeutic and disposition services.
On a continuum of care these services are at the complex end of treatment services and focused on individuals.

Intensive Assessment and Treatment services will assist in achieving the following strategic goals:

- **Strategic Goal 1**: People are healthier, able to self-manage and live longer
- **Strategic Goal 2**: People are able to participate more in society and retain their independence for longer
- **Strategic Goal 3**: People receive timely and appropriate complex care
- **Strategic Goal 4**: Health inequalities between population groups in our community will reduce.

by ensuring the provision of timely acute and elective services across the population before the burden of disease significantly impacts on individuals and their ability to participate in society.

Intensive Assessment and Treatment strategies will be identified for each of our priority areas:

- **Child and Youth Health Services**
- **Older People’s Health Services**
- **Hospital and Specialist Services**
- **Mental Health and Addiction Services**

### 5.4.1 Child and Youth Health Services Intensive Treatment and Assessment Strategies

**Aim: To ensure children and young people have timely access to appropriate specialist services**

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11 YTD</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quantity:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ASH rates 0-4yrs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Māori</td>
<td>120</td>
<td>138</td>
<td>148</td>
</tr>
<tr>
<td>Other</td>
<td>140</td>
<td>162</td>
<td>148</td>
</tr>
<tr>
<td>• Number of caesarean sections as a percentage of total number of deliveries</td>
<td>23%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Effectiveness:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Paediatric waiting times (all children to be seen within six months)</td>
<td>1.5% or less than 10 children</td>
<td>3.67% or less than 11 children</td>
<td></td>
</tr>
</tbody>
</table>
5.4.2 Older People’s Health Services Intensive Treatment and assessment Strategies

**Aim:** Intensive Treatment & Assessment will ensure those over 65 with acute, life changing and life limiting conditions receive appropriate specialist treatment, care and support.

*Increase collaboration and leadership between community and hospital based clinicians, provide new and expand services relating to dementia and primary & community care improvements to avoid hospital admission.*

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11 YTD</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quantity:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The number of AT&amp;R inpatient bed days</td>
<td>9,680</td>
<td>8,212 (YTD Feb.)</td>
<td>12,651</td>
</tr>
<tr>
<td>• The number of AT&amp;R outpatient attendances</td>
<td>1,750</td>
<td>785 (YTD Feb.)</td>
<td>1,740</td>
</tr>
<tr>
<td><strong>Quality:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The number of people 75 yrs and older hospitalised for falls domiciled in the DHB region, per year.</td>
<td>New measure</td>
<td>New measure</td>
<td>New measure</td>
</tr>
<tr>
<td><strong>Effectiveness/Timeliness:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Average wait time from referral to assessment by specialist health practitioner</td>
<td>3.5 days</td>
<td>4.3 (as at Feb 11)</td>
<td></td>
</tr>
</tbody>
</table>

5.4.3 Hospital and Specialist Health Services Intensive Treatment and Assessment Strategies

**Aim:** To support efficient and effective Hospital and Specialist Health Services recognising these are an important component of Intensive Treatment & Assessment

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quantity:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Number of discharges (acutes/electives)</td>
<td>30,400 Acute 8,357 Elective</td>
<td>TBC</td>
<td>29,332 Acute 9,283 Elective</td>
</tr>
<tr>
<td>• Number of First Specialist Assessments</td>
<td>24,243</td>
<td></td>
<td>23,197</td>
</tr>
<tr>
<td>• Number of Emergency Department Attendances</td>
<td>65,492 &lt;3.5%</td>
<td></td>
<td>62,948</td>
</tr>
<tr>
<td>• Nurse hours per patient day delivered against required variance</td>
<td></td>
<td></td>
<td>5.92%</td>
</tr>
<tr>
<td><strong>Quality:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Percentage of patient developing Hospital Acquired Blood Stream Infections</td>
<td>0.06 &lt;4%</td>
<td></td>
<td>0.09</td>
</tr>
<tr>
<td>• ESPI 7 – Patients who have not been managed according to their assigned status and who should have received</td>
<td></td>
<td></td>
<td>2.3%</td>
</tr>
</tbody>
</table>
### Effectiveness/Timeliness:

- The ratio of follow-up OPD appointments to First Specialist Assessments
- Ward bed utilisation rates
- The percentage of elective services day surgery procedures performed as a total of elective admissions
- Elective services admission on day of surgery as a percentage of total elective admissions (DOSA)
- ESPI 1 – DHB services appropriately acknowledge and process all patient referrals within 10 working days
- ESPI 2 – Patients waiting > 6 months for First Specialist Assessment
- ESPI 3 – Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold
- ESPI 5 – Patients given a commitment to treatment but not treated within 6 months
- ESPI 6 – Patients in active review who have not received a clinical assessment within the last 6 months
- Treatment
- ESPI 8 – The proportion of patients treated who were prioritised using nationally recognised processes or tools
- Acute inpatient length of stay
- Theatre productivity
- Patients attending the Emergency Department are treated within their triage category

<table>
<thead>
<tr>
<th>Triage 1</th>
<th>Triage 2</th>
<th>Triage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.55</td>
<td>2.49</td>
<td>2.65</td>
</tr>
<tr>
<td>90%</td>
<td>90%</td>
<td>94.68%</td>
</tr>
<tr>
<td>&gt;60%</td>
<td>&gt;90%</td>
<td>62.81%</td>
</tr>
<tr>
<td>90%</td>
<td>0%</td>
<td>84.13%</td>
</tr>
<tr>
<td>&gt;90%</td>
<td>&lt;5%</td>
<td>100%</td>
</tr>
<tr>
<td>0%</td>
<td>0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>&lt;5%</td>
<td>2.4%</td>
<td>0.5%</td>
</tr>
<tr>
<td>0%</td>
<td>0%</td>
<td>2.4%</td>
</tr>
<tr>
<td>&gt;90%</td>
<td>4.62</td>
<td>100%</td>
</tr>
<tr>
<td>3.90</td>
<td>77.9%</td>
<td>4.62</td>
</tr>
<tr>
<td>85%</td>
<td>100%</td>
<td>77.9%</td>
</tr>
<tr>
<td>100%</td>
<td>64%</td>
<td>100%</td>
</tr>
<tr>
<td>80%</td>
<td>43%</td>
<td>64%</td>
</tr>
</tbody>
</table>

### The impact of the services we fund will be determined from the following measures:

<table>
<thead>
<tr>
<th>An increase in the proportion of people who receive prompt acute care in the Emergency Department</th>
<th>The percentage of people presenting to ED admitted, discharged or transferred within 6 hours</th>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual 09/10</td>
<td>Target 11/12</td>
<td>Target 12/13</td>
<td>Target 13/14</td>
<td></td>
</tr>
<tr>
<td>An increase in the proportion of people who receive prompt acute care in the Emergency Department</td>
<td>86.2%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td></td>
</tr>
</tbody>
</table>
How we will measure our performance:

<table>
<thead>
<tr>
<th>People needing specialist or high priority treatment as an inpatient, receive the best possible health outcome</th>
<th>Standardised intervention rates are within national standards.</th>
<th><strong>Actual 09/10</strong></th>
<th><strong>Target 11/12</strong></th>
<th><strong>Target 12/13</strong></th>
<th><strong>Target 13/14</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>304</td>
<td>As per national targets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

![Graph showing discharge rates](image)

How we will measure our performance:

<table>
<thead>
<tr>
<th>There is a reduction in the acute inpatient readmission rate</th>
<th><strong>Actual 09/10</strong></th>
<th><strong>Target 11/12</strong></th>
<th><strong>Target 12/13</strong></th>
<th><strong>Target 13/14</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>10.39%</td>
<td>9.95%</td>
<td>9.79%</td>
<td>9.79%</td>
<td></td>
</tr>
</tbody>
</table>

How we will measure our performance:

<table>
<thead>
<tr>
<th>There is a reduction in the time from referral by General Practitioners to First Specialist Assessment</th>
<th><strong>Actual 09/10</strong></th>
<th><strong>Target 11/12</strong></th>
<th><strong>Target 12/13</strong></th>
<th><strong>Target 13/14</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>83 days</td>
<td>80 days</td>
<td>80 days</td>
<td>80 days</td>
<td></td>
</tr>
</tbody>
</table>
How we will measure our performance:

<table>
<thead>
<tr>
<th></th>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a reduction in the number of people not attending first specialist assessments</td>
<td>8.5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient satisfaction will continue to improve</td>
<td>90%</td>
<td>92%</td>
<td>94%</td>
<td>95%</td>
</tr>
</tbody>
</table>
5.4.4 Mental Health Services Intensive Treatment and Assessment Services

The impact of the mental health services we fund will be determined from the following measures:

<table>
<thead>
<tr>
<th>The number of residential admissions and/or need for acute intervention reduces for individual service users</th>
<th>Increase in the number of mental health consumers with Relapse Prevention Plans</th>
<th>Actual 09/10</th>
<th>Target 11/12</th>
<th>Target 12/13</th>
<th>Target 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Māori</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Total Other</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td></td>
</tr>
</tbody>
</table>

More mental health and addiction consumers are able to remain living in their own homes and communities without the need for increased intervention

<table>
<thead>
<tr>
<th>Improving the health status of people with severe mental illness through improved access</th>
<th>0 – 19 Māori</th>
<th>0 – 19 Other</th>
<th>0 – 19 Total</th>
<th>20 – 64 Māori</th>
<th>20 – 64 Other</th>
<th>20 – 64 Total</th>
<th>65+ Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual 09/10</td>
<td>2.61%</td>
<td>2.95%</td>
<td>2.82%</td>
<td>4.58%</td>
<td>3.04%</td>
<td>3.39%</td>
<td>2.55%</td>
</tr>
<tr>
<td>Target 11/12</td>
<td>2.65%</td>
<td>2.95%</td>
<td>2.85%</td>
<td>4.58%</td>
<td>3.04%</td>
<td>3.55%</td>
<td>2.76%</td>
</tr>
<tr>
<td>Target 12/13</td>
<td>2.70%</td>
<td>3.0%</td>
<td>2.9%</td>
<td>4.65%</td>
<td>3.1%</td>
<td>3.60%</td>
<td>2.85%</td>
</tr>
<tr>
<td>Target 13/14</td>
<td>2.70%</td>
<td>3.0%</td>
<td>2.9%</td>
<td>4.65%</td>
<td>3.1%</td>
<td>3.60%</td>
<td>2.90%</td>
</tr>
</tbody>
</table>
### Addiction Services

**Aim: People experiencing an addiction define their recovery and are supported toward health, wellbeing and participation in society**

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11 YTD</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quantity:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of bed days – medical detox</td>
<td>200 bed days</td>
<td>New measure</td>
<td>New measure</td>
</tr>
<tr>
<td>Number of people accessing methadone treatment Specialist GP (Provider Arm and NGO)</td>
<td>118 cases</td>
<td>New measure</td>
<td>New measure</td>
</tr>
<tr>
<td>91 cases</td>
<td></td>
<td>New measure</td>
<td>New measure</td>
</tr>
<tr>
<td><strong>Quality:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of providers using a validated Outcomes Measurement tool</td>
<td>50%</td>
<td>New measure</td>
<td>New measure</td>
</tr>
<tr>
<td><strong>Effectiveness/Timeliness:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting times for alcohol and drug inpatient medical detox service</td>
<td>Less than 9 days</td>
<td>New measure</td>
<td>New measure</td>
</tr>
<tr>
<td>Waiting time for NGOs structured counselling</td>
<td>Less than 6 days</td>
<td>New measure</td>
<td>New measure</td>
</tr>
</tbody>
</table>

### Acute Inpatient Services

**Aim: The aim of Mental Health Intensive Treatment & Assessment services is that People with acute and/or serious mental health and addiction issues will be treated and stabilised and that People receive the best possible outcomes from their acute, specialist and/or high priority treatment**

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2009</th>
<th>Actual 2010/11 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quantity:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of occupied bed days – acute mental health inpatient: Whakatane Tauranga Older persons Health</td>
<td>85% 85% 85%</td>
<td>75% 84% 93%</td>
<td>73% 84% 82%</td>
</tr>
<tr>
<td><strong>Quality:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in collection of inpatient HoNOS data</td>
<td>60% completion 20% or less</td>
<td>New measure</td>
<td>New measure</td>
</tr>
<tr>
<td>28 acute inpatient readmission rate</td>
<td></td>
<td>New measure</td>
<td>New measure</td>
</tr>
<tr>
<td><strong>Effectiveness/Timeliness:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average length of acute inpatient stay Whakatane Tauranga Older Persons</td>
<td>14-21 days 14-21 days 30 days 70%</td>
<td>8.89 7.16 32.55</td>
<td>11.48 14.72 18.89</td>
</tr>
<tr>
<td>Increased rates of post-discharge community care (% of all clients followed up within 7 days of discharge from inpatient unit)</td>
<td>70%</td>
<td>70%</td>
<td>New measure</td>
</tr>
<tr>
<td>Increased percentage of all clients who have had contact with MHS within 7 days prior to admission</td>
<td></td>
<td></td>
<td>New measure</td>
</tr>
</tbody>
</table>
5.5 Output Class 4: Rehabilitation and Support

Rehabilitation and support services are aimed to support people to maximise their independence and increase their ability to live in the community. Access to a range of short or long-term community based services is arranged by NASC services following a ‘needs assessment’ and service co-ordination process. The range of services includes palliative care services, home-based support services, day programmes, respite and residential care services.

On a continuum of care these services provide support for individuals and their carers and in general are provided within community or home setting.

Rehabilitation and support services will assist in achieving the following strategic goals:

- Strategic Goal 1: People are healthier, able to self-manage and live longer
- Strategic Goal 2: People are able to participate more in society and retain their independence for longer

by ensuring the provision of timely and appropriate rehabilitation and support services so that individuals can return to the best possible level of participation in society as quickly as possible.

Rehabilitation and Support strategies will be identified for each of the following priority areas:

- Older People’s Health Services
- Mental Health and Addiction Services
- Hospital and Specialist Services

5.5.1 Older Peoples Health Services Rehabilitation and Support Strategies

Aim: For older people’s Rehabilitation and Support is to improve quality of home care and aged residential care by:

1. Support family / Whānau in provision and access to:
   - respite care
   - day programmes
   - social supports
2. Engage in next steps on ARC review
3. Support Whānau Ora initiative

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11 YTD</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantity:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The number of Aged Residential Care (ARC) facilities trained and providing the Liverpool Care Pathway option to residents</td>
<td>100%</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>Number of home based support services (HBSS) hours purchased</td>
<td>673,443</td>
<td>66</td>
<td>TBC</td>
</tr>
<tr>
<td>Number of restorative packages of care purchased</td>
<td>15,230</td>
<td>4,050</td>
<td>66</td>
</tr>
<tr>
<td>Number of carer support days purchased</td>
<td>24,558</td>
<td></td>
<td>2,225</td>
</tr>
<tr>
<td>Numbers of respite bed days purchased</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of days at day support programmes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality:</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>HealthShare audits of HBSS,</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Effectiveness:
- The ratio of occupied ARC beds/population over 65
- The ratio of total $ spend on HBSS/ARC

<table>
<thead>
<tr>
<th>Effectiveness</th>
<th>Target 2011/12</th>
<th>Actual 2010/11</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1:24.70</td>
<td>1:2.768</td>
<td>1:24.28</td>
</tr>
<tr>
<td></td>
<td>1:2.585</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.5.2 Hospital and Specialist Health Services Rehabilitation and Support Strategies

**Aim:** Rehabilitation and Support services aim to support people to maximise their independence and increase their ability to live in the community.

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2010/11</th>
<th>Actual 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantity (Allied health):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of dietetics/dietician contacts</td>
<td>2,453</td>
<td>1,979</td>
<td>3,560</td>
</tr>
<tr>
<td>Number of social work hours</td>
<td>3,681</td>
<td>1,810</td>
<td>200</td>
</tr>
<tr>
<td>Number of speech therapy contacts</td>
<td>1,715</td>
<td>1,852</td>
<td></td>
</tr>
<tr>
<td>Number of clients receiving the home oxygen service</td>
<td>204</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantity (District Nursing):</td>
<td>69,433</td>
<td>70,564</td>
<td></td>
</tr>
<tr>
<td>Number of district nursing contacts</td>
<td>473</td>
<td>463</td>
<td></td>
</tr>
<tr>
<td>Number of clients receiving the stomal service</td>
<td>1,852</td>
<td>1,814</td>
<td></td>
</tr>
<tr>
<td>Number of clients receiving the continence service</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Quality:
- Favourable patient feedback

5.5.3 Mental Health Services Rehabilitation and Support Strategies

**Aim:** People with experience of mental illness and addiction are supported to remain living in their homes and communities or to live independently

<table>
<thead>
<tr>
<th>How we will measure our performance:</th>
<th>Target 2011/12</th>
<th>Actual 2009/10</th>
<th>Actual 2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantity:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of occupied bed days – Housing Recovery Services (Daytime/Responsive night support) (Daytime/awake night support)</td>
<td>80% occupancy</td>
<td>New measure</td>
<td>New measure</td>
</tr>
<tr>
<td>Number of occupied bed days – Kaupapa Māori residential rehabilitation level III</td>
<td>80% occupancy</td>
<td>New measure</td>
<td>New measure</td>
</tr>
<tr>
<td>Number of occupied Kaupapa Māori crisis respite bed days</td>
<td>500 bed days</td>
<td>New measure</td>
<td>New measure</td>
</tr>
<tr>
<td>Effectiveness:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All contracted providers (within scope) report electronically through PRIMHD</td>
<td>100%</td>
<td>New measure</td>
<td>New measure</td>
</tr>
<tr>
<td>Quality:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of community providers using validated Outcomes Measurement tool</td>
<td>50%</td>
<td>New measure</td>
<td>New measure</td>
</tr>
</tbody>
</table>
6 Stewardship

6.1 Funder Interests

Bay of Plenty DHB is a Crown Entity with ownership of:

- Tauranga Hospital
- Whakatane Hospital
- District nursing services located in both Tauranga and Whakatane.
- Needs Assessment and Coordination Services (Support Net) for people with life-long and age-related disabilities
- Public Health Unit (Toi Te Ora) providing a range of health promotion and screening services NIR, HIV screening, smokefree programme
- School Dental and Adolescent Health Services based in Tauranga and Whakatane
- Corporate offices in Tauranga for the Chief Executive and members of the DHB Executive Management Team and their staff
- HealthShare – ownership shared with Midland DHBs – Waikato, Lakes, Taranaki, Tairawhiti
- 20 District Health Boards Collective (District Health Boards New Zealand – DHBNZ) to ensure organisation and collective delivery of national strategies and the organisation of national service interests
- Bay of Plenty Clinical School – Tauranga and Whakatane Campuses

6.1.1 Consultation with Minister of Health

The Bay of Plenty DHB will consult with the Minister of Health/Ministry of Health in relation to:

- Proposed service changes
- Acquisition of shares or other interests
- Entry into joint ventures and/or collaborative or co-operative agreements or arrangement (where required under s24/28 of the New Zealand Public Health and Disability Act 2000)
- Capital expenditure if required by policy and/or legislation
- In other situations as required by legislation, regulation, or contract.

6.1.2 External Reporting

Bay of Plenty DHB provides regular reporting to the Minister and Ministry of Health as outlined below.
### Reporting Information and Requests

<table>
<thead>
<tr>
<th>Reporting</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Requests</td>
<td>Ad Hoc</td>
</tr>
<tr>
<td>Financial Reporting</td>
<td>Monthly</td>
</tr>
<tr>
<td>National Data Collections</td>
<td>Monthly</td>
</tr>
<tr>
<td>Risk Reporting</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Health Target reporting</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Crown Funding Agreement non-financial reporting</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Indicators of DHB Performance</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Annual Report &amp; audited statements</td>
<td>Annually</td>
</tr>
</tbody>
</table>

### 6.1.3 Key outcomes and priorities for our DHB

Bay of Plenty DHB vision is one of “Healthy, Thriving Communities”.

Our approach in 2011/12 is to ensure purchase of services that align to the overarching national population health outcomes, the Minister of Health’s expectations, the national Health targets, and regional and local priorities.

We will ensure achievement of these priorities by monitoring our activities internally and by compliance with all national reporting and legislative requirements.

To achieve “Good health and wellbeing for all New Zealanders throughout their lives” our DHB will focus on the following in 2011/2012:

- Child and Youth Health
- Older People’s Health
- Mental Health and Addictions
- Hospital and Specialist Services
- Primary and Community Health
- Health Services for people with long term conditions

Our Outcomes Framework identifies population health outcomes for each of these focus areas as well as performance measures so we can gauge whether we are progressing towards achieving our population health outcomes, and ultimately our long term health goals, as articulated in our District Strategic Plan (DSP).

### 6.1.4 Managing Financial Risk

All District Health Boards face pressure to meet additional expenditure which must be managed within allocated funding. There is pressure to devolve services to the primary area seen as a “lower cost platform” and to increase tertiary level interventions such as cardio-thoracic surgery and cardiology procedures. This creates increasing challenges for the viability of secondary services, particularly for provincial DHBs.

In employment negotiations there will be a focus on increased workforce flexibility, increased productivity and wage increases that are affordable.

The DHB will have to manage staff numbers to appropriate levels and may implement changes to service configuration. These efforts will have to be prioritised within the DHB’s service priorities and demographics.

### 6.1.5 Quality assurance and improvement
The Funder Arm of the DHB is committed to the organisational ‘Health Excellence’ programme; this framework is a practical tool to guide and support continuous quality improvement and enables performance to be measured against other high performing organisations.

6.1.6 Risk Management, Audit and Review

An electronic risk management process is in place which facilitates escalation of risks from within the funder arm. A subcommittee of the Board - The Audit, Finance and Risk Committee review risks on a regular basis. Internal and external mechanisms are in place for evaluation of contracted providers; these are done on a planned and on an adhoc basis as required.

Each of the five Midland DHBs has a shareholding interest in HealthShare Limited, a regional DHB joint venture company that specialises in both routine and issues-based audits of service providers.

HealthShare also undertakes regional services on behalf of the five DHBs when required. HealthShare reports back to the participating DHBs throughout the year ensuring contractual obligations and standards are met by contracted providers.

Sector Services also provide a range of routine and special audits on behalf of Bay of Plenty DHB with respect to primary care services and Fee for Service Agreements (including pharmacy, dental, home based support services and Aged care).

6.2 Provider Interests

Hospital services comprise services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with ‘facilities’ classified as hospitals to enable co-location of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together.

They include:

1. Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic and rehabilitative services.
2. Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services.
3. Emergency Department services including triage, diagnostic, therapeutic and disposition services.

Bay of Plenty DHB provides Hospital Services in Tauranga and Whakatane.

6.2.1 Level of Service

Bay of Plenty DHB will ensure that both Tauranga and Whakatane Hospitals provide the amount of elective operations, procedures and assessments agreed to in our District Annual Plan. We will review the key operations we perform to ensure we are delivering the right level of service for the people in our region. We will demonstrate innovative strategies, or alternative delivery options aimed at increasing elective capacity, including initiatives across the primary/secondary interface.

6.2.2 Asset Management
The provider Arm has a robust asset management plan and processes in place to ensure timely and appropriate replacement of clinical and non-clinical equipment. Information technology, capital and other large-scale assets are managed by the appropriate division outside of the Provider Arm.

6.2.3 Quality and Patient Safety

The Provider Arm of the DHB is committed to the organisational ‘Health Excellence’ programme; this framework is a practical tool to guide and support continuous quality improvement and enables performance to be measured against other high performing organisations.

6.2.4 Risk Management

An electronic risk management process is in place which facilitates escalation of risks from any employee within the provider arm. Risks are reviewed and evaluated at a number of levels throughout the organisation and action taken as appropriate. A subcommittee of the Board - The Audit, Finance and Risk Committee review risks on a regular basis. An audit schedule is in place where planned audits occur as well as identified adhoc audits when required.

6.2.5 Subsidiaries

Our DHB has no subsidiaries.

6.3 Organisational Health

We have an established governance structure based on the requirements of the NZPHD Act 2000, through which the DHB functions.

6.3.1 Governance

Our Board assumes the Governance role and is responsible to the Minister of Health for the overall performance and management of the DHB. Its core responsibilities are to set the strategic direction for the DHB and to develop policy that is consistent with Government objectives and improves health outcomes for our population.

The Board also ensures compliance with legal and accountability requirements and maintains relationships with the Minister of Health, Parliament and the Bay of Plenty community. Seven Board members are elected by the Bay of Plenty DHB community and four are appointed by the Minister of Health.

Three statutory (mandatory) advisory committees and three non-statutory committees have been established to assist the Board to meet its responsibilities. The membership of these committees is comprised of a mix of Board members and community representatives who meet regularly throughout the year. It includes both clinical and Māori members who contribute clinical and cultural experience and understanding to decision making.

While responsibility for our DHB’s overall performance rests with the Board, operational and management matters have been delegated to the Chief Executive. The Chief Executive is supported by an Executive Management Team, which includes the Chief Operating Officer, General Manager of Planning and Funding, General Manager of Māori Health Planning and Funding, Chief Financial Officer, General Manager Human Resources, General Manager Information Management, General Manager Property Services, General Manager Corporate Services, and Head of the Clinical School.
6.3.2 Clinical Leadership

We have joined forces with other DHBs in the Midland region to develop and implement leadership initiatives. These include:

- Leadership in Practice
- Health Leaders Advanced Programme
- Midland Leadership Framework\(^1\)

Strengthening clinical leadership input into the overall direction of the DHB is a continuous and evolving partnership.

The focus for 2011/12 will be:

- ensuring senior clinicians and emerging leaders are nominated for attendance at the midland leadership programmes (Leadership in Practise and the Health Leaders Advanced Programme)
- ensuring that clinicians are involved in local and regional planning processes, including taking a lead role in the Bay Navigator
- actively supporting national and regional initiatives related to enhancing clinical leadership, clinical engagement and the development of clinical networks
- strengthening and supporting nursing leadership capacity in collaboration with the Midland Directors of Nursing through nursing leadership networks.

A key mechanism for assisting with the development of a regional approach to clinical training is via the Midland Regional Training Network. The framework for the Midland regional training network (implementation was under the guidance of Health Workforce New Zealand) has been established. The network will initially focus on the career opportunities and development of the medical workforce of PGY2 in the 11/12 year. The network has also identified GP training and the development of rural hospital lists as important work areas for the network in the out years.

6.4 Building Capability (including productivity initiatives)

The Health and Disability services sector has managed significant changes over the last two decades and the fast pace of change will increase in the future. For our DHB a significant change driver is the increased service demand arising from an ageing population that is facing an increasing burden of long-term diseases and multiple health issues.

The focus will remain on improving the way patients are cared for; both in the hospitals and in the community to better manage acute demand and the burden of long-term (chronic) conditions. With the economic downturn and funding constraints of 2011/12 and beyond, it is clear that maintaining service coverage and investing in value areas will require greater efficiency, savings, and reprioritisation across the system.

Our well-established Service Improvement Unit aims to improve patient outcomes and patient safety by freeing up staff time for patient care. Time will be freed up by eliminating waste and improving systems. The staff dealing with the daily realities of work in health care will be given tools and support so they can lead service improvements. Service

\(^1\) For further information please see [www.midlandleadership.co.nz](http://www.midlandleadership.co.nz)
improvements will be delivered within the organisation’s quality framework (Health Excellence).

6.4.1 Service Improvement

The focus of service improvement remains on improving the way patients are cared for, both in our hospitals and in the community, to better manage acute demand and the burden of long-term/chronic conditions. With ongoing demand and cost pressures it is clear that maintaining service coverage and investing in value areas will require greater efficiency, savings, and reprioritisation across the system. The most significant opportunities to improve productivity, safety and quality will result from staff-led improvements that reduce variation in practice. Service improvements are delivered within the organisation’s quality framework (Health Excellence) and are facilitated by an experienced and established Service Improvement Unit. The focus will continue to be on delivering more value with the same resource. Whilst significant gains are expected in terms of quality of patient care, efficiency and improved staff morale it is not possible to pre-empt the outcome of improvement initiatives in terms of financial savings, and frequently impacts cannot be solely attributed to one initiative or programme. BOP DHB will monitor initiatives as they progress and evaluate any savings made as a result. BOP DHB is strongly focused on ensuring the best value for money, and is committed to service improvement, whilst living within its means.

The Unit facilitates and supports a number of small and large programmes of improvement work.

Key activity includes:

- Operations Centre – a clinically-led initiative to develop a centralised and integrated operations centre to smooth patient flow across the hospitals. Activity includes: contingency planning, business continuity, business rules, forecasting and planning, dataset, standard operating procedures, and service memorandums of understanding.

- The Productive Hospital (NHS Productive Programmes) – continuing successful implementation of the NHS productive programmes: productive ward, productive community, and the productive operating theatre across the Bay of Plenty, other NHS projects will be considered for implementation as appropriate.

- Facility Change Management – supporting staff in lean process redesign and change management for the completion of Project Leo (Tauranga Hospital campus redevelopment) and Project Waka (Whakatane Hospital campus redevelopment).

- Sustainable Work Systems – continuation of the staff-led partnership programme with the Public Service Association to improve clerical processes to be patient-centred and efficiently and effectively support clinical activity.

- Bay Navigator – clinician-led single system approach to health that integrates care across primary and secondary services through pathway redesign.

- Building Capacity – building organisational capacity for change, leadership, and teamwork through experienced facilitation of programmes such as TeamSTEPPS.

6.4.2 Workforce Development

Change continues to be driven by workforce shortages and an ageing workforce. We are committed to ensuring the culture within our DHB supports the change required to achieve
our vision of ‘Healthy, Thriving communities’ notwithstanding the pace of change. Our DHB will continue to foster a culture of adaptability, innovation, quality, openness, transparency and teamwork. These qualities will help the DHB remain sustainable, keep improving the health status of and reduce inequalities for the Bay of Plenty population. We will be regarded as an employer of choice.

The Minister has highlighted the need for DHBs to improve retention of permanent clinical staff, reduce vacancy rates and strengthen clinical leadership and networks.

Recruitment is clearly an important focus in terms of ease of access to information for applicants and cost to DHBs. The national job portal www.kiwihealth.careers.com has been implemented to create a “one stop shop” for those looking for a health job (be they overseas or domestic job seekers). Initially, all DHB and NZBS health job vacancies are being made available online. There are links available from the national job board to both regional and district websites. The intent of the national job portal is to facilitate easy access for applicants, reduce recruitment advertising costs as well as minimize any use of costly 3rd party agencies.

Our DHB is committed to strengthening clinical leadership and a culture of enduring clinical/management partnerships. Our Provider Arm structure reflects these partnerships with a triumvirate leadership model adopted for each service cluster made up of a business, medical and nurse leader. A strong Clinical Board at a governance level and Clinical Governance Committee at Provider Arm level further support this approach.

Technical advisory groups present a useful tool for clinically led, cross-sectoral advice to inform planning and funding decisions.

Our organisational structure enables clinical leadership, accountability and decision making at all levels.

Nurturing a connection between the secondary students of the Bay of Plenty and careers in the health sector; placing an emphasis on the learning environment of the Clinical School both from a teaching and research perspective; and improving the engagement of staff are all key strategies the DHB employs to secure a sustainable workforce.

Workforce development and strong organisational health are central to our DHB to ensure that we provide high quality effective services and meet the continued challenges of the health needs of our community. Through supporting flexibility and innovation; providing leadership and skill development opportunities; and being a ‘good employer’ our DHB aims to be a preferred employer of health workers. As a ‘good employer’ we have a number of policies that promote equity, fairness and a safe and healthy work environment. These policies address:

- Fair and transparent recruitment to ensure we meet current and future workforce needs and retain staff.
- Our zero-tolerance of all forms of harassment and bullying.
- Equitable training and development opportunities for all employees.
- The management and disclosure of adverse events to ensure a safe, quality working environment.

The DHB is committed to developing a workforce profile and understanding the needs and expectations of its workforce. We are committed to promoting leadership opportunities and a positive culture for our organisation.
Our DHB employs 2,880 staff with the full time equivalent value being 2,124 staff, 64% of staff identify as NZ or Other European and 10% as Māori. The majority of staff employed are health professionals.

Our remuneration policy forms part of an overall employment relations strategy for employees covered by individual employment agreements that includes defining the role of employees, performance management and appropriate reward mechanisms. Approximately 89% of DHB employees are covered by salary scales and terms and conditions in National MECAs.

Within the DHB Provider Arm staff turnover rates average approximately 8% per year. We have been successfully addressing staff retention over the last 5 years and have seen a steady decline in staff turnover from 17.84% per annum in 2003/04 to the present rate.

During 2011/12 we will continue to develop our clinical leaders and senior managers and provide appropriate training to realise their full leadership capabilities.

Our DHB intends growing both its research and teaching capacity and capability through an ongoing emphasis on the Bay of Plenty Clinical School.

6.4.3 Workforce Innovation

Bay of Plenty DHB has a strong commitment to workforce innovation, recognising that the future workforce is critical to service delivery and that the risks associated with an ageing workforce will become an increasing issue, as will recruiting and retaining adequate numbers of suitably trained staff in an increasingly competitive and complex environment.

In order to proactively address these issues, we have and will continue to focus on staff engagement, staff participation and workforce development during the 2011/12 year.

We will continue to work in partnership with unions to progress implementation of the whole of system care capacity demand management strategies; these are local strategies that have been developed as a result of the pilot that was completed with the Safe Staffing, Healthy Workplaces (SSHW) Unit. One of the aims for Bay of Plenty DHB is to sign agreement with SSHW to become a model site.

In addition we plan to:

- Engage with Bipartite forum to implement the variance response tool as it relates to each professional group or service.
- Engage with Bipartite forum to progress the implementation of the operations centre which is a key strategy in the short, medium and long term capacity, demand and resource management.

Further to the results of the staff engagement surveys (Pulse Surveys) undertaken in 2007, 09 and 10, and in line with the 2010 initiative of appointing Pulse Champions to increase staff response to the Pulse Survey which was extremely successful, the role of Staff Engagement Leader was established in January 2011. Priority tasks for the role are to analyse the results of the Pulse Survey, liaise with and support Executive Team Members, Pulse Champions and Cluster leaders to create service action plans to enhance positive activities within the organisation and address the areas employees perceive could be better, in an ongoing manner.

Staff Recognition ceremonies for those attaining 10, 15, 20, 25, 30 and 35+ years and congratulatory letters for 1, 2, and 5 years service will continue, orientation of staff will be
reviewed and improved where necessary and follow-up with new employees will be made, three months following commencement.

Improvement and development of other Staff Engagement initiatives, such as recruitment and retention will also be an important part of the role. The role also exists to make a difference in assisting employees understand how the organisation works and the part their role and all BOPDHB roles play, in the successful delivery of optimal health services by the DHB, for the Bay of Plenty region.

The following table highlights some of the key workforce initiatives planned within the Provider Arm of Bay of Plenty DHB.

<table>
<thead>
<tr>
<th>Action</th>
<th>Short term Measure (1-5 years)</th>
<th>Long term outcome measure (5-10 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The Provider Arm will focus on efforts to recruit and retain staff to achieve a valued and stable workforce. There will be a strong emphasis placed on ensuring the health workforce is appropriately trained to reflect the areas of need.</td>
<td>• Stable integrated workforce will be established.</td>
<td>There is consistent quality of care provided in a cost effective way that ensures people are supported well in their community.</td>
</tr>
<tr>
<td>• A joint training needs analysis over the primary and secondary sector will be undertaken as a starting point to support consistent and high quality clinical services across the region.</td>
<td></td>
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</tr>
<tr>
<td>• Clinical school will provide support and training for current and future workforce. Exploration of future workforce models will occur with training and support provided which could include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Enhancement</strong>: A more flexible workforce approach by increasing advanced practice roles e.g. Nurses in the community and inpatient services will have greater opportunity to specialise in their fields as Clinical Nurse Specialists and Nurse Practitioners.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Substitution</strong>: e.g. Pharmacists taking on some elements of a GP role for long term disease management.</td>
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<tr>
<td>• <strong>Delegation</strong>: Innovation creating new jobs by creating a new type of worker e.g. the hospitalist, the Health Care Worker (HCW).</td>
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</tr>
<tr>
<td>• Professional leadership and development within each of the allied health specialties will support continuing improvement in the quality of care provided and enable the skills and experience of these staff to be effectively leveraged.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Support for unlocking the potential of frontline teams to reduce variation in quality and productivity at the team level.</td>
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<td></td>
</tr>
<tr>
<td>• Strong clinical leadership and management support for a one service two sites model of care.</td>
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<td></td>
</tr>
<tr>
<td>• Developing a supportive and collaborative career pathway for PGY1, PGY2 and GPs in training and rural hospitalists via a Midland networked approach to training.</td>
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</tbody>
</table>
6.4.4 Bay of Plenty Clinical School

The Bay of Plenty Clinical School has campuses at Tauranga and Whakatane. The school takes a multidisciplinary focus and supports all training and education for the Bay of Plenty District Health Board. The Clinical School is a key mechanism for attracting, retaining and repatriating staff to Bay of Plenty DHB due to the undergraduate, post graduate, research and continuing education programmes it offers to Bay of Plenty DHB staff. There is an Education Subcommittee who advises the Executive Council and the Clinical School on the future education and research needs for Bay of Plenty DHB. In excess of a third of Auckland Medical School students get exposure to Bay of Plenty DHB during their undergraduate programme and in 2010 over 120 overseas students spent some time at Bay of Plenty DHB, there are a number of positive consequences in having these visiting clinicians, including enriching the culture of the DHB and increasing our profile through the student and overseas networks.

6.4.5 Information Technology

The strategic direction our DHB takes towards its ICT services reflects not only our vision of ‘Healthy, Thriving Communities’, but also the implications and requirements of national and regional information strategies. Accordingly our approach to ICT services incorporates the requirements of the Health Information Strategy of New Zealand (HIS-NZ) an information framework aimed at contributing to achievement of the Government’s broad Health Strategies.

Our DHB also recognises that it must be a part of a regional response and as such aims to contribute to three regional information goals:

- provide integrated/shared information to enhance health care planning and improve population health outcomes
- collaborate to reduce costs and enhance risk mitigation within information areas
- provide technical and information support for shared service initiatives in non-IT areas.

The prioritised regional projects for progression during 2011/12 are:

- progress the Midland Connected Health programme.
- medications Management Programme.
- development of a Clinical data repository.

Apart from these prioritised projects, work will occur within the region to advance other initiatives – albeit without formal regional processes being established. This next tier of initiatives will include:

- Undertaking preliminary work in preparation for establishing the Clinical Workstation programme.
- Expansion of the current PACS/RIS solution shared by BOP and Waikato DHBs to include a third DHB (Tairawhiti) and thereby creating the regional default solution.

While regional initiatives will take a priority, ensuring that key local priorities are also met will be important. The ongoing campus redevelopments at Tauranga and Whakatane campuses will require IT support to ensure the facilities are future-proof, while the drive for improved operational performance within the provider arm will be supported by local IT initiatives such as:
• Integrated operations centre.
• Electronic medical records – “Paperlite” departments.
• Leveraging technology to reduce the barriers to service delivery – e.g. VC, telephony.

6.4.6 Quality and Patient Safety

Our DHB recognises that for continuous quality improvement to be successful it must be based on the provision of comprehensive risk management processes and systems which provide the foundation for patient safety. ‘Health Excellence’ is our organisational commitment to performance excellence utilising an internationally recognised framework, namely Baldrige Health Criteria for Performance Excellence. The vision for Health Excellence is ‘Striving to achieve the highest quality health care.’ The framework is a practical tool to guide continuous improvement and our journey to a culture based on quality outcomes. It enables our DHB performance to be measured against other high performing organisations.

During 2011/12 we will begin the implementation of our Health Excellence Strategic Plan starting with a number of services within our Provider Arm undertaking comprehensive self-assessments against the Baldrige Health Care Criteria for Performance Excellence. Our implementation programme for Health Excellence during 2011/12 will generate a greater organisational commitment to Health Excellence, improved workforce engagement, build on our culture of learning and innovation and offer a framework for regularly reviewing business performance.

A focus on good financial performance is likely to help drive quality improvement in 2011/12 and beyond. Fundamental to quality improvement is process improvement/redesign. It is more important than ever that Bay of Plenty DHB gets its processes right and shows that these benefit the patients, staff, public and DHB financial status. Clinical leadership is key to achieving the quality and safety goals.

Bay of Plenty DHB will implement the Quality and Safety Commission’s work programme:
• the national introduction of a standardised medication chart and reconciliation of medicines process to reduce medication errors
• reduce hospital acquired infections
• learn from preventable adverse events that happen to those using our service
• ensure consumers are actively engaged in decision making about health services
• review current hospital satisfaction survey to make recommendations about consumer feedback in the future.

6.4.7 Capital and Infrastructure

Significant gain has been made during the 2010-11 year with the completion of Building 50 in May 2011 on the Tauranga Hospital campus, housing the Intensive Care, Cardiac Care, High Dependency and medical day stay units. The completion of the Bay of Plenty Clinical School with associated skills laboratory has added significantly to our ability to attract, train and retain clinical staff.

The building programme will continue during 2011/12, with the major focus will on the completion of Project Leo, this will occur following the fit-out of the paediatric ward in the West Wing of Tauranga Hospital in December 2011.
Significant early works will be completed on the Whakatane hospital campus prior to the commencement of the building of the new hospital in late 2011 (subject to Ministerial approval).

There will be ongoing challenges to ensure that the inpatient and outpatient facilities continue to meet demand and that additional car parking is available to match increasing bed numbers.

6.4.8 Productivity Improvement Initiatives

Driven by a patient-centred approach, the DHB will continue its commitment and dedication to improving hospital productivity, service quality and overall patient experience during 2011/12.

In terms of procurement the DHB has worked constructively on several fronts, local, regional and national and expects this collaborative approach to continue during 2011/12.

At a local level the DHB has identified larger medical consumable spend suppliers and developed preferred supplier agreements. This has not only attracted significant cost savings based on current product volumes and range but will also provide certainty around prices going forward for budget holders.

At a regional level, the DHB is a member of the Midland Supply Group which is made up of Procurement Managers from Waikato, Lakes, Taranaki and Tairawhiti. This group has been in existence for several years and investigates opportunities for collective procurement.

The DHB has participated in several large tenders including physiology implantation services and ACC provider services and leads several productive initiatives including nutritionals, patient monitoring systems, general and medical waste and patient hoists.

We are participating in the hospital quality and productivity (HQ&P) project. This project is working towards a HQ&P framework which would include regular reporting on DHB Provider Arm performance.

The indicators we will be measuring to enable us to plan initiatives and monitor success are:

- weighted inpatient average length of stay
- percentage elective day of surgery admission
- percentage elective day surgery
- outpatient: did not attend rate
- percentage of radiotherapy patients for whom the treatment commenced within time thresholds of first specialist assessment
- inpatients unplanned acute readmission rate
- outpatient: follow up to first ratio
- percentage of returns to emergency department within 48 hours
- percentage of patients with pressure ulcers as a complication
- percentage of patients with urinary tract infections as a complication.

Improving the quality and safety of our health services is a priority for our DHB. ‘Health Excellence’ is our organisational commitment to performance excellence utilising an
internationally recognised framework, namely Baldrige Health Criteria for Performance Excellence. This enables our DHBs performance to be measured against other high performing organisations.

6.4.9 Co-operative developments

Working collaboratively with others, both across the sector and with other health and social service providers is integral to the success of our DHB in achieving the goals set out in our DSP. We are committed to sharing resources with regional DHBs and providers as well as collaborating with the Ministry, The National Health Board, DHBNZ\[11\], NGOs\[12\] and other service providers in order to achieve specific outcomes.

Our DHB is committed to working with other providers in order to influence the social determinants of health that are external to the health system to achieve the best health outcomes for the population.

National

At a national level Bay of Plenty DHB works with the education and justice sectors to improve outcomes for the Bay of Plenty population through health, nutrition, physical activity and mental health initiatives; crossing the sectors in an effort to meet shared goals.

Similarly, we are committed to a number of national programmes, which will improve the health of the community, including B4 School Checks, Newborn Hearing Screening and the Human Papillomavirus Immunisation programme. There are a number of other national programmes such as the National Value for Money Programme, National Procurement Programme and Workforce groups that our DHB is focused on to ensure our clinical and financial sustainability.

Regional

As well as continuing to progress existing regional networks, the Midland DHBs have developed a Clinical Services Plan (CSP) for the Midland region.

The focus for 2011/12 will be on:

- Renal services
- Cardiology/cardiac services
- Maternity services
- Primary Care services
- Mental Health Services
- Cancer Services.

Multidisciplinary clinical networks will be established for each of the above priority areas to ensure the development of sustainable regional models of care.

Other regional priority areas for 2011/2012 include:

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\[11\] DHBNZ (District Health Boards New Zealand) has the overall purpose of assisting DHBs in meeting their objectives and accountabilities to the Crown.

\[12\] NGOs (Non-Governmental Organisations) for more information on NGOs go to http://www.moh.govt.nz/ngo
• Information for Clinicians
• Workforce
• Māori Health

The following regional activities also contribute to ensuring a collaborative, intersectoral approach is taken to addressing the health needs of our communities:

**Collaboration Bay of Plenty (CoBoP):** This is a network of senior managers from local and central Government agencies serving the Bay of Plenty and Lakes districts. The network was initiated in 2005 to promote the achievement of local and regional community wellbeing through effective co-operation and collaboration, and efficient use of resources. Bay of Plenty DHB actively participates in CoBoP within a number of different groups.

**Healthy Homes Projects:** The DHB actively supports this intersectoral project with the sector, which sources funding to provide low cost insulation and energy efficiency measures to low income households in the district. Health practitioners are advised of application processes that high needs families can use to improve the health of their members.

**Midland Regional Smokefree Initiative:** Lakes DHB is the lead DHB for this Midland programme (across five DHBs) which provides a high level, consistent, coordinated leadership approach to achieving the Midland Smokefree Vision by 2020.

**Lakes/Bay of Plenty Rheumatic Fever Steering Group:** This group provides oversight of the rheumatic fever programme. This is an excellent example of research being converted into action through public funding, community engagement, interagency collaboration and a clear strategic direction. In addition rheumatic fever is almost exclusively experienced within Māori families, so this work will impact on health inequalities. The Rotorua Area Primary Health Services (RAPHS) register for the secondary prevention of Acute Rheumatic Fever was developed in the Lakes DHB district, BOP cases are now being loaded onto the register.

**Local**

Bay of Plenty DHB is involved in a wide range of local collaborative activities, these include:

**Safe City Project:** Tauranga has achieved designation as an international safe city. The goal of this initiative is in coordinating an intersectoral approach for the prevention and reduction of intentional and unintentional injury. The Tauranga Safe City project has now been extended to cover the Western BOP District Council. A child injury prevention interagency group is being considered for the Eastern BOP. Programmes have included anti-bullying in schools, an Off-licence Alcohol Accord, family violence prevention work, and linkage to the DHB’s Child and Youth Mortality Review Group.

**Family Violence intervention Project (VIP) Governance Group:** This group is a multiagency group established to focus on the reduction of family violence through screening processes in DHB departments and monitoring the implementation of and outcomes associated with the family violence strategy documents. The programme currently covers child abuse and neglect, and spousal violence, and is considering elder abuse.

**Pathway to Health:** The DHB is a core funder alongside SPARC for this project which has drawn together the three Eastern BOP district councils, Sport BOP, Mataatua Sports, and Toi Te Ora into a sub-district activity. This links to a number of strategic initiatives e.g. walking and cycling strategies, and weight management.
Let’s Go Whānau: This programme has received funding through SPARC and with further funding support from the DHB and Eastern Bay of Plenty local authorities will be able to operate at least for three years.

This programme takes a Whānau approach rather a broader community one, and is particularly applicable to Māori, and the way they participate in unstructured and semi-structured sport and recreation. In addition Let’s Go Whānau will operate in more isolated communities away from the three main centres of Whakatane, Opotiki and Kawerau.

Local Settlement Network: This network is intersectoral and guides the work of the migrants and refugees Settlement Support Coordinator for the Western BOP. There are a number of issues that have been identified and priorities for action have been determined for implementation.

Bay of Plenty Pacific Island Advisory Group: The main focus of the Pacific Advisory Group to date has been engaging with the Pacific communities, identifying their expressed health needs, and looking at the barriers to their accessing primary health services in particular, but also their higher than average DNA rates for outpatients. The group provides advice to the DHB as to how it can make mainstream services more responsive to Pacific peoples.

Welcome Bay interagency group: This group was called together when evidence was noted of greater social distress in the suburb, e.g. petty crime, family violence, and graffiti. The group involves a number of Government agencies, Tauranga City Council, and local community and iwi representatives. The community itself has prepared a community plan for implementation.

Bay of Plenty DHB is engaged in other collaborative initiatives through relationships with:

- BOP Regional Transport Committee.
- BOP Pharmacy Group to explore opportunities around improving access to the Emergency Contraceptive Pill and NRT for smoking cessation.
- Salvation Army around gambling issues.
- Local Authorities for LTPs, drinking water subsidy scheme applications, administration of the Sale of Liquor Act etc.
7 Service Configuration

7.1 Service Coverage

There are no planned service coverage changes in 2011/12.

7.2 Service Change

The following areas are highlighted as potential areas of service change:

<table>
<thead>
<tr>
<th>Change</th>
<th>Description of the Change</th>
<th>Benefits of the change</th>
<th>Link lower funding path?</th>
<th>Change due to Local Regional, or National reasons?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist Services</td>
<td>Current pharmaceutical dispensing costs are financially unsustainable with 5-7% year on year increases. Current workforce poorly integrated with primary care. Little motivation in funding arrangements to focus on health outcomes and management of long term conditions. Proposal to look at an alternative way of funding community pharmacist services.</td>
<td>Contain dispensing costs. Improve health outcomes for people with long-term conditions. Reduce health inequalities. Support better, sooner, more convenient care.</td>
<td>Yes</td>
<td>National initiative to improve community pharmacist services. National commitment to review pharmacist services as part of current national agreement.</td>
</tr>
<tr>
<td>Midland Regional Clinical Services Plan</td>
<td>As part of the Regional Clinical Services planning process clinical action groups will be established for renal services, cardiology/cardiac services, maternity services and primary care services. Regional networks for cancer and mental health are already established and aligned with this initiative. The groups will develop into multidisciplinary clinical networks as regional models of care develop. Any service changes that evolve as a result of this work are likely to be planned for in 2013 and beyond.</td>
<td>Reduce duplication of effort enabling DHBs to collectively develop sustainable solutions. Develop integrated approach to recruitment and retention within the global marketplace. Standardised planning, evaluation and procurement of new technology solutions within a clinical environment</td>
<td>This work is consistent with the national expectation of an increased focus on regional approaches, and with the strong focus on regionalisation agreed across the Midland DHBs</td>
<td></td>
</tr>
<tr>
<td>Change</td>
<td>Description of the Change</td>
<td>Benefits of the change</td>
<td>Link lower funding path?</td>
<td>Change due to Local Regional, or National reasons?</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Bay Navigator</td>
<td>Bay Navigator provided a mechanism for re-design across the health system in the Bay of Plenty. It includes the development of a website as a key access point for clinical staff across the Bay to access to find the best treatment path for particular issues. Cross-functional teams of GP’s and hospital clinicians will work together in workshops to develop care pathways for the care of respiratory, diabetes, child health and cardiology conditions in the first instance. It is a partnership between all the PHO’s and the DHB, and is designed to bring primary and secondary clinicians together to become a part of, a new direction in health care for the Bay of Plenty. A care pathway is an algorithm that offers a flowchart format of the decisions to be made and the care to be provided for a given patient, or patient group, for a given condition in a ‘step-wise’ sequence. The Bay of Plenty District Health Board’s Bay Navigator, is a project to develop care pathways for the improvement of the patients overall journey, and the continuity of care across different disciplines and sectors, with the aim of reducing duplication and improving the efficiency of resources within a constrained financial setting and medical workforce.</td>
<td>To create a fundamental reorientation of the health system across the Bay of Plenty, and to widen inter-sectoral collaboration, including: • increased focus on supporting people/Whānau to take a greater responsibility for their health the development of primary health care and community services to support people/Whānau in a community based setting • better use of secondary care based specialist resources and greater responsiveness to, and support for, primary health care services • shared responsibility for the health and well-being of the patient population • a whole of system approach taking into consideration resource allocation and community partnerships</td>
<td>Potentially</td>
<td>Consistent with the Better Sooner More Convenient Strategy, and the imperative to deliver services closer to home.</td>
</tr>
<tr>
<td>Change</td>
<td>Description of the Change</td>
<td>Benefits of the change</td>
<td>Link lower funding path?</td>
<td>Change due to Local Regional, or National reasons?</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------</td>
<td>------------------------</td>
<td>--------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>EBP(3)ho Business case</td>
<td>The Eastern Bay business case is to: Create one Regional Primary Health Organisation for the Eastern Bay; Establish an Integrated Family Health Network; Base high needs services, processes, training and systems on two Whānau Ora models to include the National Māori PHO Coalition model; Construct targeted initiatives to focus on improving the health outcomes for (1) tamariki and youth; (2) people with acute demand and long-term conditions; and (3) people with mental health needs; and Plan for the development of an Integrated Family Health Centre.</td>
<td>The 3 original Eastern Bay of Plenty Primary Health organisations have merged into one regional Primary Health Alliance. The benefits include a reduction in bureaucracy, a decrease in fragmented health services, sustainable programmes, improved outcomes, financial performance and quality.</td>
<td>The merging of the PHOs has resulted in a reduction of management fees.</td>
<td>The Eastern Bay PHOs had initiated the change within the Primary sector identifying the need to strategise regarding possible PHO configurations. This concept was later enforced by the Ministry’s direction through the BSMC health care strategy.</td>
</tr>
</tbody>
</table>

### 7.3 Service Issues

There are no current or emerging service issues.
8 Production Planning

The information used to build this table has been drawn from volume data in the 2011/12 Production Plan, across forecast (2010/11), and planned (2011/12) years. The scope of services counted has been limited to those purchase unit codes that meet two criteria: a national price must exist; and the unit of measure must be output (not input or programme) based.

The most important results in the table are those in the 'Total volume growth' line, which gives the percentage change in outputs across planned growth from 2010/11 to 2011/12.

The percentage growth weight column contains the weighted contribution to output growth, relative to each service. The weights are based on volume weighted to the national case-mix price.
<table>
<thead>
<tr>
<th>Summarised Outputs (DHB of Service)</th>
<th>Bay of Plenty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2010/11 Output Plan</strong></td>
<td><strong>% growth</strong></td>
</tr>
<tr>
<td></td>
<td><strong>2010/11</strong></td>
</tr>
<tr>
<td><strong>Case-weighted inpatient discharges</strong></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>3,250</td>
</tr>
<tr>
<td>Medical</td>
<td>15,927</td>
</tr>
<tr>
<td>Medical electives</td>
<td>800</td>
</tr>
<tr>
<td>Medical acute</td>
<td>15,127</td>
</tr>
<tr>
<td>Medical other</td>
<td>-</td>
</tr>
<tr>
<td>Surgical</td>
<td>17,311</td>
</tr>
<tr>
<td>Surgical electives</td>
<td>8,810</td>
</tr>
<tr>
<td>Surgical acute</td>
<td>8,501</td>
</tr>
<tr>
<td>Surgical other</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total case-weighted inpatient discharges</strong></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>36,488</td>
</tr>
<tr>
<td><strong>Outpatient services (expressed as events)</strong></td>
<td></td>
</tr>
<tr>
<td>ED</td>
<td>36,609</td>
</tr>
<tr>
<td>Medical first</td>
<td>13,094</td>
</tr>
<tr>
<td>Medical follow up</td>
<td>21,736</td>
</tr>
<tr>
<td>Oncology</td>
<td>3,800</td>
</tr>
<tr>
<td>Renal</td>
<td>4,000</td>
</tr>
<tr>
<td>Scope</td>
<td>4,064</td>
</tr>
<tr>
<td>Surgical first</td>
<td>13,270</td>
</tr>
<tr>
<td>Surgical follow up</td>
<td>27,334</td>
</tr>
<tr>
<td><strong>Other services (expressed as events)</strong></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>2,599</td>
</tr>
<tr>
<td>Medical</td>
<td>11,723</td>
</tr>
<tr>
<td>Surgical</td>
<td>4,258</td>
</tr>
<tr>
<td>Health of Older People</td>
<td>17,851</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>206,106</td>
</tr>
<tr>
<td><strong>All non-inpatient services (expressed as case-weighted outputs)</strong></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16,265</td>
</tr>
<tr>
<td><strong>Total volume growth</strong></td>
<td>52,753</td>
</tr>
</tbody>
</table>
9 Prospective Statement of Financial Performance

The Bay of Plenty District Health Board continues its commitment to manage expenditure within the provided funding and live within our means. The Bay of Plenty District Health Board is therefore committed to maintaining breakeven results during the coming three financial years.

Many cost increases impact the Bay of Plenty District Health Board at greater rates than provided for in the Funding Envelope, such as staff increases dictated by National Multi Employer Collective Agreements and supply costs. The Bay of Plenty District Health Board will cover this by carefully assessing the services provided to ensure best value for money.

The District Annual Plan commits the Bay of Plenty District Health Board to underlying breakeven results for the period 1 July 2011 to 30 June 2014.

## PROSPECTIVE STATEMENT OF FINANCIAL PERFORMANCE
FOR THE THREE YEARS ENDED 30 JUNE 2012, 2013 AND 2014

<table>
<thead>
<tr>
<th></th>
<th>Actual 2010</th>
<th>Estimate 2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government Revenue</td>
<td>583.2</td>
<td>606.0</td>
<td>625.5</td>
<td>648.1</td>
<td>670.9</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>6.9</td>
<td>5.9</td>
<td>5.5</td>
<td>5.7</td>
<td>5.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>590.1</td>
<td>611.9</td>
<td>631.0</td>
<td>653.8</td>
<td>676.8</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Costs</td>
<td>190.1</td>
<td>186.8</td>
<td>197.9</td>
<td>205.4</td>
<td>213.1</td>
</tr>
<tr>
<td>Outsourced Costs</td>
<td>24.9</td>
<td>23.2</td>
<td>21.0</td>
<td>21.6</td>
<td>22.4</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>46.6</td>
<td>51.9</td>
<td>53.0</td>
<td>54.9</td>
<td>56.6</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>46.5</td>
<td>51.9</td>
<td>54.2</td>
<td>56.6</td>
<td>58.7</td>
</tr>
<tr>
<td>Payments to Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Health</td>
<td>191.0</td>
<td>200.1</td>
<td>202.3</td>
<td>209.1</td>
<td>216.1</td>
</tr>
<tr>
<td>Mental Health</td>
<td>22.1</td>
<td>23.6</td>
<td>24.7</td>
<td>25.5</td>
<td>26.3</td>
</tr>
<tr>
<td>Disability Support Services</td>
<td>63.6</td>
<td>68.8</td>
<td>72.1</td>
<td>74.7</td>
<td>77.4</td>
</tr>
<tr>
<td>Public Health</td>
<td>1.9</td>
<td>1.3</td>
<td>1.1</td>
<td>1.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Māori Health</td>
<td>4.8</td>
<td>4.7</td>
<td>4.7</td>
<td>4.9</td>
<td>5.1</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>591.5</td>
<td>612.3</td>
<td>631.0</td>
<td>653.8</td>
<td>676.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(1.4)</td>
<td>(0.4)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

**Adjustment for Mental Health / Public Health Ringfence**

<table>
<thead>
<tr>
<th></th>
<th>Actual 2010</th>
<th>Estimate 2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ringfence / Surplus / (Deficit)</td>
<td>1.4</td>
<td>0.5</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Underlying Result</td>
<td>0.0</td>
<td>0.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

9.1 Ring Fence Reserves

The actual result for the year ended 30 June 2010 and the forecast result for the year ended 30 June 2011 reflect cyclical deficits through usage of the remaining Mental Health Ring Fence Reserve. The underlying result for both periods was or is forecast to be breakeven or better.
9.2 Financial Performance by DHB Arm

The Bay of Plenty District Health Board operates three Arms for the purposes of its District Annual Plan.

9.2.1 Funding Arm (funds)

The District Health Board receives, within the Funding Arm, a Crown appropriation for the purchase of health and disability services. This funding revenue is used to purchase services from the Non-Government Organisation sector and the District Health Board.

9.2.2 Governance and Funder Administration

Governance and Funder Administration is the Arm of the DHB that includes the board and governance costs of the Bay of Plenty District Health Board along with the costs of administrating the Funding Arm by the Funding & Planning division.

9.2.3 Provider Arm

This output class includes the health and disability services directly provided by the Bay of Plenty District Health Board in the two hospitals under its control and various community services along with the necessary support functions.

PROSPECTIVE FINANCIAL PERFORMANCE BY DISTRICT ANNUAL PLAN ARM FOR THE THREE YEARS ENDED 30 JUNE 2012, 2013 AND 2014

<table>
<thead>
<tr>
<th>$m</th>
<th>Actual 2010</th>
<th>Estimate 2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Arm</td>
<td>2.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Gov. &amp; Funder Admin</td>
<td>(2.2)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Funding Arm</td>
<td>(1.4)</td>
<td>(0.4)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

National prices, as calculated and advised by the Ministry of Health, have been used to generate the Price Volume Schedule between the Funding Arm and the Provider Arm.

For the purposes of the Statement of Intent, the Bay of Plenty operates the following output classes:

- Prevention
- Early detection and management
- Intensive Assessment and Treatment Services
- Rehabilitation and support.

These output classes are defined in chapter 5 of this document.
PROSPECTIVE FINANCIAL PERFORMANCE BY STATEMENT OF INTENT OUTPUT CLASS
FOR THE THREE YEARS ENDED 30 JUNE 2012, 2013 AND 2014

Prospective Summary of Revenues and Expenses by Output Class

<table>
<thead>
<tr>
<th>Output Class</th>
<th>2011/12 Plan</th>
<th>2012/13 Plan</th>
<th>2013/14 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Detection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
<td>192.5</td>
<td>199.5</td>
<td>206.6</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>192.5</td>
<td>199.5</td>
<td>206.6</td>
</tr>
<tr>
<td>Net Surplus / (Deficit)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Rehabilitation &amp; Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
<td>102.9</td>
<td>106.6</td>
<td>110.3</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>102.9</td>
<td>106.6</td>
<td>110.3</td>
</tr>
<tr>
<td>Net Surplus / (Deficit)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
<td>14.6</td>
<td>15.1</td>
<td>15.6</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>14.6</td>
<td>15.1</td>
<td>15.6</td>
</tr>
<tr>
<td>Net Surplus / (Deficit)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Intensive Assessment &amp; Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
<td>321.0</td>
<td>332.6</td>
<td>344.3</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>321.0</td>
<td>332.6</td>
<td>344.3</td>
</tr>
<tr>
<td>Net Surplus / (Deficit)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

9.2.4 Financial Assumptions

The Bay of Plenty District Health Board has made a number of significant assumptions in arriving at its Prospective Financial Performance Statements as summarised in the following table:

<table>
<thead>
<tr>
<th>Assumption</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>4.010%</td>
<td>$21.8m</td>
<td>$21.8m</td>
</tr>
<tr>
<td>Staff Costs (average movement)</td>
<td>2.000%</td>
<td>2.000%</td>
<td>2.000%</td>
</tr>
<tr>
<td>Staff Costs (numbers)</td>
<td>1.250%</td>
<td>1.800%</td>
<td>1.800%</td>
</tr>
<tr>
<td>Interest Rate - CHFA</td>
<td>6.000%</td>
<td>6.000%</td>
<td>6.000%</td>
</tr>
<tr>
<td>Interest Rate - Working Capital</td>
<td>3.700%</td>
<td>3.700%</td>
<td>3.700%</td>
</tr>
<tr>
<td>USD/NZD</td>
<td>0.7500</td>
<td>0.7000</td>
<td>0.7000</td>
</tr>
</tbody>
</table>

The following further assumptions have been made by the Bay of Plenty District Health Board:

- The cap on Management and Administration Full Time Equivalents has been reflected in the forecasts;
- Cost challenges for the Provider Arm, Planner/Funder and Corporate Support Areas are achieved.
9.2.5 Significant Financial Risks

All District Health Boards face pressure to meet additional expenditure which must be managed within allocated funding.

The impact of policy changes are included in a base increase in funding via the Future Funding Track.

In employment negotiations there will be a focus on increased workforce flexibility, increased productivity and wage increases that are affordable.

The Bay of Plenty District Health Board will have to manage staff numbers to appropriate levels and may implement changes to service configuration. These efforts will have to be prioritised within the Bay of Plenty District Health Board’s service priorities and demographics.

9.2.6 Crown Revenue

Bay of Plenty District Health Board will continue to operate within the long-term revenue provided by Government.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out year forecast revenue may change as a result of Government policy, new initiatives and other factors.</td>
<td>Estimates of future revenue have been based on information supplied from the Ministry of Health.</td>
</tr>
<tr>
<td>Census figures indicate a growth in the population of the Bay of Plenty of between 2% &amp; 3% per annum. This exceeds the amount currently included in Ministry of Health, Statistics New Zealand and Treasury estimates.</td>
<td>Revenue is allocated using a Population Based Funding approach and this is updated as census information becomes available. Adjustments are generally made over a 2-3 year period but are not included in the Ministry of Health’s demographic adjuster estimates until they occur.</td>
</tr>
</tbody>
</table>

9.2.7 Other Revenue

Other revenue is earned from a variety of sources and is expected to continue to grow at a rate approximately equal to inflation.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOPDHB has no long term undertakings for much of this revenue.</td>
<td>The revenue has multiple sources and the risk of significant change is minimised.</td>
</tr>
</tbody>
</table>

9.2.8 Net Inter-district Flows (IDFs)

All District Health Board’s have some instances where people who are resident within a particular District Health Board’s jurisdiction receive services in other districts.

The Bay of Plenty District Health Board has significant outflows throughout the year to Auckland City Hospital, Auckland City Children’s Hospital and Waikato Hospital for tertiary services and some upper level secondary services. Outflows also occur to Lakes District Health Board for some persons resident in the Murupara/Uruwera areas who may access services at Rotorua Hospital rather than travelling to Tauranga or Whakatane hospitals. A similar inflow occurs to Tauranga Hospital for people residing in the Waihi area (which is within the Waikato District Health Board region).
The Bay of Plenty District Health Board’s major inflow is through holidaymakers over the Christmas and New Year period in particular.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>New or additional inter-district flows are identified by other DHBs.</td>
<td>There is an established national process for identification and wash-up of IDF.</td>
</tr>
<tr>
<td>Some DHBs provide services that are not prioritised for purchase by the BOPDHB.</td>
<td>Where possible efforts are made to minimise outflows to other DHBs and access criteria are agreed.</td>
</tr>
<tr>
<td>Other DHBs may no longer be able to deliver IDF volumes to Bay of Plenty residents due to change in their services or population/volume growth.</td>
<td>There is an established national process for changes to IDF.</td>
</tr>
</tbody>
</table>

### 9.2.9 Payments to Providers

Payments are made to health and disability service providers in both the Non-Government Organisation sector and the Bay of Plenty District Health Board’s own provider arm.

Bay of Plenty District Health Board allocates funding received through a Crown appropriation using a robust process to prioritise benefit against health need.

Expenditure on health & disability services within the district is expected to grow in line with long-term revenue growth. The Bay of Plenty District Health Board is committed to not expending more funding than it is allocated.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impacts of new Government initiatives may result in new services being purchased at additional cost.</td>
<td>The BOPDHB would expect to receive additional revenue to meet the additional costs associated with particular Government initiatives introduced outside the BOPDHB’s prioritisation process.</td>
</tr>
<tr>
<td>Many health and disability services can be demand driven and unmanaged increases in volumes result in increased costs.</td>
<td>Some services are purchased on a capitated, risk share or fixed basis to reduce the BOPDHB’s exposure to unexpected increases in demand driven volumes.</td>
</tr>
</tbody>
</table>

### 9.2.10 Employment Costs

The largest single cost for the Bay of Plenty District Health Board, either directly through its own Provider Arm or indirectly through the Non Government Organisation sector, is employee costs.

The Bay of Plenty District Health Board is expected to directly employ 2,349 FTE during the year ended 30 June 2012. Employee numbers are expected to grow by a small percentage each year reflecting the growth in volumes driven by demographic change and new service initiatives.

Many employee groups are now on regional or national Multi-Employer Collective Agreements.

Bay of Plenty DHB is committed to maintaining the overall cost of employee wage movements, including step increases, within the future funding increases.
<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee expectations remain high.</td>
<td>The DHB works to clearly explain the funding available to it for pay increases.</td>
</tr>
<tr>
<td>The move to national and regional MECA have made local management of cost growth difficult.</td>
<td>The DHB works to clearly explain to all parties the funding available to the DHB for pay increases. Bargaining is carried out within the Health Sector’s ‘good faith’ process. Some agreements are on a partnership basis.</td>
</tr>
</tbody>
</table>

### 9.2.11 Operating Costs

Bay of Plenty District Health Board operating costs are broken into three classifications:

- **Outsourced costs** – those costs related to parts of the services that have been outsourced or subcontracted to third parties.
- **Clinical costs** – those costs directly related to the provision of the health and disability services provided by the BOPDHB, including pharmaceuticals and consumables.
- **Infrastructural Costs** – those costs indirectly related to the provision of health and disability services by the BOPDHB, including transport, hotel services, interest, depreciation and capital charge costs.

Each classification has different imperatives around cost growth but as an average increases are expected to remain within the long-term revenue growth.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost growth expectations remain high particularly for clinical supplies.</td>
<td>National provider and supplier contracts (including NZ Blood and Pharmac) are often negotiated on a national level.</td>
</tr>
<tr>
<td>Approximately $17m of purchases are influenced, directly or indirectly, by movements in the exchange rate, the majority in relation to the United States Dollar.</td>
<td>Purchasing is in New Zealand Dollars wherever possible. Longer term contracts are used to help minimise short-term fluctuations in price. For significant items, purchased in a foreign currency, then foreign exchange hedging is considered and utilised where appropriate.</td>
</tr>
<tr>
<td>Fuel prices can have a significant impact on the running costs of more than 300 vehicles.</td>
<td>The DHB has limited ability to control the direct impact of a fuel price increase. The DHB does encourage efficient use of vehicles including carpooling.</td>
</tr>
<tr>
<td>Increases in interest rates.</td>
<td>The DHB manages interest rate risk through the use of interest rate hedging and fixed interest mechanisms if appropriate.</td>
</tr>
<tr>
<td>The capital charge rate may change.</td>
<td>No change is expected in the current year. The DHB would expect revenue to be adjusted accordingly to neutralise any change in rate.</td>
</tr>
</tbody>
</table>
9.2.12 Prospective statement of cashflows

Operating cashflows remain materially cumulatively positive throughout the forecast period.

The operating cashflow surplus along with additional equity and borrowings will be utilised for the significant capital investment currently underway at Tauranga Hospital (Project LEO) and the East Wing together with those being planned for Oral Health Services and redevelopment of the Whakatane Hospital site.

Active cash management uses excess cash balances ahead of borrowing or equity injections to delay and reduce the level of borrowing or equity injections.

### PROSPECTIVE STATEMENT OF CASHFLOWS
FOR THE THREE YEARS ENDED 30 JUNE 2012, 2013 AND 2014

<table>
<thead>
<tr>
<th></th>
<th>$m</th>
<th>Actual 2010</th>
<th>Estimate 2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating</td>
<td></td>
<td>18.0</td>
<td>25.3</td>
<td>24.0</td>
<td>25.4</td>
<td>25.8</td>
</tr>
<tr>
<td>Investing</td>
<td>(37.8)</td>
<td>(51.9)</td>
<td>(31.9)</td>
<td>(43.7)</td>
<td>(31.3)</td>
<td></td>
</tr>
<tr>
<td>Financing</td>
<td>19.5</td>
<td>21.3</td>
<td>9.4</td>
<td>20.2</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Total Cashflow</td>
<td>(0.3)</td>
<td>(5.3)</td>
<td>1.5</td>
<td>1.9</td>
<td>(0.6)</td>
<td></td>
</tr>
</tbody>
</table>

9.2.13 Prospective statement of financial position

Bay of Plenty District Health Board remains in a strong financial position, necessary to service the current and upcoming levels of borrowing required for redevelopment.

The Statement of Financial Position reflects the increased investment in the building infrastructure of the BOPDHB which is partially supported by increased borrowing, increased equity and operating cashflow.

### PROSPECTIVE STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2012, 2013 AND 2014

<table>
<thead>
<tr>
<th></th>
<th>$m</th>
<th>Actual 2010</th>
<th>Estimate 2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Assets</td>
<td>23.7</td>
<td>18.7</td>
<td>20.3</td>
<td>22.3</td>
<td>22.4</td>
<td></td>
</tr>
<tr>
<td>Current Liabilities</td>
<td>60.9</td>
<td>66.2</td>
<td>66.5</td>
<td>66.9</td>
<td>67.8</td>
<td></td>
</tr>
<tr>
<td>Working Capital</td>
<td>(37.2)</td>
<td>(47.5)</td>
<td>(46.2)</td>
<td>(44.6)</td>
<td>(45.4)</td>
<td></td>
</tr>
<tr>
<td>Term Assets</td>
<td>191.3</td>
<td>228.5</td>
<td>243.1</td>
<td>269.0</td>
<td>282.7</td>
<td></td>
</tr>
<tr>
<td>Term Liabilities</td>
<td>84.0</td>
<td>98.1</td>
<td>107.5</td>
<td>125.4</td>
<td>133.8</td>
<td></td>
</tr>
<tr>
<td>Equity</td>
<td>70.1</td>
<td>82.9</td>
<td>89.4</td>
<td>99.0</td>
<td>103.5</td>
<td></td>
</tr>
</tbody>
</table>

9.2.14 Equity and Long-Term Debt Facilities

Bay of Plenty District Health Board relies on a mix of debt and equity to fund assets utilised in the delivery of health services.

Government policy requires the Bay of Plenty District Health Board to source all long-term debt and equity from the Crown through the Crown Health Financing Agency ("CHFA"). The CHFA facilities are secured by a negative pledge.

The Bay of Plenty District Health Board is allowed to maintain a working capital facility with a trading bank. A working capital facility is thus maintained with the Westpac Banking Corporation Limited ("Westpac"), who also provides transactional banking facilities. The facility consists of a bank overdraft and revolving multi-option credit facility to a maximum
of $20 million. The Westpac working capital facility is secured by a negative pledge. Without Westpac’s prior written consent, Bay of Plenty DHB cannot perform the following actions:

- Create any security over its assets except in certain circumstances;
- Lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- Make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health;
- Dispose of any of its assets except disposals in certain circumstances in the ordinary course of business; and;
- Provide services to or accept services from a person other than for proper value and reasonable commercial items.

The Bay of Plenty District Health Board must meet a cash flow cover covenant, under which Earnings Before Interest Tax Depreciation must exceed funding costs by at least 1.75 times.

As at 31 January 2011, the Bay of Plenty District Health Board had the following borrowings:

<table>
<thead>
<tr>
<th></th>
<th>Actual 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westpac</td>
<td>$nil</td>
</tr>
<tr>
<td>CHFA</td>
<td>$87.6m</td>
</tr>
</tbody>
</table>

The commitment to the Tauranga Hospital Redevelopment Project (project LEO) and other likely infrastructure redevelopments require increased levels of borrowings and equity support. The estimated levels of borrowing and equity support required may fluctuate due to:

1. Stronger or weaker than expected financial performance;
2. Escalation of construction costs and additional compliance costs not foreseen when the business case(s) are prepared;
3. Possible new redevelopment and service configurations; and
4. The need to maintain current equipment replacement programmes.

Bay of Plenty District Health Board remains committed to minimising its reliance on additional borrowings or equity support.

Increased interest costs and capital charge costs from additional borrowings and equity support are to be affordable and must be met from within the operational budget of Bay of Plenty District Health Board.

**PROSPECTIVE ESTIMATES OF DEBT AND EQUITY AS AT 30 JUNE 2012, 2013 AND 2014**

<table>
<thead>
<tr>
<th>$m</th>
<th>Actual 2010</th>
<th>Estimate 2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term Debt</td>
<td>82.6</td>
<td>97.2</td>
<td>106.6</td>
<td>124.5</td>
<td>132.9</td>
</tr>
<tr>
<td>Equity from the Crown</td>
<td>70.1</td>
<td>82.9</td>
<td>89.4</td>
<td>99.0</td>
<td>103.5</td>
</tr>
<tr>
<td>Current &amp; Long-term debt drawn</td>
<td>17.6</td>
<td>14.6</td>
<td>9.4</td>
<td>17.9</td>
<td>8.5</td>
</tr>
<tr>
<td>Current &amp; Long-term debt repaid</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Net Equity injections</td>
<td>6.5</td>
<td>13.2</td>
<td>6.5</td>
<td>9.6</td>
<td>4.5</td>
</tr>
</tbody>
</table>

All debt is unsecured.
9.2.15 Asset Management

Bay of Plenty District Health Board maintains a long term Asset Management Plan, which delivers a strategic approach to asset maintenance, replacement and investment. The plan reflects the joint approach taken by all District Health Boards and current best practice within the health sector.

The plan itself utilises the framework identified as most appropriate by a joint-District Health Board workgroup and was based on the International Infrastructure Management Manual.

Currently the Board has allocated funding for investment in normal asset replacement and some new assets.

Project LEO, the Tauranga Campus Redevelopment Project, is outside the scope of the normal capital investment and is being funded by a combination of debt, equity and operating cashflows, including cashflows generated from efficiency and effectiveness projects as part of the process reengineering.

<table>
<thead>
<tr>
<th>$m</th>
<th>Actual 2010</th>
<th>Estimate 2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Depreciation</td>
<td>14.2</td>
<td>15.5</td>
<td>18.1</td>
<td>18.6</td>
<td>18.5</td>
</tr>
<tr>
<td>Tauranga Campus and other Strategic Regular Capital Expenditure</td>
<td>29.6</td>
<td>43.7</td>
<td>22.7</td>
<td>34.0</td>
<td>21.7</td>
</tr>
<tr>
<td>Total Capital Expenditure</td>
<td>38.6</td>
<td>52.7</td>
<td>32.7</td>
<td>44.5</td>
<td>32.2</td>
</tr>
</tbody>
</table>

9.2.16 Capital Expenditure Business Cases

The Bay of Plenty District Health Board understands that approval of the District Annual Plan is not approval of any particular business case. Some business cases will still be subject to a separate approval process that includes Ministry of Health, National Health Board and Treasury officials prior to a recommendation being made to the Minister of Health.

The Board also requires Management to obtain final approval in accordance with delegations prior to purchase or construction commencing.

Alternate Funding

As business cases are finalised for presentation to the Board or Ministry, managers will review the most appropriate financing option currently available for the particular item. This may result in items being acquired via donation or leasing options and therefore not being purchased via the capital expenditure programme.

Strategic Capital Developments

Provision has been made in the fixed asset additions for the completion of Project Leo, redevelopment of the East Wing of Tauranga hospital, Oral Health Project and Redevelopment of Whakatane hospital.

Asset Disposals

The Bay of Plenty District Health Board actively reviews assets to ensure that it has no surplus assets. No significant assets are scheduled for disposal during the plan period as a
result of being surplus. Some minor asset disposals will occur as part of the regular capital replacement programme.

**Disposal of Land**

The approval of the Minister of Health is required prior to the Bay of Plenty District Health Board disposing of land. The disposal process is a protective mechanism governed by various legislation and policy requirements.

**Revaluations**

All Land and Buildings were revalued during the year ended 30 June 2009, the next such review being due as at 30 June 2012.

The revaluation of land and buildings is not expected to produce a material change. The revaluation may add additional costs related to depreciation and capital charge in the financial year 2012/2013, and, as stated no allowance has been made. This is a risk to the commitments should it become evident that the change is likely to be material. This is not considered likely as at the date of preparation of these budgets.

**9.2.17 Procedure for buying shares**

The approval of the Ministers of Health and Finance is required prior to the Bay of Plenty District Health Board taking a shareholding interest in any entity.
9.2.18 Prospective detailed financial statements

The Prospective Financial Statements have been completed in a manner consistent with accounting policies and procedures that will be used for the annual Financial Statements. The major accounting policies are disclosed in the Bay of Plenty District Health Board’s Statement of Intent 2012/2014.

### Consolidated Statement of Prospective Financial Performance

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>$590.1</td>
<td>$611.9</td>
<td>$631.0</td>
<td>$653.8</td>
<td>$676.8</td>
</tr>
<tr>
<td>Less operating expenditure</td>
<td>$279.5</td>
<td>$281.5</td>
<td>$290.4</td>
<td>$300.6</td>
<td>$311.4</td>
</tr>
<tr>
<td>External provider expenditure</td>
<td>$283.4</td>
<td>$298.5</td>
<td>$304.9</td>
<td>$315.3</td>
<td>$326.0</td>
</tr>
<tr>
<td>Governance &amp; Funding</td>
<td>$6.2</td>
<td>$4.7</td>
<td>$4.3</td>
<td>$4.5</td>
<td>$4.7</td>
</tr>
<tr>
<td>Administration</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Taxation (may apply to subsidiaries and associates)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Operating Expenditure</strong></td>
<td>$569.1</td>
<td>$584.7</td>
<td>$599.6</td>
<td>$620.4</td>
<td>$642.1</td>
</tr>
<tr>
<td>Surplus/(Deficit) before Interest, Depreciation and Capital Charge</td>
<td>$21.0</td>
<td>$27.2</td>
<td>$31.4</td>
<td>$33.4</td>
<td>$34.7</td>
</tr>
<tr>
<td>Interest</td>
<td>$4.8</td>
<td>$6.0</td>
<td>$6.4</td>
<td>$7.3</td>
<td>$8.1</td>
</tr>
<tr>
<td>Depreciation</td>
<td>$14.2</td>
<td>$15.5</td>
<td>$18.1</td>
<td>$18.6</td>
<td>$18.5</td>
</tr>
<tr>
<td>Capital Charge</td>
<td>$3.4</td>
<td>$6.1</td>
<td>$6.9</td>
<td>$7.5</td>
<td>$8.1</td>
</tr>
<tr>
<td><strong>NET SURPLUS/(DEFICIT)</strong></td>
<td>$(1.4)</td>
<td>$(0.4)</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$0.0</td>
</tr>
</tbody>
</table>

### Consolidated Statement of Prospective Movements in Equity

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crown equity at start of period</td>
<td>$65.0</td>
<td>$70.1</td>
<td>$82.9</td>
<td>$89.4</td>
<td>$99.0</td>
</tr>
<tr>
<td>Surplus/(Deficit) for the period</td>
<td>$(1.4)</td>
<td>$(0.4)</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$0.0</td>
</tr>
<tr>
<td>Contributions from Crown</td>
<td>$6.5</td>
<td>$13.2</td>
<td>$6.5</td>
<td>$9.6</td>
<td>$4.5</td>
</tr>
<tr>
<td>Distributions to Crown</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td><strong>OPERATING CASHFLOWS</strong></td>
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<td>(43.7)</td>
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<td>Cash inflows from financing activities</td>
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### Consolidated Statement of Comprehensive Income

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<td>7.5</td>
<td>8.1</td>
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<td>631.0</td>
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<td>676.8</td>
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<td><strong>Total Comprehensive Income/(Deficit)</strong></td>
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<td>(0.4)</td>
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10 Appendices

Midland Region Clinical Services Implementation Plan

Organisational Structure

Our Outcomes Framework

Monitoring Framework Performance Measures

Glossary of Terms
Midland Region
Clinical Services Implementation Plan
2011/12

20 May 2011

Note: This plan should be read in conjunction with the draft Annual Plans of the five Midland Region District Health Boards along with their corresponding Maori Health Plans.
INTRODUCTION

The draft Clinical Services Plan (CSP) submitted to the National Health Board (NHB) describes a vision for the future of health services in the Midland Region and provides a framework for DHB planning and acting collaboratively on a regional basis. It does not prescribe radical changes in current patient flows or existing configuration of hospital services. Rather, it focuses on how the region can work together to support vulnerable services, to improve equity of access to regional services and to improve health outcomes across the region as a whole.

With the submission of the draft Midland Regional Clinical Services Plan (MRCSP) to the National Health Board, and subsequent feedback, the programme’s focus shifts to the following activities:

- Actions to commence implementation of Priority Action Areas identified in the MRCSP and other activities identified by the NHB.
- Establishment of regional governance processes.
- Working in partnership with the NHB, commence the development of a integrated Regional Service Plan (RSP) to replace the District Strategic Plans (DSPs) by 2012/13. This activity will occur concurrently with the implementation of actions outlined in this plan, so effectively the programme splits into two parts:
  - Implementation of 2011/12 operational actions; and
  - Strategic Development of more wide-ranging regional activity in 2012/13 and beyond.

CONTEXT

Regional Collaboration

There is significant collaboration in the Midland region already from a service development perspective (for instance primary care, mental health, cancer, cardiac, trauma and renal services) through to an infrastructure perspective (Information, Workforce, and Maori health). This implementation Plan prioritises the work streams either currently in train or proposed to be established, and does not cover the exhaustive range of regional clinical activity. It is first and foremost, a Plan of action around specific areas that clinicians identified in the formulation of the MRCSP as priorities for action. However, this activity is scalable and the networks established for these priority areas are able to be replicated in other service areas.

Health Targets

Due to the agreed scope in developing the MRCSP, this Plan does not have an explicit health target lens. Achievement of health targets continues to be predominantly a local activity as evidenced in the District Annual Plans, although with the implementation of the Midland Health Network Trust business case in four of the five midland regions, and EBPHA in the fifth, there is some sub-regional collaboration occurring in the improvement of immunisation and diabetes targets. This plan outlines those targets where they relate to the service areas identified (Diabetes and CVD). There is also a reference to targets in the Primary Care section of this plan.

APPROACH TO IMPLEMENTATION

Transitional Period

This document presents a realistic, achievable 2011/12 Implementation plan. It doesn’t address the broad range of strategic issues raised in the base Midland Clinical Services Plan such as aged care, diagnostics and access to outpatient sub-specialty rates, in part because some of the work to address is occurring both at a national level (aged care), sub-regional level (diagnostics) or local level (outpatients), and in part because the Midland region is realistic about it can deliver on in the 2011/12 financial period. Therefore a common issue does not necessarily need to be addressed regionally – unless there is value in doing so – and this Implementation plan summarises those areas that the DHBs have chosen for Action in 2011/12.
Significant activity on developing the strategic mid and longer term activity required to populate the 2012/13 and ultimately 2013/14 Regional Service Plans will commence as this implementation plan begins. This activity will require joined up thinking and engagement across our DHBs and the wider sector from those who fund services to those who are expected to operate and deliver them in primary, secondary and tertiary settings. To ensure funding is appropriately agreed and committed this activity needs to occur well in advance of the annual planning and budgeting cycle.

To this end, all regional activity within the scope of this programme will use robustly defined performance measures (as specified for development in the 2011/12 period) in assessing the efficiency and effectiveness of ongoing regional initiatives in 2012/13 and beyond. Furthermore, the necessary stakeholder engagement required will be initially driven from the action groups outlined in this plan.

So successful delivery of the 2011/12 implementation plan will directly impact on the quality and content of the 2012/13 RSP and DHB Annual Plans.

**Areas of Focus**

For 2011/12 the Implementation Action Plan focuses on areas where collaborative actions can lead to improved service delivery, quality and viability. The areas are split across Service Priorities and Infrastructure Priorities, as outlined in the table below.

**Table 1: Service and Infrastructure Priorities**

<table>
<thead>
<tr>
<th>Service priorities</th>
<th>Infrastructure priorities</th>
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<tbody>
<tr>
<td>Maternity Services</td>
<td>Information for Clinicians</td>
</tr>
<tr>
<td>Renal Services</td>
<td>Building the Workforce</td>
</tr>
<tr>
<td>Cardiac Services</td>
<td>Maori Health</td>
</tr>
<tr>
<td>Primary Care with an emphasis on Rural Health</td>
<td></td>
</tr>
<tr>
<td>Cancer Control</td>
<td></td>
</tr>
<tr>
<td>Mental Health Services</td>
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</table>

**Service Priorities**

Six Service Priorities have been identified as requiring regional action to improve quality and strengthen clinical services that have been identified as being vulnerable.

Clinical networks will be the primary vehicle through which change will be driven and delivered. This was one of the key areas the RCSP identified in its plan development. Clinicians noted the need for clinical networks to lead service improvement through the use of integrated patient pathways, common clinical policies, and shared clinical audit programmes. Networks would help small FTE services to develop a sustainable services plan to ensure quality and safety, with unsustainable local services transferred in a planned way to regional locations or supported regionally. The six Service Priority Areas that will be led through a strong clinical governance framework will be:

1. **Renal Services**: Disparate access issues and workforce vulnerabilities exist. Focus will be on finalising, then implementing, new models of care to strengthen the services regionally.

2. **Cardiology/cardiac services**: Disparate access issues and workforce vulnerabilities exist, with a poor interface across the continuum. The opportunity exists to make a difference to population health outcomes and inequalities through a cardiology pathway that is strongly rooted across the continuum of care from prevention through to specialist care, back out the cardiac rehabilitation. This is a combination of existing regional work on cardiology/cardiac services, additional development in new initiatives such as HeartHealth, and Better, Sooner, More Convenient Care cardiac service development programmes.
3. **Maternity Services:** Maternity services are the lynchpin of acute services in provincial areas, and obstetrics was clearly identified as a vulnerable service early in the development of this plan. There are workforce issues across maternity services, and opportunities to strengthen quality improvement activities regionally.

4. **Primary Care Services:** Because of the current transformational changes occurring in community services, and the greater focus on integration with specialist services, primary care was identified as an earlier priority area for regional action with a particular focus on rural health. There is a significant role for the sector to address issues of acute demand, improved access to chronic care services, seamless care across community services, and a greater choice for patients in how they access their health care.

5. **Mental Health Services:** The objective of this workstream is to provide optimal treatment for people with mental health conditions. As this network has existed for some time the initiative listed in this plan continue to build on earlier regional activity.

6. **Cancer Services:** The Midland Cancer Network involves cancer continuum stakeholders working across organisational and service boundaries to reduce the incidence; reduce the impact of cancer; address inequalities with respect to cancer and improve the experience and outcomes for people with cancer.

Each of the first four areas above has varying vulnerabilities which the Midland region believes can best be approached and supported through regional collaboration. The last 2 areas – cancer services and mental health services – have been incorporated into this Plan on the basis that they already form a substantive component of regional activity and hence need to be incorporated into the RCSP framework.

Each of the Service Priorities would be supported by a strong multidisciplinary clinical network with a focus on integrated patient pathways, common clinical policies, a potential shared workforce, and shared clinical audit programmes.

**Infrastructure Priorities**

To improve financial and clinical sustainability, the Midland region has chosen three infrastructure areas to focus on. Each of these areas will have their own work programme.

These are:

1. **Information for Clinicians** – this workstream will Implement the Midland region Information Services Plan. This includes:
   - Implementing regional connectivity as a first phase of the Midland Connected Health programme, allowing health service providers to exchange information and data securely.
   - Development of a Clinical Workstation Programme across the region will allow Clinicians to have access to common tools.
   - The Medications Management Programme will include agreed region configuration/architecture for ePharmacy.
   - A Clinical Data Repository with secure access to core clinical information will also be developed.

2. **Workforce** – this work stream will address the changing models of care required to meet increasing demand for health services, and address the most commonly raised issues across the region relating to recruitment, retention and future sustainability of the workforce. Workforce development activity underpins the collective response required to ensure access to quality, sustainable services across the whole region, and Midland DHBs share responsibility for planning and undertaking forward-looking action on workforce development that minimises duplication.

3. **Maori Health** – A reduction in health inequalities must remain a core focus of regional work, ensuring that DHBs pool their resources and understanding of how to reduce health inequalities, and implements a monitoring plan to ensure health inequalities are addressed at all organisational levels.
Each of these priorities will have standalone work programmes that both inter-face with the Service Priorities above, but also set a broader plan of action for improving regional infrastructure.

The development of action plans for each of the Service Priorities therefore presents an opportunity to standardise terms of reference, development process and outputs. The work-plan in each service priority areas will be informed by the work in the Infrastructure Priority areas. The same approach can then be applied to further services in the future.

**Service Change**

There is nothing in this Implementation Plan that requires a service change process, given that the focus of the Actions is on strengthening clinical networks and quality improvement initiatives in key priority areas, and not specific service reconfigurations. As the clinical networks become established and developed multi-year work programmes, service configurations may result. These issues - should they arise - will be addressed in the formation of the next iteration of the RSP.

**Elective Services**

Where there is a natural flow of service provision, the Midland region is moving towards greater integration of each DHB’s elective services. Purchasing appropriate regional volumes will allow sustainable service development.

Service development will be supported by regional referral pathways, clinical networks and consistently applied access criteria. Appropriate levels of service delivery will be supported in each DHB.

Individual DHBs will monitor the level of service provision delivered to their population. Both DHB of Domicile and DHB of Services will work together to manage referrals.

**GOVERNANCE AND DECISION-MAKING**

**Regional Principles**

A series of principles designed to facilitate regional decision-making was developed in 2009 for the MRCSP refreshing earlier work. These principles are central to effective decision making in the development and implementation of the Midland Regional Clinical Services Plan and further regional actions.

1. Regional Services will be delivered according to the following criteria:
   a. Tertiary
   b. Vulnerable
   c. More cost effective and sustainable to do regionally

2. Secondary services are provided from domicile DHBs unless an alternative delivery option is demonstrated to be the most clinically appropriate, sustainable and cost effective solution including financial and non financial transition costs. Sustainability considerations include financial, clinical and workforce considerations.

3. Waikato DHB will be the main provider of tertiary clinical services in the Midland region but individual DHB’s may have other historical arrangements.¹²

4. Tertiary clinical services should not be duplicated across the region unless development of satellite services are demonstrated to be the most appropriate sustainable and cost effective solution.

5. Corporate services should not be duplicated unless local services have demonstrated to be the most sustainable and cost effective solution.

---

¹² Over time some services currently delivered in a tertiary setting will be able to transition to a secondary setting due to advances in technology. These principles do not preclude Midland DHBs for offering these types of services in the future as the setting changes.
6. Clinical Alliances will provide evidence based clinical leadership in determining the most appropriate service configuration for the Midland region.

7. Equity of access to regional services.

8. Secondary and tertiary care is acknowledged as episodic in response to short term higher health needs. Primary and community care provides ongoing care in response to change in health needs over the course of an individual’s lifetime.

9. All DHBs will have input into the development of Regional Service Plans.

10. Funding prioritisation for local services remains a local DHB responsibility.\(^{13}\)

11. Funding prioritisation of Regional Services will be regionally determined.

**Regional Decision-Making Framework**

The framework illustrated in Figure 1 below will require terms of reference to be developed for each group including the Regional Chief Executives and Chairs Group.

**Figure 1: Regional Decision-Making Framework**

<table>
<thead>
<tr>
<th>Community Services Leadership Forum</th>
<th>Regional Steering / Leadership Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Manageral</td>
<td>• Clinical</td>
</tr>
<tr>
<td>• Programme Office</td>
<td></td>
</tr>
</tbody>
</table>

| Regional Chief Executives and Chairs Group |

| Region Maori Governance forum |

| Service Priorities |

| Infrastructure Priorities |

**Governance Structure for Work Programmes**

Individual Service Priority Groups will have a mix of people who are service-specific from a clinical perspective and managerial from a broad scope of expertise such as CIOs, GMs HR. The managerial appointments will form the core of the revised steering group that will sit above these four Service Priority Groups. As for the MRCS, membership will be across the region. Where these groups are already formed, the clinical leader has been identified in the action plan. For some services the clinical lead is a generalist such as a Chief Medical Advisor; the intention is to pass leadership onto specialists for each service wherever this is possible as the network develops. The projects are not being led by specific DHBs or Chief Executives. At stated each of the projects will be led by the Chair of the Clinical Networks – some of which are currently being established to oversee the implementation plans. Over the top of that, will sit a governance group made up of key clinical and managerial staff within DHBs and primary care.

\(^{13}\) Further discussion needs to be had on what remains a local service and what becomes a regional service.
The development of a Midland shared service agency (HealthShare) for back-office functions is progressing well through the Midland Regional Cooperation Project. An interim structure for HealthShare has been approved from 1 July and this includes a planning function to progress the current and future regional plans.

Dispute Resolution Process

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

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

OTHER KEY ISSUES

Capital

The Regional Asset Management Plan (2009) remains the central Capital Planning document for the Midland region. As the need arises to change models of care from clinical consideration of different service options, the RAMP will be updated to reflect these service changes. As the year one implementation of action plans is focussed on initial clinical engagement and evaluation of current models, there are no significant changes to the figures provided in the RAMP. The RAMP will be revised when the capital impact of any changes in service design or configuration is known.

Risk Management

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigating action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. NHB feedback requires extensive rework in a short time frame</td>
<td>CEs meeting with NHB face to face to discuss feedback and timing</td>
</tr>
<tr>
<td>2. Lack of agreement / endorsement by individual DHBs on action plans leads to only superficial changes to services</td>
<td>Continue to keep stakeholders engaged (Boards and CEs). Ensure understanding of legislative and NHB requirements. Explore sub-regional options for implementation of individual services.</td>
</tr>
<tr>
<td>3. Not enough time resources available from key individuals to develop and action any real change</td>
<td>Understand developing resource need as implementation develops and address accordingly; seek CEs/Clinical endorsement on the importance of this work.</td>
</tr>
<tr>
<td>4. Detailed plans are developed and costed but are ultimately rejected by CEs</td>
<td>Ensure the scope and TOR for each action group understood by all parties; regular progress report to CEs asking for general endorsement as workplans develop.</td>
</tr>
<tr>
<td>5. Action Plans are developed but do not have clinical endorsement</td>
<td>Ensure clinicians in each clinical service are well briefed by the group as planning develops and are given the opportunity to contribute</td>
</tr>
<tr>
<td>6. Time is wasted by ‘starting from scratch’ in developing action plans</td>
<td>The framework developed for the MRCSP is employed, clear terms of reference, experience action group members, thorough evaluation of earlier work completed on regional service plans, implementation and local vulnerable services plans (rural health)</td>
</tr>
<tr>
<td>7.</td>
<td>Implementation is unsuccessful due to financial constraints</td>
</tr>
<tr>
<td>8.</td>
<td>Proposals reached have low community acceptability</td>
</tr>
</tbody>
</table>

**Process for Monitoring and review**

A performance management framework is integral to the RCSP’s success. Every Priority Area will develop a standardised reporting framework to feedback progress against the implementation plan on a monthly basis through to the RCSP Steering Committee, and then on to CEs/Chairs. Any risk issues identified (including slippage of timeframes) will be reported through this mechanism.

**Funding implications**

Each of the workstreams may, through the process of implementing their action plans, identify projects or initiatives that may in effect require regional investment. A standardised process to ensure these funding proposals are escalated through the right channels (i.e. clinical forums, regional DHB executive forums including GM Planning and funding), and then through to the RCSP Committee will be developed.

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

This section of the report outlines our approach to monitoring our progress against implementation of this plan.

We have adopted an intervention logic perspective in order to identify how we will measure the impact of our actions on key outcome areas. Each of the action groups will be tasked with developing service specific performance measures as an early deliverable of the programme. This process will be led by the clinicians in each service area and will be informed by and aligned with any national initiatives. This will ensure the no duplication occurs and the measures developed are fit for purpose. Planned dates for this work being completed are outlined in each service action plan.

Conceptual framework

Figure 2 below shows the intervention logic model applied to our approach to implementing and monitoring the service related regional collaborative programmes.

Figure 2: Intervention logic model

Each service programme contributes to the over-arching vision for the region in accordance with the regional framework presented at figure 3 overleaf.

Overview of information provided

In the six tables following figure 3, we have described the activities that will be taken for each service priority area within specified timeframes. We identify the impact areas that each of the activities maps to and provide clear specification of how the impact will be measured.

Detailed targets will be developed in conjunction with local DHB analytical expertise for inclusion in the next iteration of this document.

We then provide an outline of key actions in relation to the three supporting infrastructure priority areas.
Figure 3: Over-arching performance framework

Midland District Health Boards: performance framework

**VISION**
- Long-term strategic direction:
  - All New Zealanders lead longer, healthier and more independent lives
  - All residents of Midland District Health Boards lead longer, healthier and more independent lives

**OUTCOMES**
- (5-10 year changes in communities or systems):
  - Improved health outcomes for the Midland population
  - Reduced disparities in health outcomes between Māori and other populations
  - Clinical and financial sustainability of the health system in the Midland region

**IMPACTS**
- (Intermediate, medium term outcomes):
  - Improved quality of clinical care
  - Improved integration of services and consistency of clinical pathways/practice
  - Improved access to services and reduced disparity in access between different population groups
  - Reduced acute demand on secondary services
  - Improved recruitment and retention of staff
  - Improved financial performance and cost effectiveness of services

**OUTPUTS**
- (Priority services, products & programmes):
  - Maternity services
  - Renal services
  - Cardiac services
  - Primary care (with emphasis on rural health)
  - Cancer services
  - Mental Health services

**ACTIVITIES**
- (Time-bound actions):
  - Establish clinical networks
  - Implement performance framework
  - Implement Better, Sooner, More Convenient business cases
  - Implement shared clinical pathways across the Region
  - Increase renal service capacity, inc development of a dialysis unit
  - Implement recommendations of the elective services cancer reviews
  - Implement Midland Regional strategic plans in relation to mental health e.g. the eating disorders strategy
  - Develop regional locum pools

Examples of activities include:
Area 1: Maternity services: Clinical Lead: Jeremy Gasson, Clinical Director Waikato DHB

Objective: Address issues associated with low critical mass in smaller DHBs, lack of measurement of clinical outcomes, and inequality of access to specialist care.

<table>
<thead>
<tr>
<th>Summary of key actions 2011/12</th>
<th>To achieve these medium term impacts...</th>
<th>To contribute to these 5-10 year outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Appointment of regional clinical network- The Action group which sits at the core of this emerging network and meets monthly commenced meeting in Mar 2011. While primary maternity services are beyond the remit of DHBs to manage and are not the driver of the vulnerability in this service, this group includes representation from both hospital based midwives and independent Lead Maternity Carers (LMCs) as they are seen as vital partners in the development of the services along with obstetricians and other clinical colleagues. If primary maternity services were devolved to DHBs we would consider this in out years. Consumer representatives will be identified and added to this group in the first quarter of the 2011/12 year.</td>
<td>The regional clinical network implements strategies to support DHBs with recruitment / retention difficulties associated with insufficient critical mass, leading to: ✓ 1: Improved recruitment and retention of maternity staff in smaller DHBs; ✓ 1ii: Improved quality and safety of maternity services through a more stable workforce, use of regional approaches to credentialing, development of integrated clinical pathways across DHBs and providers (eg management of higher risk pregnancies) and more active monitoring of performance through regional clinical audit and related activities; ✓ 1iii: Improved financial performance of maternity services associated with lower use of locums and reduced crisis management. ✓ 1iv: Create a region wide training experience for trainees allowing them to experience the opportunities available in both larger tertiary and smaller provincial facilities while remaining part of a region wide collegial network.</td>
<td>Over time these initiatives lead to: ✓ 1A: Improved clinical outcomes through safer maternity services ✓ 1B: Reduced disparity in clinical outcomes for maternity services between population groups resulting from consistent credentialing and regional clinical pathways; ✓ 1C: Improved financial and clinical sustainability of maternity services resulting from a stable workforce and measurably consistent clinical quality. ✓ 1D Retention of clinical trainees within the Midland Region reducing the reliance on Locums and IMGs.</td>
</tr>
<tr>
<td>✓ Develop a regional work programme to support the Implementation of the National Quality standards within current financial constraints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Develop regional workforce plans including midwifery within current financial constraints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Establish regional locum pool (evaluate current national initiatives first),</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Examine feasibility of staff rotations through smaller hospitals as part of RMO training. The intent is to provide a training package that ensures trainees are exposed to a wide variety of clinical tasks while providing support across the region particularly in the smaller secondary hospitals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Create a virtual resource hub containing educational material, and network member details; and in addition seek to provide common training opportunities using the training resources available across the region.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Develop a Performance Framework to measure clinical network improvements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>..to deliver these milestone outputs in 2011/12</td>
<td>...measured by...</td>
<td>...measured by...</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>✓ 1a: Regional clinical network established with Terms of Reference approved by July 2011</td>
<td>✓ 1i: Trend analysis of workforce data (against baseline 2010) e.g: no of open positions, length of time positions have been open; time to hire, turnover; length of service; &amp; IMGs, and employee satisfaction; increased attendance at CME for non-DHB employees.</td>
<td>1A and 1B: Trend analysis of clinical outcome measures such as: reductions in peri-natal and neonatal mortality and morbidity rates, including analysis by population groups and geographic areas.</td>
</tr>
<tr>
<td>✓ 1b: Regional work programme on implementation of National Quality Standards approved by Sept 2011</td>
<td>✓ 1ii: Trend analysis of clinical intervention rates (e.g. caesars, forceps, episiotomy etc); % breast feeding on discharge; hosp readmissions of mothers and babies; and analysis of Apgar scores.</td>
<td>✓ 1c:</td>
</tr>
<tr>
<td>✓ 1c: Regional workforce plan developed by Dec 2011</td>
<td>✓ 1iI: Reduced spend on locums across the region, compared with baseline from 2009</td>
<td>- Continued provision of services at outlying DHBs without safety issues</td>
</tr>
<tr>
<td>✓ 1d: Regional locum pool established</td>
<td></td>
<td>- Reduced use of locum/provisionally registered staff</td>
</tr>
<tr>
<td>✓ 1e: Decision taken regarding staff rotations through smaller hospitals and if agreed, implementation plan developed</td>
<td></td>
<td>- Cost per birth in line with national average</td>
</tr>
<tr>
<td>✓ 1f: Performance framework to measure clinical network improvements developed by Sept 2011 in alignment with those required in the National Quality and safety programme to ensure no duplication or inconsistencies arise. The action group will ensure this alignment by seeking close engagement with the team driving the national work programme. The intent is to avoid regional initiatives developing in isolation from key national initiatives.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ 1g Link in via IT colleagues at the infrastructure level with the shared maternity record project. This is already on the list of initial tasks for the action group to address and ensure clinical representation and input.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:**
- To deliver these milestone outputs in 2011/12.
Area 2: Primary Care services. Clinical representatives to be provided from each of the BSMC business case groups

**Objective:** Address issues of acute demand, achieve improved access to chronic care services, implement seamless care across community services, and provide greater choice for patients in how they access their health care.

<table>
<thead>
<tr>
<th>Area 2: Primary Care services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of key actions 2011/12</strong></td>
</tr>
<tr>
<td>✓ Implementation of BSMC primary care business cases including implementation of Integrated Family Health centres, development of new models of care to support improved child health, whanau ora, chronic care management, community services, and primary mental health.</td>
</tr>
<tr>
<td>✓ Establish a Midland Community Services Leadership Forum twice yearly for clinicians and PHOs to share developments and innovations in the implementation of BSMC.</td>
</tr>
<tr>
<td>✓ Establish a regional rural health network to share innovation across primary care providers and DHBs and to develop a prioritised Action plan to address specific rural health issues.</td>
</tr>
<tr>
<td>✓ Implement year 1 priorities from RISSP with respect to integration of primary and secondary information systems.</td>
</tr>
<tr>
<td>✓ Finalise and monitor BSMC / health Targets for: Midland Network; East Bay Primary Health Alliance; and Moeru Coalition.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To achieve these medium term impacts...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of the regional BSM is expected to lead to more cost effective models of care, and hence to:</td>
</tr>
<tr>
<td>✓ 2: Improved performance on health targets</td>
</tr>
<tr>
<td>✓ 2i: Improve workforce recruitment and retention within primary care</td>
</tr>
<tr>
<td>✓ 2ii: Improve the patient journey and integration across primary and secondary care through shared clinical pathways</td>
</tr>
<tr>
<td>✓ 2v: Reduce acute demand on secondary services by better and earlier management of long term conditions and better access to timely diagnostic services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To contribute to these 5-10 year outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over time these initiatives will lead to:</td>
</tr>
<tr>
<td>✓ 2A: Improved clinical outcomes through the development and implementation of evidence based shared clinical pathways</td>
</tr>
<tr>
<td>✓ 2B: Reduced disparity in clinical outcomes for chronic condition between population groups resulting from consistent regional clinical pathways and audit.</td>
</tr>
<tr>
<td>✓ 2C: Improved financial and clinical sustainability of primary care services resulting from a stable workforce and a primary care focused health sector.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>...measured by...</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ 2a: Midland Community Services Leadership Forum established with Terms of Reference approved by Aug 2011</td>
</tr>
<tr>
<td>✓ 2b: Regional rural health network established by Sept 2011</td>
</tr>
<tr>
<td>✓ 2c: Implement Y1 primary care priorities from RISSP by Jul 2012</td>
</tr>
<tr>
<td>✓ 2d: Quarterly throughout 2011/12.</td>
</tr>
<tr>
<td>✓ 2i. Achievement of planned improvements in health targets (see target table)</td>
</tr>
<tr>
<td>✓ 2ii: Achievement of target GP: population ratios</td>
</tr>
<tr>
<td>✓ 2iii: Development shared clinical pathways.</td>
</tr>
<tr>
<td>✓ 2iv: Reduced COPD, CHF and respiratory admissions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>...measured by...</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ 2A and 2B: Trend analysis of clinical outcome measures such as: ambulatory sensitive hospitalisations, including analysis by population groups and geographic areas.</td>
</tr>
<tr>
<td>✓ 2C: Reduced use of locum/provisionally registered staff, and lower IMG ratios</td>
</tr>
</tbody>
</table>
**Area 3: Cardiac services. Clinical Lead: Gerry Devlin, Clinical Director Waikato DHB**

**Objective:** The opportunity exists to make a difference to population health outcomes and inequalities through a cardiology pathway that is strongly rooted across the continuum of care from prevention through to specialist care, back out the cardiac rehabilitation.

<table>
<thead>
<tr>
<th>Area 3: Cardiac services</th>
<th>Summary of key actions 2011/12</th>
<th>To achieve these medium term impacts...</th>
<th>To contribute to these 5-10 year outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Appointment of a regional clinical cardiac network and terms of reference to oversee the Implementation Plan</td>
<td>The regional network drives change across the continuum, with an emphasis on measurement against best practice, leading to:</td>
<td>Over time these initiatives lead to:</td>
<td></td>
</tr>
<tr>
<td>✓ Implement the recommendations of three BSMC business cases for improving management of cardiac disease that will focus on:</td>
<td>✓ 3. Increased access to cardiac risk assessment and risk modification services in primary care</td>
<td>✓ 3A: Reduced incidence of Cardiovascular disease through Primary Prevention</td>
<td></td>
</tr>
<tr>
<td>- Improving access to screening, assessment, diagnosis and treatment services for people with Cardiovascular Disease</td>
<td>✓ 3i. Changes in referral and management approaches to bring them closer to evidence based practice (through the development, implementation and audit of shared regional clinical pathways across primary and secondary care)</td>
<td>✓ 3B: Reduced incidence of Cardiovascular disease through Secondary Prevention</td>
<td></td>
</tr>
<tr>
<td>- Implement integrated Clinical Pathways / Guidelines for people with Cardiovascular Disease or at risk of developing Cardiovascular Disease across primary and secondary services</td>
<td>✓ 3ii. Reduced inequity of access to cardiac tertiary services</td>
<td>✓ 3C: Improve patient cardiac outcomes</td>
<td></td>
</tr>
<tr>
<td>- Develop service delivery alternatives and innovations for people who are at risk, disengaged or who have significant barriers to services</td>
<td>✓ 3v. The ability to monitor our improvements both clinically and financially</td>
<td>✓ 3D: Reduced cardiac mortality</td>
<td></td>
</tr>
<tr>
<td>- Reduce inequity and improve access to tertiary coronary services through: annual monitoring of intervention rates; implementation of regionally agreed protocols; increased funding to meet national equity targets; and improved equity of access to effective cardiac rehabilitation services.</td>
<td>✓ 3E: Reduced disparity in clinical outcomes between population groups resulting from consistent regional clinical pathways and clinical audit against those pathways</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Develop a Performance Framework to monitor service improvements</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
...to deliver these milestone outputs in 2011/12

- 3a: regional cardiac network established by July 2011
- 3b: BSMC business case recommendations implementation commenced by June 2012
- 3c: implement a coordinated approach to equitable access to tertiary coronary services by June 2012
- 3d: Develop a performance framework by October 2011
- 3e: deliver the ACS project before 30 June 2012 to allow it to inform the discussion as to future service configuration.

Key objectives are:

- To develop coherent regional clinical cardiac governance processes
- To address efficiency issues in getting secondary patients in the region into tertiary care
- To address equity of access and prioritise implementation approaches on districts with poorest access
- Determine the secondary and tertiary providers capacity, potential efficiency gains and develop approaches to maximise use of existing resources across the region
- To determine measurement indicators that demonstrate effectiveness of deliverables/products of project
- To determine cost implications and funding streams if capacity needs to increase
- Link with the Heart Health pilot – in Lakes and Tairawhiti DHBs

...measured by...

- 3i: DHBs meet their DAP 2011/12 health targets with respect to CVD and diabetes (see table below)
- 3ii & iii: trend analysis of changes in referral patterns.
- 3iv: Development, implementation and monitoring of measures of service improvement to drive 2012/13 RSP & out year accountabilities.

...measured by...

- 3A-E: Trend analysis of clinical outcome measures such as:
  - Age adjusted CVD risk scores
  - CVD morbidity and mortality rates
  - Rates by geographic and ethnic group
<table>
<thead>
<tr>
<th>Regional Volumes - Vulnerable Services</th>
<th>Unit of Measure</th>
<th>Actual 2008/09 Volumes</th>
<th>TOTAL 2008/09</th>
<th>Planned 2011/12 Volumes</th>
<th>TOTAL 2011/12</th>
<th>Planned Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiac</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiology Inpatient Discharges - Acute</td>
<td>Discharge</td>
<td>1,664</td>
<td>227</td>
<td>90</td>
<td>3,184</td>
<td>5,509</td>
</tr>
<tr>
<td>Cardiology Inpatient Discharges - Elective</td>
<td>Discharge</td>
<td>291</td>
<td>159</td>
<td>75</td>
<td>275</td>
<td>441</td>
</tr>
<tr>
<td>Cardiology - 1st attendance</td>
<td>Attendance</td>
<td>581</td>
<td>329</td>
<td>50</td>
<td>550</td>
<td>1,246</td>
</tr>
<tr>
<td>Cardiothoracic - Inpatient Services (DRGs) - Acute</td>
<td>Discharge</td>
<td>3</td>
<td>40</td>
<td>17</td>
<td>23</td>
<td>165</td>
</tr>
<tr>
<td>Cardiothoracic - Inpatient Services (DRGs) - Elective</td>
<td>Discharge</td>
<td>7</td>
<td>38</td>
<td>17</td>
<td>21</td>
<td>113</td>
</tr>
<tr>
<td>Cardiothoracic - 1st attendance</td>
<td>Attendance</td>
<td>58</td>
<td>25</td>
<td>10</td>
<td>26</td>
<td>121</td>
</tr>
<tr>
<td>Cardiothoracic - Subsequent attendance</td>
<td>Attendance</td>
<td>38</td>
<td>17</td>
<td>3</td>
<td>6</td>
<td>145</td>
</tr>
</tbody>
</table>
Area 4: Renal services. Clinical Lead Tom Watson, Chief Medical Advisor

Objective: Develop & implement new facilities and new models of care to address disparate access and workforce vulnerability issues.

### Area 4: Renal services

<table>
<thead>
<tr>
<th>Summary of key actions 2011/12</th>
<th>To achieve these medium term impacts...</th>
<th>To contribute to these 5-10 year outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Appointment of a regional clinical renal network and terms of reference to lead renal service development, and in particular to:</td>
<td>✓ The clinical leadership and clinical governance provided by the network will:</td>
<td>Over time these initiatives lead to:</td>
</tr>
<tr>
<td>- Develop and implement shared clinical protocols and pathways to improve the primary and secondary care interface</td>
<td>✓ Increase renal service capacity (physical and workforce)</td>
<td>✓ 4A: Improved <strong>clinical outcomes</strong> through optimal treatment of early stage renal disease and management of fully developed disease -- resulting in increased life expectancy for renal patients</td>
</tr>
<tr>
<td>- Develop a Performance Framework to establish clinical network gains</td>
<td>✓ Improve access to services across the region with higher intervention rates for renal services than in previous periods</td>
<td>✓ 4B: <strong>Reduced disparity</strong> in clinical outcomes for renal services between population groups and DHB areas</td>
</tr>
<tr>
<td>✓ Improve regional capacity to treat patient with renal disease, and address local capacity issues by:</td>
<td>✓ Reduce within region disparities in access to renal services</td>
<td>4C Piloting of more <strong>cost effective</strong> treatment options -- such as supported dialysis.</td>
</tr>
<tr>
<td>- Implementing new in centre dialysis services at Waikato Hospital, including development of a new dialysis unit</td>
<td>✓ Result in more integrated approaches to best practice across primary and secondary care -- particularly in relation to treatment of early renal disease in primary care settings.</td>
<td></td>
</tr>
<tr>
<td>- Establishing a new incentre dialysis service at Whakatane Hospital</td>
<td>✓ Enable monitoring of actual performance against guidelines</td>
<td></td>
</tr>
<tr>
<td>✓ Manage current capacity issues through the trial of alternative forms of supported dialysis in Whakatane and then at Tairawhiti</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

...to deliver these milestone outputs in 2011/12

- 4a: Regional clinical network established with Terms of Reference approved by October 2011.
- 4b: Develop shared clinical management protocols by July 2012.
- 4c: Performance framework to measure clinical network improvements developed by January 2012.
- 4d: New Waikato facility developed by Dec 2011.
- 4e: New Whakatane facility developed by June 2012.

...measured by...

- 4i: Increase in regional in centre dialysis stations from x to y
- 4ii: Increase in numbers of patients receiving dialysis from x to y
- 4iii: Reduce disparities in access -- bringing Tairawhiti and Whakatane closer to regional mean (see table below)
- 4iv: Ability to show compliance with agreed clinical pathways

...measured by...

- 4A: time on dialysis to death
- 4B: trend analysis of clinical outcomes between population groups
- 4C: cost of renal services per person relative to national average.
### Regional Volumes - Vulnerable Services

<table>
<thead>
<tr>
<th>Renal Medicine - Inpatient Services (DRGs) - Acute</th>
<th>Unit of Measure</th>
<th>Actual 2008/09 Volumes</th>
<th>Actual 2008/09</th>
<th>Planned 2011/12 Volumes</th>
<th>Planned 2011/12</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge</td>
<td>BOP</td>
<td>Lakes</td>
<td>Tairawhiti</td>
<td>Taranaki</td>
<td>Waikato</td>
<td></td>
</tr>
<tr>
<td></td>
<td>44</td>
<td>129</td>
<td>46</td>
<td>28</td>
<td>569</td>
<td>816</td>
</tr>
<tr>
<td></td>
<td>208</td>
<td>94</td>
<td>67</td>
<td>32</td>
<td>630</td>
<td>1,031</td>
</tr>
<tr>
<td>Elective</td>
<td>Discharge</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>31</td>
<td>47</td>
</tr>
</tbody>
</table>

| Renal Medicine - 1st attendance Attendance     |                  |                        |               |                        |                |          |
|                                                 | Attendance       | 200                    | 59            | 44                     | 144            | 302      | 750      |
|                                                 |                 |                        |               |                        |                |          |
| Renal Medicine - Subsequent attendance Attendance |                  | 774                    | 454           | 309                    | 1,193          | 2,301    | 5,030    |
|                                                 |                 |                        |               |                        |                |          |
| Renal Medicine - Recurrent home based CAPD Clients |                  | 687                    | 293           | 1                      | 293            | 1,056    | 2,329    |
|                                                 |                 |                        |               |                        |                |          |
| Renal Medicine - Recurrent home based Haemodialysis Clients |                  | 18                     | 14            | 8                      | 13             | 64       | 118      |
|                                                 |                 |                        |               |                        |                |          |
| Renal Medicine - CAPD Training Clients          |                  | 219                    | 186           | 0                      | 50             | 415      | 870      |
|                                                 |                 |                        |               |                        |                |          |
| Renal Medicine - Haemodialysis Training Clients |                  | 2                       | 2             | 0                      | 0              | 9        | 13       |
|                                                 |                 |                        |               |                        |                |          |
| Renal Medicine - Incentre Haemodialysis Attendance |                  | 2,134                  | 1,807         | 227                    | 5,364          | 15,198   | 24,729   |

<table>
<thead>
<tr>
<th>Planned Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>26%</td>
</tr>
<tr>
<td>81%</td>
</tr>
<tr>
<td>7%</td>
</tr>
<tr>
<td>-1%</td>
</tr>
<tr>
<td>33%</td>
</tr>
<tr>
<td>-2%</td>
</tr>
<tr>
<td>6%</td>
</tr>
<tr>
<td>132%</td>
</tr>
<tr>
<td>4%</td>
</tr>
</tbody>
</table>
## Area 5: Cancer services

**Clinical Lead:** Dr Charles de Groot, Clinical Director

**Objective:** Implement collaborative action to reduce the incidence and impact of cancer, and to reduce outcome disparities between population groups and DHBs

### Summary of key actions 2011/12

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Implement first stages of the Midland Radiation Oncology Services Plan 2010-2020</td>
</tr>
<tr>
<td>✓ Complete development of Midland Medical Oncology Plan</td>
</tr>
<tr>
<td>✓ Support Tairawhiti DHB tertiary cancer review findings</td>
</tr>
<tr>
<td>✓ Implement recs of lung cancer elective service review</td>
</tr>
<tr>
<td>✓ Implement recs of bowel cancer elective service review</td>
</tr>
<tr>
<td>✓ Implement 1st stages of Midland Palliative Care Services Plan</td>
</tr>
<tr>
<td>✓ Implement infrastructure recs to improve access to MDMs</td>
</tr>
<tr>
<td>✓ Host national lung cancer work group developments, incl lung cancer service framework and standards for MD teams</td>
</tr>
</tbody>
</table>

### To achieve these medium term impacts...

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ 5i. Ensure timely access to radiotherapy</td>
</tr>
<tr>
<td>✓ 5ii. Ensure timely access to medical oncology and chemotherapy treatment and develop capability for oncology indicator audit</td>
</tr>
<tr>
<td>✓ 5iii. Streamline Tairawhiti DHB cancer patient journey</td>
</tr>
<tr>
<td>✓ 5iv. Streamline lung cancer journey to improve timeliness and increase multidisciplinary (MD) involvement</td>
</tr>
<tr>
<td>✓ 5v. Streamline bowel cancer journey to improve timeliness and increase MD involvement</td>
</tr>
<tr>
<td>✓ 5vi. Increased provider compliance with the Liverpool Care Pathway</td>
</tr>
</tbody>
</table>

### To contribute to these 5-10 year outcomes

Over time these initiatives lead to:

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ SA: Improved clinical outcomes through more timely access to best practice therapies.</td>
</tr>
<tr>
<td>✓ SB: Reduced disparity in clinical outcomes through the use of consistent pathways and measurement of compliance with key process steps.</td>
</tr>
<tr>
<td>✓ SC: Improved financial sustainability through earlier detection and greater multi-disciplinary involvement leading to more evidenced based treatment decisions and better cure rates.</td>
</tr>
</tbody>
</table>

### To deliver these milestone outputs in 2011/12

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ 5a: Meet Cancer work-plan timelines – see attachment below</td>
</tr>
<tr>
<td>✓ 5b: Refer to the Midland Cancer Network 2011-12 Work Plan for detail relating to key actions outlined above. The work plan aligns with the Midland Cancer Network Strategic Plan 2009-2014 and the National Cancer Work Programme priorities</td>
</tr>
<tr>
<td>✓ 5c: 100% patients requiring radiotherapy treated within 4/52</td>
</tr>
<tr>
<td>✓ 5d: 100% patients requiring chemotherapy are treated within 4/52 from decision to treat</td>
</tr>
<tr>
<td>✓ 5e: Number TDH patient journeys involving &gt;2 providers.</td>
</tr>
<tr>
<td>✓ 5f: Lung cancer compliance rates:</td>
</tr>
<tr>
<td>- % lung patients achieve 2/52 wait - receipt initial referral to FSA</td>
</tr>
<tr>
<td>- % lung cancer patients that achieve 62 day wait – receipt of initial referral to first anticancer treatment</td>
</tr>
<tr>
<td>- % lung cancer patients presented at MD meeting</td>
</tr>
<tr>
<td>✓ 5g: Bowel cancer compliance rates:</td>
</tr>
<tr>
<td>- % colonoscopy Cat1&amp;2 referrals that receive procedure within 2 or 6 weeks</td>
</tr>
<tr>
<td>- % bowel ca patients that meet 28 wait from diagnosis to first anticancer treatment</td>
</tr>
<tr>
<td>- % bowel cancer patients presented at MD meeting</td>
</tr>
<tr>
<td>✓ 5h: 85% targeted sites implemented Liverpool Care Pathway</td>
</tr>
</tbody>
</table>

### ...measured by...

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ 5a: 5 year survival rates for lung cancer, colorectal cancer, breast cancer and prostate cancer</td>
</tr>
<tr>
<td>✓ 5b: Reduced difference in survival rates between DHBs</td>
</tr>
<tr>
<td>✓ 5c: Cost of cancer care versus NZ norms (age, gender and ethnicity adjusted)</td>
</tr>
</tbody>
</table>
**Area 6: Mental health Services.** Clinical Lead: Eseta Nonu-Reid, Programme Director

**Objective:** Provide optimal treatment for people with mental health conditions.

### Area 6: Mental health services

#### Summary of key actions 2011/12

- Continue to implement the Midland Regional Eating Disorders Strategic Plan 2009-2015
- Commence implementation of the Midland Co-existing Problems Strategic Plan 2010-2015
- Commence Midland Mental Health and addiction Needs Assessment
- Continue to progress the Midland Mental Health and Addictions Workforce Development Strategic Plan 2011-2014
- Implement child and youth continuum of care project

#### To achieve these medium term impacts...

- 6: Midland consumers with eating disorders have access to specialist eating disorder services and are not placed inappropriately in mental health acute units.
- 6i: Consistent regional approach to management of coexisting disorders
- 6ii: Programmes better tailored to meet consumer needs in relation to addictions
- 6v: Develop a more sustainable clinical workforce by 2014
- 6x: Children and youth receive best practice treatment without being dislocated from family

#### To contribute to these 5-10 year outcomes

- 6A: Reduced impact of eating disorders on Midland population
- 6B: Reduced impact of coexisting disorders on Midland population
- 6C: Reduced prevalence of alcohol and drug related conditions / less harm associated with A&D conditions
- 6D: Reduced waiting time for access to services (associated with a stable workforce)
- 6E: Reduced impact of childhood mental health issues on Midland population

#### ...to deliver these milestone outputs in 2011/12

- 6a: Clinical pathways agreed with Auckland Regional Eating Disorders service, Thrive residential service, and & Starship Hospital by June 2012
- 6b: National CEP training is co-ordinated, delivered and evaluated in each Midland district, and regional agreement reached on CEP levels of competencies by Dec 2011
- 6c: Utilisation tables are refreshed to include NGO PRIMHD data by June 2012
- 6d: 100% achievement of 2011 - 12 workforce development objectives
- 6e: SLA agreed with ADHB family unit, and alternatives to Child Youth inpatient beds being provided out of area identified by December 2011

#### ...measured by...

- 6: Eating disorders: access rate for Midland DHB patients against budgeted funding
- 6i: Comparable access criteria applied regionally
- 6ii: Information on addiction needs available to inform service response
- 6v: reduced staff turnover and decrease in vacant roles.
- 6x: % reduction in the number of Midland DHB young people (17 years and under) admitted to adult mental health inpatient units

- 6 A ,B, C: Trend analysis of admissions and LOS for each condition
- 6D: Trend analysis of waiting times to access services
- 6E: Reduced numbers of bed days of children and adolescents in out of region specialist units.
INFRASTRUCTURE PRIORITY AREAS

Infrastructure priority one: Information systems

Objective: To deliver an integrated shared care solution across primary and secondary health care providers in the Midland region by 30th June 2014.

The Midland Region Information Services Plan (MRISP) was developed concurrently with the MRCSP and consequently the two documents are aligned. The MRISP supports the Midland Region Clinical Services Plan (MRCSP), the National Health IT Plan, the Midland Better Sooner More Convenient (BSMC) initiatives and the clinical and business service needs of the region over a four year period.

The MRISP describes the core components and work streams, and their associated initiatives, which will be required to achieve the stated shared care goal. While revised structures and processes in the sector are still emerging, the MRISP outlines at a high level the activities and the priorities of those activities, to be carried out, noting that specific funding, workforce capability and business process decisions will be required for a successful implementation and delivery of the business and clinical benefits. The detail of these decisions and the processes to achieve them will be refined and further developed as specific solutions are agreed.

The MRISP supports the Clinical Services Plan in three areas. Firstly, it supports the collective activities defined for each of the six focus areas; secondly, it supports the priority services identified within the plan; and lastly it develops the regional IT infrastructure required.

These activities are described in the Future Vision section of the “Providing robust information for clinicians” focus area within the MRCSP (section 5.5), with initial focus as follows:

- A shared repository of laboratory tests
- A shared repository of clinical events, such as radiology records
- Full implementation of a regional electronic discharge and referral protocol
- Support for common development of clinical pathways across the region
- Decision support systems
Sharing of records between primary care and secondary care
Development of a clinician led oversight group to ensure that progress is made

- Over the medium term (five years) – four DHBs will be using same product (ISoft)
- Efforts must be made to explore the integration between hospitals and primary care, and development of a single clinical workstation is a strong possibility.
- There is a single point of co-ordination and articulation of priorities, with appropriate regional resourcing for health information projects

Implementation of the MRISP is achieved through six programmes of work.

- Clinical Data Repository Programme
- Clinical Workstation Programme
- Medications Management Programme
- Integrated Patient Care Programme
- Business Intelligence Programme
- Midland One Health Programme

Each of these programmes of work has defined goals that support the Midland IS Goal. The link from the regional clinical services and national IT visions, to the June 2014 Midland IS Goal and the supporting programmes of work can be represented as shown in the schematic below.
National Health IT Plan
To achieve high quality health care and improve patient safety, by 2014 New Zealanders will have a core set of personal health information available electronically to them and their treatment providers regardless of the setting as they access health services.

Midland Clinical Services Plan: Future vision for 2021
A: All health practitioners will have online access to the clinical records that they need
B: There will be a shared desktop and a shared repository of electronic health records.
C: Mobile access will be taken for granted
D: Privacy safeguards and audits will be in place, but will not restrict access for clinical purposes.
E: Future changes to information systems will be rolled out evenly across all DHBs
F: Comprehensive implementation of a patient management system to support shared care
G: The "one health" vision in Connected Health will have been achieved and refined.
H: Videoconference and other telehealth facilities to support home based and rural health services.
I: Information and systems will be in place to support priority services
J: Shared databases are in place to support analysis and reporting of outcome measures.

Midland IS Goal
An integrated shared care solution across primary and secondary health care providers in the Midland region by 30th June 2014

Midland One Health Goal
All users can collaborate, contribute and consume information services in a trusted and secure environment.

Clinical Data Repository Goal
All health practitioners have timely access to core clinical information.

Clinical Workstation Goal
Standard user interface for access to clinical information and tools defined and being rolled out across Midland.

Integrated Patient Care Goal
Integrated patient care solution rollout in progress within the region.

Business Intelligence Goal
Access to a core set of information and standard reports for effective planning and management of health services are utilised across Midland.

Clinical Data Repository Goal
Support for standards that provide NZers access to their core health information.

Medications Management Goal
Standardised Medication Management systems implemented across the region.
Specific MRISP Goals

By June 30th 2012 we will have:

- Regional access to laboratory results, discharge summaries, referrals, medications and primary care information related to priority services.
- A hospital pharmacy system, based on a regional configuration, implemented in all Midland DHBs.
- Electronic referrals and discharges implemented across the region.
- A secure and trusted data network “Midland Connected Health” linking 98 health service sites in the region and 90% of health service delivery locations through high speed broadband and/or mobile connections.
- A single login for users of the regional IT services delivered through Midland Connected Health.

By June 2014 we will have:

- Regional access to clinical data extended to a full set of core clinical information including radiology reports and images, clinic letters, other diagnostic results and other patient documentation.
- A standard regional Clinical Workstation user interface for access to all clinical information and tools is defined and being rolled out across Midland.
- An integrated medication management solution implemented across the region.
- DHB and Primary Care managers, analysts and clinicians with access to information and tools to support health service planning and management.
- A secure and trusted data network ‘Midland Connected Health” linking all health service sites in the region.
- The ‘One Health’ environment where all users can collaborate, contribute and consume information services with each other in a secure and trusted environment.

A single login capability, aligned with national standards, available for users across a wider set of systems in Midland region.

The workplan, which has already commenced in the 2010/11 Financial Year, is outlined in the following table:
**Infrastructure priority two: Maori Health: Led By Midland GMs Maori Health**

**Objective:** reduce or eliminate health disparities between Maori and non-Maori.

Maori in the Midland region have much higher mortality rates at all ages than non-Māori. There are financial as well as social justice imperatives to achieve parity of health outcome for Māori. If Māori moved to the same utilisation rates as Non-Māori, the region would see a reduction of about 7% of caseweights below the levels otherwise expected. The capitalised value of this health gain is $600 to $700 million over ten years.

Health services may not in themselves be able to eliminate the gap, but decisive regional action in the following areas can have a major impact on health disparities:

- Ensure that Māori/Iwi actively participate in decision making at all levels of regional clinical service planning, funding, projects, initiatives, service delivery and monitoring;
- Support the development of a regional clinical services action plan for Māori health. Improve Māori access to cardiovascular risk assessment and treatment;
- Reduce Māori smoking rates;
- Pilot Whānau Ora programmes focusing on Mothers and babies and long term conditions, in alliance with the Māori PHO Coalition; and
- Invest in kaupapa Māori primary care services within the Midland region.

For 2011/12, Maori Health Plans have also been developed at a local level. While the targets contained within those documents are locally focussed, the aims outlined above are incorporated within them. The Midland DHBs are already working together in areas such as tobacco control, and Maori mental health. The indicators listed below represent further areas of collaboration.

<table>
<thead>
<tr>
<th>Regional Priority</th>
<th>Indicators</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| Cardiovascular disease | Number of tertiary cardiac interventions | 1. Despite higher burden of mortality and morbidity from CVD Māori do not access tertiary interventions at a higher rate.  
2. Access to tertiary cardiac services is constrained by distance; utilisation may be lower for DHBs which are more distant from Waikato Hospital. |
| | Acute rheumatic fever hospitalisations (6 monthly) | 1. Both initial and recurrent episodes of ARF affect Midland DHB Māori at high rates.  
2. Economies of scale in ARF prevention and management interventions can be achieved by working collaboratively across the multiple DHBs.  
3. The Public Health Unit serving BOPDHB and Lakes DHB has overseen the implementation of several ARF initiatives; the resources, knowledge, and results of these initiatives are transferable into neighbouring DHBs. |
### Infrastructure: Maori Health

#### Summary of key actions 2011/12

- Ensure Mi\(\text{ā}\)ori actively participate in the Midland Region clinical governance group.
- Report against the ongoing implementation of “Kia ora Hauora”, the Midland region Mi\(\text{ā}\)ori health workforce development initiative.
- Commission from the cardiology network in conjunction with the primary care advisory group, a costed regional strategy to achieve CVD screening of 90% of the high need population within 5 years. 2010/11 Quarter 2 results for Midland are:
  - Waikato: 64%
  - Lakes: 67%
  - Bay of Plenty: 57%
  - Tairawhiti: 66%
  - Taranaki: 56%
- Develop a costed plan to reduce, over 10 years, Midland Mi\(\text{ā}\)ori smoking rates to non-Mi\(\text{ā}\)ori rates.
- Establish an alliance contract or memorandum of agreement with the Mi\(\text{ā}\)ori PHO coalition to trial Whanau Ora priority programmes (mothers and babies and long term conditions).
- Inclusion of Mi\(\text{ā}\)ori health outcome indicators in clinical TORs.
- Report to the Midland Region Iwi Governance Group against performance in relation to regional clinical service targets, outcomes or indicators that relate to Mi\(\text{ā}\)ori health gain.

#### To achieve these medium term impacts...

- Mi: Increased numbers of Maori in clinical roles.
- Mi: Increased Maori CVD screening rates.
- Mi: Increased investment in kaupapa Maori primary care services in the region.
- Mi: Whanau ora programmes achieve programme outcomes related to mothers & babies and long term condition management.
- Mi: Routine focus on Maori clinical outcomes in clinical reporting.
- Mi: Increased accountability for health disparities.

#### To contribute to these 5-10 year outcomes...

- Over time these initiatives will lead to Maori having the same (or similar) life expectancy and hospital use pattern as non-Maori, resulting in improved health and reduced hospital spending.

#### ...to deliver these milestone outputs in 2011/12

- Refer to local DAPs for specific milestones and timelines.

#### ...measured by...

- Mi: Maori as % of the Midland health workforce.
- Mi: CVD screening rates.
- Mi: Maori smoking rates.
- Mi: Presence of Maori primary care services.
- Mi: Whanau ora programme evaluations.
- Mi: Maori health inclusion in routine reporting.

#### ...measured by...

- Trend analysis of Maori versus non-Maori life expectancy, morbidity and mortality.
Infrastructure priority three: Workforce: Clinical Leader: Ross Lawrenson, chair of Midland Training Network

Objective: Establish a Midland Training network to facilitate establishment of a suitably qualified workforce to meet regional service delivery needs.

Initial Priorities for the Midland Training Network:

- Develop a Midland Workforce plan as outlined in the MRCSP
- Establish a regional workforce hub (PGY1/2 and GP)
- Identify and co-ordinate priority regional activities (will assess MRCSP service priority areas for early development opportunity
- Develop a plan to target recruitment and retention of RMOs.
- Aim to improve recruitment to GP roles
- Ensure systems in place to collect regional workforce data

Specific milestones for 2011/12 are:

Regional training networks (Midland Training Network)

The planned model will feature four postgraduate training networks, covering the upper, central and lower North Island and the South Island. These training networks will be virtual bodies - collaborative ventures bringing together employers, education providers and professional bodies, facilitated and overseen by HWNZ. The training networks will take a co-ordinating and integrating role to support effective health professional training from novice to expert. The end benefit of the networks is a suitably qualified workforce to meet regional and national service delivery needs.

A Midland Region Training Network (formerly Hub) plan for 2011/12 has been developed and reviewed by Health Workforce NZ.

Performance Measures will include:

- Attraction and retention of House Officer year 1 and 2 doctors within the region
- Sufficient numbers of House officer year 2 doctors entering General practice.

As each of the Service Areas contains a workforce component, strong linkages between these groups and regional workforce need to be established from the outset. The Chair of the Midland Training Network will sit as part of the programme Steering group to ensure close alignment and appropriate prioritisation of work plans as this activity develops.
1.1 Organisational Structure
1.2 Our Outcomes Framework

Government Priority (NZ Health Strategy)
Population Health Outcome:

We will know this is happening when:
- People are healthy, able to self manage and live longer
- People who are at health risk are diagnosed & managed earlier
- People with early chronic conditions are managed to minimise illness progression
- People with chronic conditions receive coordinated care to reduce premature disability and death
- People and their whanau with end stage conditions are supported to live and die well
- People needing public health care receive it in a better, sooner, more convenient way
- People have confidence in the public health care system

Good Health and Wellbeing for all New Zealanders throughout their lives

To achieve that outcome we must focus on:

1.2.1 Child & Youth
Healthy Start, Healthy Learning and Play

1.2.2 Health of Older People
Healthy, independent and dignified aging

1.2.3 Hospital and Specialist Services
Timely, effective, quality care treatment and support

1.2.4 Long Term Conditions
Reducing the burden of chronic conditions

1.2.5 Primary Health
Promoting health, preventing disease, providing early diagnosis, treatment and care

1.2.6 Mental Health and Addictions
Partnerships in recovery

1.2.7 Public Health
To inform and prevent

1.2.8 Maori Health
Enhancing health and supporting aspirations for determination and control over Maori health and wellbeing

1.2.8 Maori Health
Enhancing health and supporting aspirations for determination and control over Maori health and wellbeing
1.2.1 Child & Youth Health

Population health outcomes:
- More babies are born healthy
- Health barriers to learning and play are minimised

We will know this is happening when:
- Baby birth weights are in normal ranges
- The incidence of preventable childhood disease is reducing

To achieve these outcomes we will focus on:
- Oral Health: Improving self confidence, removing barriers to healthy nutrition
- Birth & Motherhood: Setting the scene, delivering & supporting a healthy mother and baby
- Childhood Immunisation: Reducing the incidence of preventable childhood diseases
- Sexual health: Supporting informed consent and reducing the incidence of sexually transmitted disease
- Paediatric secondary services: Culturally appropriate, timely paediatric care

Screening: Opportunity is taken to identify and reduce barriers to a healthy lifestyle
Key impacts:
Children and youth will have:
- Better nutrition through better oral function
- Improved oral hygiene
- Improving access over time a fluoridated water supply

Oral Health
Improving self-confidence, removing barriers to healthy nutrition

We will know this is happening when:
- Consumption of sugar-based drinks is decreased
- Breastfeeding rates are increased
- All children understand and implement correct oral hygiene measures
- An increasing number of communities and local authorities wish to pursue fluoridation
- There is a reduction in the number of decayed, missing or filled teeth
- Increase the percentage of children who are caries free

To achieve these impacts we must provide these services groups

School based dental services
Improving oral health in school age children

Adolescent dental services
Improving oral health in adolescents

Specialist dental services
Oral surgical services

We will know these services are effective when:
- All schools and pre-schools are ‘water only’
- All parents are aware of healthy nutrition practices for children
- Oral hygiene messages are consistent, visible and targeted
- Information and support is provided to communities who wish to promote fluoridation

By purchasing these outputs:

School based dental services
- School based dental visits
- Special dental services for children and adolescents

Adolescent dental services
- Adolescent dental visits
- Basic dental care for adult mental health consumers in residential care
- Administration of adolescent dental health services

Specialist dental services
- Emergency dental care for low income adults
- Orthodontic services for children of low income families

We will know these outputs are delivered successfully when:
- Expected service volumes are met
- Service specifications are met
- Service coverage targets high need populations
Key impacts:
Expectant mothers will:
• Be well informed and supported
• Have health conditions identified early
• Have referrals made to appropriate support agencies
• Receive immunisation and breastfeeding support

Birth and motherhood
Setting the scene, delivering and supporting a healthy mother and baby

We will know this is happening when:
• The incidence of preventable childhood disease and injury reduce (age specific ASH rates)
• Mothers report favourably on support and care

To achieve these impacts we must provide these service groups

Prenatal services
Setting the scene for a new baby

Postnatal services
Specialist support and care

Support in the home
Supporting mother and baby in family life

Birth
Mother and baby are well after birth

Specialist Care
Specialist care results in a satisfactory outcome for mother and child

We will know these services are effective when:
• Delivery specialist confirm mothers are informed and aware
• Specialist support and LMC’s confirm appropriate referral
• Mother and baby receive excellent birth care and support
• Mother is aware of importance of breastfeeding

By purchasing these outputs

Prenatal services
• Pregnancy & parenting education
• Neonatal home care

Postnatal services
• Postnatal stays in a primary maternity facility (mother & baby)
• Specialist neonates

Support in the home
• Strengthening families (Incredible Years programme)
• Support services for mothers & their pepi

Birthing
• Maternity facility - fees for labour and delivery
• Maternity facility – fees for postnatal
• First obstetric consults
• Subsequent obstetric consults
• Maternity inpatient DRGs

Specialist Care
• Maternity outpatient first specialist appointments
• Maternity outpatient follow ups
• Amniocentesis
• Phexus clinics – multidisciplinary clinics
• Foetal medicine/anomalies clinics

Prenatal courses and information
DHB non-specialist antenatal consults

Lactation Clinic
• Breastfeeding & lactation clinics
• Mothercraft unit
Key impact:
- There is a reduction in the incidence and impact of vaccine preventable childhood diseases

Childhood Immunisation
*Reducing the incidence of preventable childhood diseases*

We will know this is happening when:
- Immunisation rates improve

To achieve this impact we must provide these service groups:
- General Childhood Immunisation
  - Immunising against common childhood infectious disease
- Rheumatic Fever Immunisation
  - Immunising children to prevent chronic disease progression
- Outreach immunisation services
  - Reaching out to immunise ‘at risk’ populations
- HPV Immunisation

We will know these services are effective when:
- Immunisation targets are met
- Barriers to access and uptake are identified and action taken to overcome
- All providers have capacity to promote immunisation
- Caregivers are knowledgeable regarding the benefits of immunisation
- Targeted rural families are reached and immunised

By purchasing these outputs:
- General childhood immunisation
  - Immunisation projects and programmes set up
  - Immunisation
- Rheumatic fever immunisation
  - Well child – Rheumatic fever prevention
- Outreach immunisation services
  - Outreach immunisation services provided by PHOs
- HPV Immunisation
  - HPV programme
  - HPV programme (communications)

We will know these outputs are delivered successfully when:
- Expected service volumes are met
- Service specifications are met
- Immunisation messages are consistent, targeted and visible
- All schools and pre-schools implement Health (Immunisation) Regulations 1995
- Service coverage targets most at need population
Key Impacts:
• Adolescents are aware of and demonstrate good sexual health knowledge

Sexual Health
Supporting informed consent and reduced incidence of sexually transmitted infections

We will know this is happening when:
• Teen pregnancy is within national norms
• Sexually transmitted infections in adolescents are within or below national accepted levels
• Evidence of informed consent to sexual activity is apparent

To achieve this impact we must provide these service groups

Sexual Health Clinics accessible to adolescents
Adolescents are able to access sexual health advice and support

We will know these services are effective when:
• Adolescents are aware of and access clinics
• Utilisation rates are met
• Peer review of service is acceptable

By purchasing these outputs

Sexual health clinics accessible to adolescents
• School based sexual health clinics
• Youth sexual health services

We will know these outputs are delivered successfully when:
• Expected service volumes are met
• Service specifications are met
• Service coverage targets ‘high need’ youth.
Key impacts:
- Children with acute, life changing and life limiting conditions receive appropriate specialist treatment, care and support

Paediatric Secondary Services
Culturally appropriate, timely, effective specialist paediatric care

We will know this is happening when:
- Professional peer review supports care pathways
- Whānau, caregivers and children report favourably on treatment and care
- Care is coordinated across multiple providers

To achieve this impact we must provide

Paediatric medical services
- Specialist paediatric cardiac – inpatient services
- Specialist paediatric cardiac – 1st attendance
- Specialist paediatric endocrinology – 1st attendance/sub attendance
- Specialist paediatric haematology
- Specialist paediatric neurology
- Paediatric medical inpatients
- Paediatric medical outpatients (1st & sub attendances)
- Paediatric acute assessments
- Paediatric community programme
- Specialist paediatric respiratory

Paediatric surgical services
- Paediatric surgical services
- Paediatric outpatients (1st & sub attendances)

Paediatric oncology services
- Specialist paediatric oncology
- Specialist paediatric oncology (1st & subsequent attendances)
- IV chemotherapy – specialist paediatric oncology

We will know these outputs are delivered successfully when:
- Expected service volumes are met
- Service specifications are met
- Service coverage targets ‘high need’ populations

We will know this is happening when:
- Children and young people are receiving timely paediatric care by appropriately skilled staff as close to home as possible
Key impacts:
- Children with potential or actual health issues are identified and referred for treatment.

To achieve this impact we must provide these service groups:

We will know this is happening when:
- All children are screened for health issues

We will know these services are effective when:
- All school aged children receive checks
- Referring health professionals report favourably on referral service and advice
- Inter agency professionals have confidence in screening and referral processes
- Whānau/caregivers follow advice of health professional undertaking health check

By purchasing these outputs:

We will know these outputs are delivered successfully when:
- Expected service volumes are met
- Service specifications are met
- Service coverage targets ‘high need’ populations

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Screening
The opportunity is taken to identify and reduce barriers to a healthy lifestyle

Regular health checks
Opportunity is taken to identify and reduce barriers to a healthy lifestyle

Regular health checks
- Well Child checks
- B4 School checks
- Preschool health services
- Well Child – school aged services (0-5)
- Well Child – school aged services (5-18)
- School health services

Regular health checks
- Child protection services
- Early childhood development support
- Family violence project coordination
- Family violence – mental health services
- Well Child – rheumatic fever service
1.2.2 Health of Older People

Population health outcomes:
- More people over 65 live in their own homes and continue to participate in their community
- Health barriers to positive ageing are minimised

Health of Older People
Healthy, independent and dignified ageing

We will know this is happening when:
- The average age of entry to ARC facilities increases
- The need for home based support increases
- Over 65 community participation increases
- Older people are more visible

To achieve these outcomes we will focus on

- Home and community support
  Older people remain in their home and participate in the community
- Secondary services for older people
  Specialist care and support
- Residential Care
  Residential care for those unable to stay in their home
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<td>Environmental support</td>
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**Intervention Intent:**
We will know these services are effective when:
- There is a reduction in the number of avoidable acute presentations of those over 65 years
- Carers are supported and able to continue caring

**By purchasing these outputs:**

- Expected service volumes are met
- Service specifications are met
- Service coverage targets most at need populations
- People receiving services comment favourably
- Day programme attendance rates increase
- Respite utilisation rates increase
Impacts/Intermediate Outcomes
By focusing on secondary services for older people:
- Those over 65 with acute, life changing and life limiting conditions receive appropriate specialist treatment, care and support.

Impact measures:
We will know this is happening when:
- Acute readmissions reduce
- Those older people needing acute care and/or their families report favourably on the care/treatment received

To have the desired impact we will provide these service groups
- Services to restore ability
  Able to return home
- Services to minimise the risk of readmission
  Safe in the home
- Needs Assessment services
  Arranging the right level of care

Intervention Intent:
We will know these services are effective when:
- Acute readmissions reduce

By purchasing these outputs
- Assessment, treatment and rehab services
  Inpatients, outpatient clinics, domiciliary assessments and education sessions
- Rapid Response Team
  (Includes gerontology nurse-led rapid response team)
- Needs Assessments
  (Includes initial, complex, reassessments and reviews)
- Transitional Care Facility based level 2

We will know these outputs are delivered effectively when:
- Expected service volumes are met
- Service specifications are met
- Favourable comments from older people and their Whānau about the quality of care/service received
- Evidence of quality plans in place
Impacts/Intermediate Outcomes:
By focusing on residential care, older people will receive a level of care appropriate to their needs.

Impact measures:
We will know this is happening when:
- Acute readmissions reduce
- Residential care facilities exceed national standards
- Residents and whanau/family report favourably on the quality of their care/care of their loved one.

To have the desired impact we will provide these service groups:
- Rest Home Level Care: Short and long term residential care
- Hospital Level Care: Greater level of care for older people
- Māori Liaison Services: Coordinating care for Māori
- Dementia services

Intervention Intent:
We will know these services are effective when:
- For those aged over 65 hospital admissions are reduced.

By purchasing these outputs:
- Rest Home Level Care: Aged Residential
- Hospital Level Care: Transitional Care Beds
- Dementia Services: Residential care (dementia)

We will know these services are effective when:
- Expected service volumes are met.
- Service Specifications are met.
- Positive feedback on services is received.
1.2.3 Hospital and specialist services

Population Health Outcomes:
- Delivering the best patient experience possible for people needing acute, specialist and high priority treatment

Hospital and Specialist Services
Timely, effective, quality care, treatment and support

Impact measures:
We will know this is happening when:
- Demand is managed in a prioritised, clinically appropriate and financially sustainable manner
- Service delivery, productivity, timeliness, quality and cost benchmarks are met or exceeded
- Favourable comment is received from stakeholders including patients

To have the desired impact we will provide these service groups

Surgical Services
Medical Services
Emergency Services
Allied Health
Impacts/Intermediate Outcomes:
By focusing on surgical services:
• Required surgical interventions will be safe, assist treatment and recovery and contribute to a better quality of life for the patient.

Impact measures:
We will know this is happening when:
• Standard discharge ratios indicate equitable access or rational variance
• ESPI compliance is achieved
• Nationally recognised prioritisation tools are used
• Patients and referrers express confidence in

To have the desired impact we will provide these service groups

First Specialist Attendances
Assessing the need, benefits and risk

Procedures
Excellent outcomes from necessary procedures

Subsequent Attendances
Assessing success

Intervention Intent:
We will know these services are effective when:
• The procedure is successfully completed and complications avoided
• Patient and referrer are aware of results and recommendations within agreed time frames

By purchasing these outputs


Procedures:
Emergency med services Cardiology – inpatient service Spec Paediatric endocrinology Paediatric medical service Elective services coordination Gen surgery (inpatient service) Minor operations Anaesthesia services Cardiothoracic services Orthohinolaryngology ENT minor operations Gynaecology Termination of pregnancy Gynaecology Neurosurgery Ophthalmology Orthopedics Fracture clinic Gait laboratory Spinal Plastics (incl burns) Urology Vascular surgery Sexual health

Subsequent attendances:
• Pain clinic
• General Surgery
• Breast operations
• Cardiothoracic
• Orthohinolaryngology
• Gynaecology
• Neurosurgery
• Ophthalmology
• Orthopedics
• Fracture clinic
• Gait laboratory
• Spinal
• Plastics (incl burns)
• Urology
• Vascular surgery
• Sexual health

We will know these outputs are delivered effectively when:
• Expected service volumes are met
• Service specifications are met
• Average length of stay is aligned to national standards
Impacts/Intermediate Outcomes:
By focusing on medical services:
- Required medical interventions are safe, assist treatment and recovery and contribute to a better quality of life for the patient

Medical Services

Impact measures:
We will know this is happening when:
- Standard discharge ratios indicate equitable access or rational variance
- Nationally recognised prioritisation tools are used
- Patients and referrers express confidence in the service

To have the desired impact we will provide the following services:

First specialist attendances
Assessing the need, benefits and risk

Procedures
Excellent outcomes from necessary procedures

Subsequent attendances
Assessing success

By purchasing these outputs

First specialist attendances:
- Outpatient dental treatment
- General medicine
- Medical HSC
- Cardiology
- Specialist paediatric cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- Haematology
- Infectious diseases
- Neurology (incl. botox)
- Therapy & metabolic
- Specialist paediatric neurology
- Oncology
- Specialist paediatric oncology
- Paediatric medical outpatient
- Renal medicine
- Respiratory
- Immunology
- Sleep apnoea
- Clinical genetics

Procedures
- Tissue typing bone marrow donor
- Family options for chronically ill children
- Inpatient dental
- IVF programme
- Sperm freezing
- General internal medical services
- Adult acute assessments
- Cardiology
- Specialist paediatric cardiology
- Dermatology
- Endocrinology & diabetics
- Gastroenterology
- Capsule endoscopy
- Haematology
- IV chemotherapy
- Oral chemotherapy
- Specialist paediatric haematology
- Venereology & HIV
- HIV/AIDS viral load testing
- Neurology
- Paediatric surgery
- Nurse led interventions

Subsequent attendances
- General medicine
- Cardiology
- Cardiac education
- Specialist paediatric cardiology
- Dermatology – UV treatment
- Endocrinology
- Gastroenterology
- Haematology (incl. chemo)
- HIV
- Neurology
- Oncology
- (radiotherapy/sterotactic radiosurgery)
- IV chemotherapy
- Paediatric med outpatient & home visits
- Renal medicine-haemodialysis
- Respiratory education
- Rheumatology
- Immunology
- Pain specialist
- Genetics service

We will know these outputs are delivered effectively when:
- Cancer waiting times are met
- Expected service volumes are met
- Service specifications are met
- Favourable comment...
Impacts/Intermediate Outcomes

By focusing on Emergency Services:
- We will minimise the impact of acute health needs
- Effectively stabilise those in need of acute care

Impact measures:
We will know this is happening when:
- Patients, referrers and referred units report favourably on service provided

To have the desired impact we will provide the following services

Emergency Services

Emergency services

We will know these services are effective when:
- Acute patients are stabilised and referred to appropriate services within clinically prudent timeframes.

By purchasing these outputs

Emergency Services

Emergency department triage level 2 (including admitted patients)
- Emergency department triage level 3 (including admitted patients)
- Emergency department triage level 4 (including admitted patients)
- Emergency department triage level 5 (including admitted patients)
- Emergency department triage level 6 (including admitted patients)

We will know these outputs are delivered effectively when:
- Waiting time standards are met (ED Health Target)
- Referred units comment favourably on referral process, triage and treatment
- National ED critical benchmarks are met including discharge times
- Patients and referrers express confidence in the service
Impacts/Intermediate outcomes:
- We will restore optimal patient function by providing a range of diagnostic, technical, therapeutic and direct patient care, including support services.

Impact measures:
We will know this is happening when:
- Patients, referrers and referred units report favourably on service provided

To have the desired impact we will provide the following services:

Movement & Strength

Caring for the whole person

District Nursing

We will know these services are effective when:
- Rehabilitation expectations are met
- Issues, barriers, concerns are addressed

By purchasing these outputs:

Movement & Strength
- Occupational therapy
- Orthotics
- Physiotherapist
- Community services – orthotics
- Orthotics
- Accredited equipment assessment

Caring for the whole person
- Dietetics/Dietician
- Podiatry
- Social work
- Speech therapy
- Prosthetic eyes
- Psychological services – mental health
- Youth sexual health
- Family information service
- Hospital at home – cystic fibrosis drugs
- Regional advocacy service for consumer complaints
- Viral STI education
- Family planning service
- Patient transport, travel and accommodation services

District Nursing
- Professional nursing service
- Specialist community nursing service
- Home oxygen
- Stomal service
- Continenence service
- Home help
- Meals on wheels
- Personal care
- Enteral feeding

We will know these outputs are delivered effectively when:
- Waiting time standards are met
- Referred units comment positively on referral process, triage and treatment
- Patients and referrers express confidence in the services
1.2.4 Long Term Conditions

Population Health Outcomes:
- People adopt habits and lifestyles that promote and maintain their lifelong health
- People with chronic conditions are managed to reduce the impact of their condition on their lives

Impact measures:
We will know this is happening when:
- There is a decreased percentage of people (corrected for age) with chronic conditions progressing to more acute phases of disease
- Decreased percentage of those with chronic conditions requiring frequent hospitalisation
- Increased percentage of people who are able to manage their conditions
- Age-standardised mortality rate by ethnicity (Data source = New Zealand Cancer Registry)
- Five year relative survival rate by stage, ethnicity, age group, deprivation level etc
- Age standardised mortality rate by ethnicity shows reducing inequality

To have the desired impact we will provide these service groups
- Diabetes care: Detecting earlier and reducing the impact
- Cancer care: Detecting earlier and reducing the impact
- Respiratory: Reducing incidence and improving management of respiratory disease
- CVD: Reducing the incidence and impact of CVD
- Healthy Eating, Healthy Action: Taking action to prevent chronic disease
Impacts/Intermediate Outcomes:
By focusing on diabetes care:
  • The impact of diabetes on patients' lives will be reduced.

Impact measures:
We will know this is happening when:
  • Increasing percentage of diabetics with acceptable blood results
  • Rates of retinopathy, nephropathy and neuropathy with diabetes as a contributing factor reduce
  • Reduced dependence on renal dialysis
  • Reduced requirement for significant medical/surgical intervention
  • Greater numbers of early stage diabetes is identified
  • A healthy lifestyle that avoids the risk of diabetes and maintains good control is demonstrated by at risk groups

To have the desired impact we will provide these service groups

Detection
Detecting diabetes early

Management & Treatment
Information to eliminate the risk, minimise the impact

Education & Health Promotion
Information to eliminate the risk, minimise the impact

Intervention Intent:
We will know these services are effective when:
  • Diabetes screening targets are met
  • Greater numbers of early stage diabetes identified
  • Treatment is effective of safe
  • Patients are able to manage their own condition
  • At risk groups are aware of risk reduction techniques and appropriate lifestyle choices.

By purchasing these outputs

Detection
Management services for diabetes

Management and Treatment
• Free GP annual diabetes checks

Management and Treatment
• Diabetes nurse educator
• Diabetes 1st attendance
• Diabetes subsequent attendance
• Diabetes funding screening

Education & Health Promotion
• Diabetes education and care
• Diabetes education and management
• Specialist education and management
• Educator Development Coordinator services
• High Risk Type 1 Diabetes support
• High risk diabetes type 1 support for up to 18 year olds

We will know these outputs are delivered effectively when:
  • Service specifications are met
  • Patients are informed of lifestyle choices and management methods
Impacts/Intermediate Outcomes:
By focusing on cancer care:
- The impact of cancer of patients lives will be reduced
- Cancer survival rates will increase

Impact measures:
We will know this is happening when:
- Cancer is detected earlier
- Treatment is commenced earlier

To have the desired impact we will provide the following services:

Detection
- Ki Mi Hauora Cancer service for McLeod Family
- Cervical screening
- Breast screening

Treatment
- Oncology
- IV chemotherapy
- Oral chemotherapy
- Radiotherapy/stereotactic radiosurgery

Intervention intent:
We will know these services are effective when:
- Increased incidence of cancer detected at an earlier stage
- The potential impact of cancer is mitigated, reduced or delayed

By purchasing these outputs

We will know these outputs are delivered effectively when:
- Cancer waiting times are met
- Expected service volumes are met
- Screening targets are met
- Maintaining provider accreditation (in terms of quality standards)
- Customer feedback (adverse events/customer satisfaction surveys)
Impacts/Intermediate Outcomes
By focusing on respiratory services:
- The impact of respiratory illness on patient’s lives will be minimised
- The incidence and impact of tobacco related harm is reduced

Impact measures:
We will know this is happening when:
- There is a reduced uptake by denormalising tobacco use
- Increased cessation rates among young people and pregnant women by ensuring culturally appropriate cessation services are available and taken up
- Strengthen and enforcement of the SFE Act by ensuring all premises operate within the bounds of the legislation

To have the desired impact we will provide the following services:

Asthma Service
Tobacco

Intervention Intent:
We will know these services are effective when:
- All public outdoor spaces are smokefree
- Tobacco is not supplied to minors
- All public events are smokefree
- All homes and cars are smokefree
- All marae are smokefree tuturu
- All health professionals are aware of and routinely refer smokers to cessation services
- All schools have smoking cessation support available
- All workplaces support staff to quit smoking

By purchasing these outputs:

Asthma service
- Community asthma services
- Asthma management - Māori

Tobacco
- Smoking cessation initiative – respiratory
- Tobacco control (delivery of training solutions in secondary health)

We will know these outputs are delivered effectively when:
- Service specifications are met
- Service coverage targets at risk groups
Impacts/Intermediate outcomes:
By focusing on healthy eating, healthy action

Health eating, healthy action
Taking action to prevent chronic disease

Impact measures:
We will know this is happening when:
- Patients, referrers and referred units report favourably on service provided

To have the desired impact we will provide the following services

Movement & Strength
- Occupational therapy
- Orthotics
- Physiotherapist
- Community services – orthotics
- Orthotics
- Accredited equipment assessment

Caring for the whole person
- Dietetics/Dietician
- Podiatry
- Social work
- Speech therapy
- Prosthetic eyes
- Psychological services – non mental health
- Youth sexual health
- Family information service
- Hospital at home – cystic fibrosis drugs
- Regional advocacy service for consumer complaints
- Viral STI education
- Family planning service
- Patient transport, travel and accommodation services

District Nursing
- Professional nursing service
- Specialist community nursing service
- Home oxygen
- Stomal service
- Continence service
- Home help
- Meals on wheels
- Personal care
- Enteral feeding

We will know these services are effective when:
- Rehabilitation expectations are met
- Issues, barriers, concerns are addressed

By purchasing these outputs

We will know these outputs are delivered effectively when:
- Waiting time standards are met
- Referred units comment positively on referral process, triage and treatment
- Patients and referrers express confidence in the services
1.2.5 Primary Health

Population Health Outcomes:
Keeping more people well by:

- Intervening earlier to detect, manage and treat existing health conditions
- Better education and advice so they can manage their own health
- Reaching those who are at risk of developing long term or acute conditions

Primary Health Care
Promoting health, preventing disease, providing early diagnosis, treatment and care

Impact measures:
We will know this is happening when:

- More individuals manage their own health better
- Continuity of care is seamless and coordinated
- Health care professionals work together to provide a multidisciplinary approach
- Service is accessible, affordable and appropriate
- Service coverage reaches ‘high needs’ groups

To those outcomes we must focus on:

- Primary Health Organisations
  Frontline primary care
- Diagnostics
  Identifying the problem
- Non PHO Primary Health Treatment
  Frontline primary care
- Professional Support
  Supporting a sustainable primary care workforce
Impacts/Intermediate Outcomes:
Keeping more people well by:
- Intervening earlier to detect, manage and treat existing health conditions
- Better education and advice so they can manage their own health
- Reaching those who are at risk of developing long term or acute conditions

Impact measures:
We will know this is happening when:
- Standard discharge ratios indicate equitable access or rational variance
- ESPI compliance is achieved
- Nationally recognised prioritisation tools are used
- Patients and referrers express confidence in the service

To have the desired impact we will provide these service groups

Health Promotion
Improving Access for ‘at risk’ communities or those with ‘high needs’
Treatment, support & advice

Primary Health Organisations
Frontline primary care

Intervention Intent:
We will know these services are effective when:
- The procedure is successfully completed and complications avoided
- Patient and referrer are aware of results and recommendations within agreed time frames

By purchasing these outputs

PHO Health Promotion Plan with programmes and measures
Improving access First contact services
Treatment, support & advice

Treatment, support & advice
- PHO Management Services
- PHO flu incentives
- Non-capitated GP visits
- Community based services
- Models of care
- COPD pilot
- Capitated GP visits
- PHO General Medical service for casual patients
- Primary mental health initiatives and innovations
- Generalist primary care

We will know these outputs are delivered effectively when:
- Expected service volumes are met
- Service specifications are met
- Average length of stay reduces
Impacts/Intermediate Outcomes:
By focusing on diagnostic services:
- Health professionals have better information to enable good treatment decisions to be made
By focusing on interventional and therapeutic services:
- Patients can obtain therapies or procedures less invasively

Impact measures:
We will know this is happening when:
- Health professionals report favourably on timeliness and reliability of requested tests and interventional therapeutic procedures

To have the desired impact we will provide the following services

Laboratory
- Fast, accurate diagnostics

Radiology
- Fast, accurate diagnostics, timely interventional and therapeutic procedures

We will know these services are effective when:
- Access to diagnostic services meets population needs
- Results are processed within agreed timeframes
- ‘Did not attends’ are minimised
- There are good patient outcomes from interventional and therapeutic procedures

By purchasing these outputs

Laboratory
- Community laboratory: Non-scheduled community laboratory tests
- Community referred tests – cardiology, neurology, audiology, endocrinology, respiratory, pacemaker physiology tests
- Lab tests and pharmacy for sexual health services

Radiology
- Community radiology
- Community radiology – DHB
- Community referred tests - cardiology

We will know these outputs are delivered effectively when:
- Expected service volumes are met
- Service specifications are met
- Favourable comment

Laboratory
- Antenatal screening

Radiology
- Secondary maternity – section 88 maternity diagnostic
Impacts/Intermediate Outcomes
Keeping more people well by:
- Intervening earlier to detect, manage and treat existing health conditions
- Better education and advice so they can manage their own health
- Reaching those who are at risk of developing long term or acute conditions

Impact measures:
We will know this is happening when:
- Patients have access to non-PHO treatment

To have the desired impact we will provide the following services:

- Oral health
  Urgent oral pain relief

- Pharmaceuticals
  Medicine & advice

- Māori Primary Health
  Increasing access to health care for Māori

We will know these services are effective when:
- Medicine use review reports effective and efficient medicine use
- Patients and other professionals report appropriate treatment
- Services are accessible

By purchasing these outputs:

- Oral health
  Oral health services for low income adults
  Kaupapa Māori oral health services

- Pharmaceuticals
  Hospital dispensing of pharmaceuticals
  Base pharmacy services
  Complex medicine services – high cost antivirals
  Unused medicines
  Pharmacy depot service
  Pharmacist comprehensive medicines management services

- Māori Primary Health
  Mobile Māori nursing service
  Primary health care and community nursing service
  Māori Primary health

We will know these outputs are delivered effectively when:
- Service specifications are met
- Service coverage targets areas of need
Impacts/Intermediate outcomes:
- Ensuring a sustainable primary health service for isolated communities

Impact measures:
We will know this is happening when:
- Turnover of rural GP’s is minimised
- Rural GP’s are able to participate in development opportunities

To have the desired impact we will provide the following services:

We will know these services are effective when:
- The Rural clinical workforce stabilises

By purchasing these outputs

We will know these outputs are delivered effectively when:
- Payment entitlement is correctly assessed and made by due date
1.2.6 Mental Health & Addiction services

**Population Health Outcomes:**
- People with experience of mental illness and addiction are able to participate fully in society and in everyday life

**Impact measures:**
We will know this is happening when:
- People with mental illness and addiction experience trustworthy agencies working across boundaries
- Service users are supported to lead their own recovery
- The community is aware of the importance of whanau/families in protecting and preserving the mental health and wellbeing of their children.

To achieve those outcomes we must focus on:
- Addiction Services: Regaining Control
- Specialist Mental Health & Addiction Services: Specialist Treatment and Stabilisation
- Community Mental Health Services: Supported Community Living
- Service Development: Continuous Improvement
Impacts/Intermediate Outcomes:
By focusing on diabetes care:
- People with substance use/misuse issues and/or problematic behaviours are able to regain control and turn their lives around.

Addiction Services Regaining Control

Impact measures:
We will know this is happening when:
- Those with addiction issues increase participation in the community
- Those with addiction issues have a reducing reliance on alcohol and drug treatment service for higher levels of care and support.

To have the desired impact we will provide these service groups

Intervention Intent:
- People who experience addiction lead their own recovery through personalised therapies and support
- Numbers of unplanned residential admissions and need for acute intervention reduces.
- Instances of those with new alcohol and drug problems stabilise.

By purchasing these outputs

Residential Addiction
Treating Serious Substance Abuse

Community Alcohol & Drug
A safe detoxification

Comprehensive Treatment & Planning
Creating self leadership

Early intervention
Preventing Dependence

We will know these outputs are delivered effectively when:
- Service specifications are met
- Quality, Quantity and Service Coverage targets met.
Impacts/Intermediate Outcomes:
By focusing on Specialist MH & A:
- People with acute and/or serious mental health and addiction issues will be treated and stabilised

Impact measures:
We will know this is happening when:
- Discharge to community services is appropriate and timely
- The risk of harm to those with mental health and addiction issues and others is minimised

To have the desired impact we will provide the following services

- Acute Services Stabilisation
- Specialist Community Services Specialist Support to remain at home

Intervention intent:
We will know these services are effective when:
- Acute episodes are stabilised
- Specialist care enables those with mental illnesses to remain in the community
- Crises are responded to in a timely and effective way
- Access to service meets requirements

By purchasing these outputs

- Acute services
  - Community Mental Health
  - Intensive Treatment at home

- Specialist community services
  - Dual Diagnosis
  - Community Mental Health Service

- Specialist community services
  - Community Eating Disorder Service
  - GP Methadone Service
  - Community Court/Liaison

We will know these outputs are delivered effectively when:
- Response is appropriate to age group.
- Service specifications are met
- Average length of stay meets targets
- Service is culturally appropriate and meets the needs of the user and whanau.
- Timeliness standards met.
- Acute/unplanned admissions within agreed standards
Impacts/Intermediate Outcomes
By focusing on respiratory services:
- People with experience of mental illness are able to enjoy everyday life.

Community Mental Health Services
Enabling participation in the Community

Impact measures:
We will know this is happening when:
- Evidence indicates individual potential is realized.

To have the desired impact we will provide the following:

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>NASC</td>
</tr>
<tr>
<td>Community Assessments</td>
</tr>
<tr>
<td>Service Coordination</td>
</tr>
<tr>
<td>Child &amp; Youth Assessments</td>
</tr>
<tr>
<td>Service Coordination</td>
</tr>
<tr>
<td>Residential Care</td>
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<tr>
<td>Day Housing &amp; Recovery Service</td>
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<tr>
<td>Night Housing Recovery Service</td>
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<tr>
<td>Community Residential</td>
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<tr>
<td>Other Residential Support</td>
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<tr>
<td>Community Support</td>
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<tr>
<td>Adult Community Support</td>
</tr>
<tr>
<td>Activity Based Recovery</td>
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<tr>
<td>Vocation Support</td>
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<tr>
<td>Peer Support</td>
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<tr>
<td>Residential Support</td>
</tr>
<tr>
<td>Supported Landlord</td>
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<tr>
<td>Community Mental Health</td>
</tr>
<tr>
<td>Tamariki &amp; Rangitahi Service</td>
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<tr>
<td>Respite</td>
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<tr>
<td>Kaupapa Māori Residential Care</td>
</tr>
<tr>
<td>Adult Planned Respite</td>
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<tr>
<td>Older Person Respite</td>
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<tr>
<td>Adult Crisis Respite</td>
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<tr>
<td>Child &amp; Youth Respite</td>
</tr>
<tr>
<td>Dual Diagnosis Respite</td>
</tr>
</tbody>
</table>

Intervention Intent:
People who experience mental illness:
- Are referred to the right place to receive the right level of care.
- They have family and whanau that are supported
- The right mix of services is regularly reassessed
- Rehabilitation and treatment

By purchasing these outputs:

<table>
<thead>
<tr>
<th>Service</th>
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<tbody>
<tr>
<td>NASC</td>
</tr>
<tr>
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<tr>
<td>Child &amp; Youth Assessments</td>
</tr>
<tr>
<td>Service Coordination</td>
</tr>
<tr>
<td>Residential Care</td>
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<tr>
<td>Clinical Rehab/Extended Care</td>
</tr>
<tr>
<td>Inpatient Beds</td>
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<tr>
<td>Community Support</td>
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<tr>
<td>Child &amp; Young Persons</td>
</tr>
<tr>
<td>Clinical Community Service</td>
</tr>
<tr>
<td>Community Support</td>
</tr>
<tr>
<td>Peer Support Adults, Families, Youth</td>
</tr>
</tbody>
</table>

We will know these outputs are delivered effectively when:
- Service specifications are met
- Service coverage targets at risk groups
1.2.7 Public Health

Population health outcomes:
- Population mitigates health risk
- Serious health issues are detected earlier
- Environmental health risk is mitigated

We will know this is happening when:
- Reported instances of disease are within benchmarked maximums
- Uptake of screening opportunities are maximised
- Reported instances of environmental illness are within benchmarked maximums

To achieve these outcomes we will focus on:
- Health Promotion & Education
  *Information to act on*
- Screening
  *Early detection, early treatment*
- Environmental health & compliance
  *Keeping our place safe*
Impacts/Intermediate outcomes:
By focusing on health promotion and education:
- We will promote and foster the development of environments that support a healthy lifestyle through nutrition
- We will reduce the incidence and impact of diabetes, cardiovascular disease and cancer

Health promotion and education
Informing to prevent

We will know this is happening when:
- The incidence of and impact of tobacco related harm is reduced
- There is a reduced uptake by young people by denormalising tobacco use
- There is an increased awareness of the nutrient value of foods
- There is an increased exposure to advertising for low-fat, salt and sugar products
- There is an increased number of people eating a variety of nutritious foods and eating more fruit and vegetables
- There is an increased consumption of water (over soft drink and juice)
- There are increased rates and duration of breastfeeding
- There are increased rates of walking & cycling for transport
- There are increased rates of people doing some vigorous exercise

To achieve these impacts we must provide these services groups

Information campaigns

We will know these services are effective when:
- Oral health measures (see Child & Youth – Oral health)
- Smoking cessation measures (see Chronic Conditions – Respiratory)
- All priority settings (schools, pre-schools, marae, workplaces) adopt physical activity guidelines and have access to affordable, available physical activity
- A consistent physical activity message is portrayed by all agencies & sectors
- Older people and people with disabilities are supported by environments that encourage them to be physically active, eat healthy food and maintain a healthy weight
- All public physical activity facilities are routinely maintained and improved
- There is a reduction in the amount of time children spend at the screen

By purchasing these outputs

Stop smoking campaigns
Immunisation campaigns
Nutrition & activity campaigns
Safe alcohol use campaigns

We will know these outputs are delivered successfully when:
- Expected service volumes are met
- Service specifications are met
- Service coverage targets high need populations
By purchasing these outputs

- Breast screening
- Cervical screening
- Screening support (enabling access)

We will know these outputs are delivered successfully when:
- Expected service volumes are met
- Service coverage targets are high
- Client satisfaction is high

To achieve these impacts we must provide these service groups

Screening

- Early detection, early treatment

We will know these services are effective when:
- Clients are aware of results and preventative treatments
- Clients with unfavourable results are receiving necessary treatments
- Information passed with referral to other health professionals is complete and accurate.

Impacts/Intermediate outcomes:
- Serious health risk is detected early
Impact/Intermediate outcomes:
- All people live in an environment that is enabling of a healthy lifestyle
- Urban design supports people to live a healthy life
- There is a reduction in the incidence and impact of infectious diseases
- Physical environments protect, promote and improve public health

We will know this is happening when:
- Housing for low-income people is safe, warm, dry and affordable
- All people live in communities that are safe, inclusive and supportive of healthy lifestyles
- Public health principles are incorporated into urban design
- Surveillance of notifiable diseases is accurate, timely and complete
- Protocol based public health follow-up is conducted for all notified diseases

To achieve this impact we must provide these service groups
- Communicable disease
- Compliance Checks
- Environmental Inequalities
- Environmental Hazards

We will know these services are effective when:
- Safe drinking water is available
- There is a reduction in the incidence and impact from biosecurity & quarantinable incidents
- Health and non-health sectors and general public are knowledgeable about infectious disease prevention
- Food safety measures are understood and implemented in all relevant settings
- The impact of a pandemic is reduced
- National, regional and local policy ensures healthy housing for all

By purchasing these outputs
- Communicable disease
- Compliance checks
  - Environmental health inspections
  - Tobacco controlled purchase operations
  - Alcohol compliance checks
- Environmental inequalities

We will know these outputs are delivered successfully when:
- Expected service volumes are met
- Service specifications are met
- Compliance checks exceed standard
### 1.2.8 Māori Health

**Population health outcomes:**
- Whānau Ora/Toi Ora

**Māori health**
*Enhancing Māori health and supporting aspirations for determination and control over Māori health and wellbeing*

**We will know this is happening when:**
- Māori return improving results against the wider determinants of health

**To achieve those outcomes we will focus on**

- **He Ranga Hua Hauora**
  *Right people, right skills, right place, right services*

- **Tino Rangatiratanga**
  *(Māori self-determination)*
  *For Māori, by Māori*

- **Tuituinga Pou Hauora**
  *(Mainstream responsiveness)*
  *Culturally responsive mainstream services*
Impacts/Intermediate Outcomes
- Māori have the right capacity and capability to address their health issues

He Ranga Hua Hauora
*Right people, right skills, right place, right services*

Impact measures
We will know this is happening when:
- Training, development and support is provided

To have the desired impact we will provide these service groups

Workforce and service development
*Right people, right services*

Intervention Intent:
We will know these services are effective when:
- Service providers report satisfaction with service
- Clients of service report favourably as to service quality

Workforce and service development

We will know these outputs are delivered effectively when:
- Providers receive necessary support
- Training and development needs have been identified
Impacts/Intermediate Outcomes
- Whanau ora for Māori

Tino Rangatiratanga
For Māori, by Māori

Impact measures:
We will know this is happening when:
- Whanau/hapu health improves
- More health services are delivered by Māori for Māori

To have the desired impact we will provide these service groups

Holistic health services

Intervention Intent:
We will know these services are effective when:
- Health issues within whanau/hapu are wider determinants facing whanau/hapu are addressed

By purchasing these outputs

Holistic health services
- Primary health care and community nursing services
- Whanau ora – Māori community health services

1.6.2.1.1
Holistic health services
Māori health promotion

We will know these outputs are delivered effectively when:
- Expected service volumes are met
- Service specifications are met
Impacts/Intermediate Outcomes

- Whanau ora for Māori

**Tuituinga Pou Hauora**
* Culturally responsive mainstream services

**Impact measures:**
We will know this is happening when:

- Culturally appropriate services are being developed and established within mainstream services
- He Ritenga: Treaty of Waitangi Principles Health Audit tool recommendations are addressed, where relevant.

To have the desired impact we will provide the following services

**He Ritenga: Treaty of Waitangi Principles Health Audit**

**Intervention Intent:**
We will know these services are effective when:

- Culturally appropriate and responsive services are delivered by mainstream services.

By ensuring these outputs

**Implementation of He Ritenga: Treaty of Waitangi Principles Health Audit**

**We will know these outputs are delivered effectively when:**

- Service is culturally appropriate and meets the need of user and whanau
- He Ritenga Audit tool is incorporated into the standard Health Share audit tool.
- Improved interface between Kaupapa Māori services and Mainstream services

**He Ritenga compliance**
## Monitoring Framework Performance Measures

### Dimensions of DHB Performance – non financial measures

### Policy Priorities Dimension

<table>
<thead>
<tr>
<th>Performance Measure and description</th>
<th>2011/12 Target</th>
<th>National Target</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PP1 Clinical leadership self assessment</strong></td>
<td>No quantitative target qualitative deliverable required.</td>
<td>NA</td>
<td>Annual</td>
</tr>
<tr>
<td>The DHB provides a qualitative report identifying progress achieved in fostering clinical leadership and the DHB engagement with it across their region. This will include a summary of the following – how the DHB is: ● Contributing to regional clinical leadership through networks ● Investing in the development of clinical leaders ● Involving the wider health sector (including primary and community care) in clinical inputs ● Demonstrating clinical influence in service planning ● Investing in professional development ● Influencing clinical input at board level and all levels throughout the DHB – including across disciplines. What are the mechanisms for providing input?</td>
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</tbody>
</table>

| **PP2 Implementation of Better, Sooner, More Convenient primary health care** | No quantitative target qualitative deliverable required. | NA | Quarterly |
| The DHB is to supply a progress report on the implementation of changes to primary health care services that deliver on the core elements of Better, Sooner, More Convenient primary health care. In particular progress must be described regarding: 1. the shifting of services from secondary care to primary care settings; 2. the development of Integrated Family Health Centres; and 3. any specific reporting requirements that may be identified in the Minister’s Letter of Expectations (to be confirmed). **AND (as applicable)** 1. Those DHBs involved in Better, Sooner, More Convenient (BSMC) primary health care business case(s) are required to supply a progress report on the implementation of the business case(s) it is involved in. The BSMC Monitoring Framework includes indicators at three levels: 2. Those DHBs involved in Better, Sooner, More Convenient primary health care business case(s) are required to supply a progress report on the operation and expenditure of the flexible funding pool, including how pool funding has been prioritised to deliver services to meet the four high-level objectives. Where problems are identified, resolution plans are to be described. | | | |

| **PP3 Local Iwi/Māori engagement and participation in DHB decision making, development of strategies and plans for Māori health gain** | No quantitative target qualitative deliverable required. | NA | Six-Monthly |
| **Measure 1 - PHO Māori Health Plans** Percentage of PHOs with MHPs that have been agreed to by the DHB. | 100% | 100% | |
| **Measure 2 - PHO Māori Health Plans** Report on how MHPs are being implemented by the PHOs and monitored by the DHB (include a list of the names of the PHOs with MHPs) OR for newly established PHOs, a report on progress in the development of MHPs (include a list of the names of these PHOs). | | | |
| **Measure 3 - DHB – Iwi/Māori relationships** Provide a report demonstrating: ● Achievements against the Memorandum of Understanding (MoU) between a DHB and its local Iwi/Māori health relationship partner, and describe other initiatives achieved that are an outcome of engagement between the parties during the reporting period. ● Provide a copy of the MoU. | No quantitative target qualitative deliverable required. | NA | |
| **Measure 4 - DHB – Iwi/Māori relationships** Report on how (mechanisms and frequency of engagement) local Iwi/Māori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring, and evaluation (include a section on PHOs). | | | |
| **Measure 5 - DHB Māori Health Plan** Provide a report by exception on national level priorities that have not been achieved in the DHB Māori Health Plan. The report will say why the priority has not been achieved, what the DHB will do to rectify it, and by when. | | | |

| **PP4 Improving mainstream effectiveness DHB provider arms pathways of care of Māori** | | | |
### Performance Measure and description

<table>
<thead>
<tr>
<th>Measure 1</th>
<th>2011/12 Target</th>
<th>National Target</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a report describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving Health outcomes and reducing health inequalities for Māori.</td>
<td>No qualitative target qualitative deliverable required.</td>
<td>NA</td>
<td>Six-Monthly</td>
</tr>
</tbody>
</table>

**PP5 Waiting times for chemotherapy treatment**

Provide a report confirming the DHB has reviewed the monthly wait time templates produced by either the relevant Cancer Centre(s) or its own DHB where treatment commenced at that DHB for the quarter. Where the monthly wait time data identifies:
- any patients domiciled in the DHB waiting more than four weeks, due to capacity issues, and/or
- wait time standards were not met, for patients in priority categories A and B DHBs must provide a report outlining the resolution path.

<table>
<thead>
<tr>
<th>PP5 Waiting times for chemotherapy treatment</th>
<th>2011/12 Target</th>
<th>National Target</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a report confirming the DHB has reviewed the monthly wait time templates produced by either the relevant Cancer Centre(s) or its own DHB where treatment commenced at that DHB for the quarter. Where the monthly wait time data identifies:</td>
<td>100% at four weeks</td>
<td>100% at four weeks</td>
<td>Quarterly</td>
</tr>
<tr>
<td>• any patients domiciled in the DHB waiting more than four weeks, due to capacity issues, and/or</td>
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<tr>
<td>• wait time standards were not met, for patients in priority categories A and B</td>
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<tr>
<td>DHBs must provide a report outlining the resolution path.</td>
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</table>

### PP6 Improving the health status of people with severe mental illness

The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for:
- child and youth aged 0-19, specified for each of the three categories Māori, Other, and in total
- adults aged 20-64, specified for each of the three categories Māori, Other, and in total
- older people aged 65+, specified for each of the three categories Māori, Other, and in total.

<table>
<thead>
<tr>
<th>PP6 Improving the health status of people with severe mental illness</th>
<th>Age 0-19</th>
<th>Age 20-64</th>
<th>Age 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>2.65%</td>
<td>4.58%</td>
<td>2.76%</td>
</tr>
<tr>
<td>Other</td>
<td>2.95%</td>
<td>3.04%</td>
<td>NA</td>
</tr>
<tr>
<td>Total</td>
<td>2.85%</td>
<td>3.55%</td>
<td>2.76%</td>
</tr>
</tbody>
</table>

**PP7 Improving mental health services using crisis intervention planning**

Provide a report on:
1. The number of adults and older people (20 years plus) with enduring serious mental illness who have been in treatment* for two years or more since the first contact with any mental health service (* in treatment = at least one provider arm contact every three months for two years or more.) The subset of alcohol and other drug only clients will be reported for the 20 years plus.
2. The number of Child and Youth who have been in secondary care treatment* for one or more years (* in treatment = at least one provider arm contact every three months for one year or more) who have a treatment plan.  
3. The number and percentage of long-term clients with up to date relapse prevention/treatment plans (NMHSS criteria 16.4 or HDS [2008]1.3.5.4 and 1.3.5.1 [in the case of Child and Youth]).
4. Describe the methodology used to ensure adult long-term clients have up-to-date relapse prevention plans and that appropriate services are provided. DHBs that have fully implemented KPP across their long-term adult population should state KPP as the methodology.

<table>
<thead>
<tr>
<th>PP7 Improving mental health services using crisis intervention planning</th>
<th>Adult (20+)</th>
<th>Child &amp; Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Non Māori</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>

**PP8 DHBs report alcohol and drug service waiting times and waiting lists**

Waiting times are measured from the time of referral for treatment to the first date the client is admitted to treatment, following assessment in any service whether it be NGO or provider arm. Reporting will be on the longest waiting time in days, plus the number of people on the waiting list for treatment at the end of the month, i.e. volume and time. Whilst assessment and motivational or pre-modality interventions may be therapeutic, they are not considered to be treatment. If a client is engaged in these processes, they are considered to be still waiting for treatment. DHBs will report their longest waiting time, in days, for each service type for one month prior to the reporting period.

<table>
<thead>
<tr>
<th>PP8 DHBs report alcohol and drug service waiting times and waiting lists</th>
<th>2011/12 Target</th>
<th>National Target</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting times are measured from the time of referral for treatment to the first date the client is admitted to treatment, following assessment in any service whether it be NGO or provider arm. Reporting will be on the longest waiting time in days, plus the number of people on the waiting list for treatment at the end of the month, i.e. volume and time. Whilst assessment and motivational or pre-modality interventions may be therapeutic, they are not considered to be treatment. If a client is engaged in these processes, they are considered to be still waiting for treatment. DHBs will report their longest waiting time, in days, for each service type for one month prior to the reporting period.</td>
<td>No quantitative target. Supply of quantitative data required.</td>
<td>NA</td>
<td>Six-Monthly</td>
</tr>
<tr>
<td>Performance Measure and description</td>
<td>2011/12 Target</td>
<td>National Target</td>
<td>Frequency</td>
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<tr>
<td>PP9 Delivery of Te Kokiri: the mental health and addiction action plan</td>
<td>No quantitative target qualitative deliverable required.</td>
<td>NA</td>
<td>Annual</td>
</tr>
<tr>
<td>PP10 Oral Health DMFT Score at year 8</td>
<td></td>
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<tr>
<td>Upon the commencement of dental care, at the last dental examination before the child leaves the DHB’s Community Oral Health Service, the total number of: (i) permanent teeth of children in school Year 8 (12/13-year-olds) that are – • Decayed (D), • Missing (due to caries, M), and • Filled (F); and (ii) children who are caries-free (decay-free).</td>
<td>Māori 2.8</td>
<td>Pacific 3.0</td>
<td>Over 1.55</td>
</tr>
<tr>
<td>PP11 Children caries free at 5 years of age</td>
<td></td>
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<tr>
<td>At the first examination after the child has turned five years, but before their sixth birthday, the total number of: (i) children who are caries-free (decay-free); and (ii) primary teeth of children that are – • Decayed (d), • Missing (due to caries, m), and • Filled (f).</td>
<td>Māori 40%</td>
<td>Pacific N/A</td>
<td>Other 66%</td>
</tr>
<tr>
<td>PP12 Utilisation of DHB funded dental services by adolescents</td>
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<tr>
<td>In the year to which the reporting relates, the total number of adolescents accessing DHB-funded adolescent oral health services, defined as: (i) the unique count of adolescent patients’ completions and non-completions under the Combined Dental Agreement; and (ii) the unique count of additional adolescent examinations with other DHB-funded dental services (e.g. DHB Community Oral Health Services, Māori Oral Health providers and other contracted oral health providers). To reduce duplication of effort, at the end of each quarter in the year to which the reporting relates, the Ministry will organise a data extract from Sector Services for all DHBs for claims made by dentists contracted under the Combined Dental Agreement, and provide this data for DHBs’ use in determining part (i) of the Numerator.</td>
<td>Total 85%</td>
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<tr>
<td>PP13 Improving the number of children enrolled in DHB funded dental services</td>
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<tr>
<td>Measure 1 - In the year to which the reporting relates, the total number of children under five years of age, i.e. aged 0 to 4 years of age inclusive, who are enrolled with DHB-funded oral health services (DHB’s Community Oral Health Service and other DHB-contracted oral health providers such as Māori oral health providers).</td>
<td>Children Enrolled 0-4 years 65%</td>
<td>NA</td>
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</tr>
<tr>
<td>Measure 2 - In the year to which the reporting relates: (i) the total number of pre-school children and primary school children in total and for each school decile who have not been examined according to their planned recall period in DHB-funded dental services (DHB’s Community Oral Health Service and other DHB-contracted oral health providers such as Māori oral health providers); and (ii) the greatest length of time children has been waiting for their scheduled examination, and the number of children that have been waiting for that period.</td>
<td>Children not examined 0-12 years 10%</td>
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<tr>
<td>PP14 Family violence prevention</td>
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<td></td>
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</tr>
<tr>
<td>Confirmation report based on audit scores for partner abuse and child abuse and neglect programme components. (Data source: Provided to DHBs by the Auckland University of Technology (AUT) Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit.)</td>
<td>140/200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP15 Improving the safety of elderly: Reducing hospitalisation for falls – (Under Development by MoH)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The number of people 75 yrs and older hospitalised for falls domiciled in the DHB region, per year.</td>
<td>2.9%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Performance Measure and description</td>
<td>2011/12 Target</td>
<td>National Target</td>
<td>Frequency</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>PP16 Workforce - Career Planning (Under Development by MoH)</strong></td>
<td>No quantitative target. Supply of quantitative data required.</td>
<td>NA</td>
<td>Annual</td>
</tr>
<tr>
<td>The DHB provides quantitative data to demonstrate progress achieved for career planning in their staff. For each of the following categories of staff a measure will be given for Numbers receiving HWNZ funding/ number with career plan for required categories:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Medical staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Allied technical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Māori Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Pacific</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Pharmacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Clinical rehabilitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **PP17 Service Change – (Under Development)** | Unknown. | NA | Quarterly |
| Under Development by MoH | | | |
### System Integration Dimension

<table>
<thead>
<tr>
<th>Performance Measure and description</th>
<th>2011/12 Target</th>
<th>National Target</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SI1 Ambulatory sensitive (avoidable) hospital admissions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 0-74</td>
<td>Mãori 106</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pacific n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other 108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 0-4</td>
<td>Mãori 120</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pacific n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other 140</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 45-64</td>
<td>Mãori 95</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pacific n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other 96</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SI2 Regional service planning**

A single progress report on behalf of the region agreed by all DHBs within that region. The report should focus on the actions agreed by each region as detailed in its regional implementation plan.

For each action the progress report will identify:

- the nominated lead DHB/person/position responsible for ensuring the action is delivered
- whether actions and milestones are on track to be met or have been met
- performance against agreed performance measures and targets
- financial performance against budget associated with the action.

If actions/milestones/performance measures/financial performance are not tracking to plan, a resolution plan must be provided. The resolution plan should comment on the actions and regional decision-making processes being undertaken to agree to the resolution plan.

**SI3 Service coverage**

Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the DAP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through:

- analysis of explanatory indicators
- media reporting
- risk reporting
- formal audit outcomes
- complaints mechanisms
- sector intelligence.

**SI4 Elective services standardised intervention rates**

For any procedure where the standardised intervention rate in the 2011/12 financial year or 2011 calendar year is significantly below the target level a report demonstrating:

1. what analysis the DHB has done to review the appropriateness of its rate
2. whether the DHB considers the rate to be appropriate for its population
   OR
3. a description of the reasons for its relative under-delivery of that procedure; and
4. the actions being undertaken in the current year (2011/12) that will ensure the target rate is achieved.

<table>
<thead>
<tr>
<th>Intervention rate</th>
<th>308 per 10,000</th>
<th>308 per 10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major joint replacement procedures</td>
<td>21 per 10,000</td>
<td>21 per 10,000</td>
</tr>
<tr>
<td>Hip</td>
<td>10.5 per 10,000</td>
<td>10.5 per 10,000</td>
</tr>
<tr>
<td>Knee</td>
<td>10.3 per 10,000</td>
<td>10.5 per 10,000</td>
</tr>
<tr>
<td>Cataract Procedures</td>
<td>27 per 10,000</td>
<td>27 per 10,000</td>
</tr>
<tr>
<td>Cardiac procedures</td>
<td>6.5 per 10,000</td>
<td>6.5 per 10,000</td>
</tr>
</tbody>
</table>
### S15 Expenditure on services provided by Māori Health providers

**Measure 1**  
DHBs to report actual expenditure (GST exclusive) on Māori providers by General Ledger (GL) code.  
- **2011/12 Target**: No quantitative target. Supply of quantitative data required.  
- **National Target**: NA  
- **Frequency**: Annual

**Measure 2**  
DHBs to report actual reported expenditure for Māori providers in comparison to estimated expenditure for Māori providers in their Annual Plan for the same reporting period, with explanation of variances.

### S17 Improving breast-feeding rates

DHBs are expected to set DHB-specific breastfeeding targets with a focus on Māori, Pacific and the total population respectively (see Reducing Inequalities below) to incrementally improve district breastfeeding rates to meet or exceed the National Indicator.

DHBs will be expected to maintain and report on appropriate planning and implementation activity to improve the rates of breastfeeding in the district. This includes activity targeted Māori and Pacific communities.

The Ministry will provide breastfeeding data sourced from Plunket, and DHBs must provide data from non-Plunket Well Child providers. DHBs are to report providing the local data from non-Plunket Well Child providers.

<table>
<thead>
<tr>
<th></th>
<th>6 weeks</th>
<th></th>
<th>3 Months</th>
<th></th>
<th>6 Months</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Māori</td>
<td>74%</td>
<td></td>
<td>Māori</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pacific</td>
<td>NA</td>
<td></td>
<td>Pacific</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>74%</td>
<td></td>
<td>Other</td>
<td>63%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>74%</td>
<td></td>
<td>Total</td>
<td>57%</td>
<td></td>
</tr>
</tbody>
</table>

- **6 weeks**: 74%
- **3 Months**: 57%
- **6 Months**: 32%
# Ownership Dimension

## Performance Measure and description

<table>
<thead>
<tr>
<th>OS3 Elective and arranged inpatient length of stay</th>
<th>2011/12 Target</th>
<th>National Target</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>The standardised ALOS is the ratio of ‘actual’ to ‘expected’ ALOS, multiplied by the nationwide inpatient ALOS. The DHB’s ‘actual’ ALOS, and the nationwide inpatient ALOS, are both defined as the total bed days for hospital patients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for hospital patients (excluding day patients) during the 12 months to the end of the quarter. The ‘expected’ ALOS is derived by taking the nation-wide ALOS for each grouping of patient discharges defined by DRG cluster and co-morbidities, multiplying this by the proportion of total discharges this group represents, and summing the result across all discharge groups.</td>
<td>3.70 Days</td>
<td>NA</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OS4 Acute inpatient length of stay</th>
<th>2011/12 Target</th>
<th>National Target</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>The standardised ALOS is the ratio of ‘actual’ to ‘expected’ ALOS, multiplied by the nationwide inpatient ALOS. The DHB ‘actual’ ALOS, and nationwide inpatient ALOS, are both defined as the total bed days for hospital patients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for hospital patients (excluding day patients) during the 12 months to the end of the quarter. The ‘expected’ ALOS is derived by taking the nation-wide ALOS for each grouping of patient discharges defined by DRG cluster and co-morbidities, multiplying this by the proportion of total discharges this group represents for the DHB, and summing the result across all discharge groups.</td>
<td>3.90 Days</td>
<td>NA</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OS5 Theatre Utilisation</th>
<th>2011/12 Target</th>
<th>National Target</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each quarter, the DHB is required to submit the following data elements, represented as a total of all theatres in each Provider Arm facility.</td>
<td>85%</td>
<td>85%</td>
<td>Quarterly</td>
</tr>
<tr>
<td>• Actual theatre utilisation,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• resourced theatre minutes,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• actual minutes used as a percentage of resourced utilisation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The expectation is that DHBs will supply information on the template quarterly. Baseline performance should be identified as part of the establishment of the target. The goal for 2011/12 will be one of the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. For DHBs whose overall utilisation is less than 85%, a target that is a substantial incremental step towards achieving the 85% target is recommended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. For DHBs whose overall utilisation is 85% or better, a target that is a small improvement over current performance is recommended</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OS6 Elective and arranged day surgery</th>
<th>2011/12 Target</th>
<th>National Target</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>The standardised day surgery rate is the ratio of the ‘actual’ to ‘expected’ day surgery rate, multiplied by the nationwide day surgery rate, expressed as a percentage. The DHBs ‘actual’ day surgery rate, and the nationwide day surgery rate, are both defined as the number of day surgery discharges for the 12 months to the end of the quarter (for elective and arranged surgical patients). The ‘expected’ day surgery rate is derived by taking the nationwide day surgery rate for discharges in each DRG, multiplying this by the proportion of total discharges the DRG represents for the DHB, and summing the result across all DRGs.</td>
<td>60%</td>
<td>60% Standardised</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OS7 Elective and arranged day of surgery admissions</th>
<th>2011/12 Target</th>
<th>National Target</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of DOSA discharges, for elective and arranged surgical patients (excluding day surgical cases) during the 12 months to the end of the quarter, divided by the total number of discharges for elective and arranged surgical patients (excluding day surgical cases) for the 12 months to the end of the quarter, to give the DOSA rate as a percentage.</td>
<td>90%</td>
<td>90% Standardised</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OS8 Acute readmissions to hospital</th>
<th>2011/12 Target</th>
<th>National Target</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>The standardised acute readmission rate is the ratio of the ‘actual’ to ‘expected’ acute readmission rate, multiplied by the nationwide acute readmission rate, expressed as a percentage. The DHB’s ‘actual’ acute readmission rate, and the nationwide acute readmission rate, are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The ‘expected’ acute readmission rate is derived using regression methods from the DRG cluster and patient population characteristics of the DHB.</td>
<td>9.95%</td>
<td>NA</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Performance Measure and description</td>
<td>2011/12 Target</td>
<td>National Target</td>
<td>Frequency</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>---------------</td>
<td>----------------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>OS9 30 Day mortality</strong></td>
<td>1.41%</td>
<td>NA</td>
<td>Annual</td>
</tr>
<tr>
<td>The measure is for a standardised mortality rate, in order to improve the comparability of the measure across the sector. The standardised mortality rate is the ratio of the ‘actual’ to ‘expected’ mortality rates, multiplied by the nationwide mortality rate, expressed as a percentage. The DHB’s ‘actual’ mortality rate, and the nationwide mortality rate, are both defined as the number of in-hospital patient deaths within 30 days of admission, as a proportion of all patient discharges, including daycases. The ‘expected’ mortality rate is derived using regression methods from the DRG and patient population characteristics of the DHB.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Measure 1: National Health Index (NHI) duplications</strong></td>
<td>&gt;3% and &lt;=6%</td>
<td>&lt;6%</td>
<td></td>
</tr>
<tr>
<td>Numerator: Number of NHI duplicates that require merging by Data Management per DHB per quarter. The Numerator excludes pre-allocated NHIs and NHIs allocated to newborns and is cumulative across the quarter.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Total number of NHI records created per DHB per quarter (excluding pre-allocated NHIs and newborns)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Measure 2: Ethnicity set to ‘Not stated’ or ‘Response Unidentifiable’ in the NHI</strong></td>
<td>&gt;0.5% and &lt;=2%</td>
<td>&lt;2%</td>
<td></td>
</tr>
<tr>
<td>Numerator: Total number of NHI records created with ethnicity of ‘Not Stated’ or ‘Response Unidentifiable’ per DHB per quarter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Total number of NHI records created per DHB per quarter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Measure 3: Standard versus specific diagnosis code descriptors in the National Minimum Data Set (NMDS)</strong></td>
<td>&gt;=55% and &lt;=65%</td>
<td>&gt;55%</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Numerator: Number of versions of text descriptor for specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Total number of specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Measure 4: Timeliness of NMDS data</strong></td>
<td>&gt;2% and &lt;=5%</td>
<td>&lt;5%</td>
<td></td>
</tr>
<tr>
<td>Numerator: Total number of publicly funded NMDS events loaded into the NMDS more than 21 days post month of discharge.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Total number of publicly funded NMDS events in the NMDS per DHB per quarter.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Measure 5: NN PAC Emergency Department admitted events have a matched NMDS event</strong></td>
<td>&gt;=97% and &lt;=99.5%</td>
<td>&gt;97%</td>
<td></td>
</tr>
<tr>
<td>Numerator: Total number of NN PAC Emergency Department admitted events that have a matching NMDS event</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Total number of NN PAC Emergency Department admitted events</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Measure 6: PRIMHD File Success Rate</strong></td>
<td>&gt;=98% and &lt;=99.5%</td>
<td>&gt;98%</td>
<td></td>
</tr>
<tr>
<td>Numerator: Number of PRIMHD records successfully submitted by the DHB in the quarter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Total number of PRIMHD records submitted by the DHB in the quarter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Measure and description</td>
<td>2011/12 Target</td>
<td>National Target</td>
<td>Frequency</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>OP1 Output Delivery</strong></td>
<td></td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td><strong>DEFINITION TO BE DEFINED</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Glossary of Terms

**Activity**
What an agency does to convert inputs to Outputs.

**Capability**
What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver the outputs required to achieve the Government’s goals.

**Crown agent**
A Crown entity that must give effect to Government policy when directed by the responsible Minister. One of the three types of statutory entities (see also Crown entity; autonomous Crown entity and independent Crown entity)

**Crown entity**
A generic term for a diverse range of entities within 1 of the 5 categories referred to in section 7(1) of the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arms length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.

**Effectiveness**
The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an Outcome and test whether outputs have the characteristics required for achieving a desired objective or Government outcome.

**Impact**
Means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. E.g. The change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations. (Public Finance Act 1989)

**Impact measures**
Impact measures are attributed to agency (DHBs) outputs in a credible way. Impact measures represent near-term results expected from the goods and services you deliver; can be measured after delivery, promoting timely decisions; reveal specific ways in which managers can remedy performance shortfalls. ([http://www.ssc.govt.nz/upload/downloadable_files/performance-measurement.pdf](http://www.ssc.govt.nz/upload/downloadable_files/performance-measurement.pdf))

**Input**
The resources such as labour, materials, money, people, information technology used by departments to produce outputs, that will achieve the Government's stated outcomes. ([http://www.ssc.govt.nz/glossary/](http://www.ssc.govt.nz/glossary/))

**Intervention**
An action or activity intended to enhance outcomes or otherwise benefit an agency or group. (Refer [http://www.ssc.govt.nz/glossary/](http://www.ssc.govt.nz/glossary/))

**Intervention logic model**
A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes
(Refer State Services Commission ‘Performance Measurement – Advice and examples on how to develop effective frameworks: [www.ssc.govt.nz](http://www.ssc.govt.nz))
<table>
<thead>
<tr>
<th><strong>Intermediate outcome</strong></th>
<th>See Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Management systems</strong></td>
<td>Are the supporting systems and policies used by the DHB in conducting its business.</td>
</tr>
<tr>
<td><strong>Measure</strong></td>
<td>A measure identifies the focus for measurement: it specifies what is to be measured.</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>Is not defined in the legislation. The use of this term recognises that not all outputs and activities are intended to achieve “outputs”. E.g. Increasing the take-up of programmes; improving the retention of key staff; Improving performance; improving relationships; improving Governance...etc are ‘internal to the organisation and enable the achievement of ‘outputs’.</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Outcomes are the impacts on or the consequences for, the community of the outputs or activities of Government. In common usage, however, the term ‘outcomes’ is often used more generally to mean results, regardless of whether they are produced by Government action or other means. An intermediate outcome is expected to lead to a end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome. (Refer <a href="http://www.ssc.govt.nz/glossary/">http://www.ssc.govt.nz/glossary/</a>) A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989).</td>
</tr>
<tr>
<td><strong>Output agreement</strong></td>
<td>Output agreement/output plan - See Purchase Agreement (refer to <a href="http://www.ssc.govt.nz/glossary/">http://www.ssc.govt.nz/glossary/</a>) An output agreement is to assist a Minister and a Crown entity (DHB) to clarify, align, and manage their respective expectations and responsibilities in relation to the funding and production of certain outputs, including the particular standards, terms, and conditions under which the Crown entity will deliver and be paid for the specified outputs (see s170 (2) CE Act 2004.</td>
</tr>
<tr>
<td><strong>Output classes</strong></td>
<td>Are an aggregation of outputs. (Public Finance Act 1989) Outputs can be grouped if they are of a similar nature. The output classes selected in your non-financial measures must also be reflected in your financial measures (s 142 (2) (b) CE Act 2004). Are groups of similar outputs (Public Finance Act 1989).</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td>Are final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).</td>
</tr>
</tbody>
</table>
Ownership

The Crown's core interests as 'owner' can be thought of as:

**Strategy** - The Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown;

**Capability** - The Crown's interest is that each state sector organisation has, or is able to access, the appropriate combination of resources, systems and structures necessary to deliver the organisation's outputs to customer specified levels of performance on an ongoing basis into the future;

**Performance** - The Crown's interest is that each organisation is delivering products and services (outputs) that achieve the intended results (outcomes), and that in doing so, each organisation complies with its legislative mandate and obligations, including those arising from the Crown's obligations under the Treaty of Waitangi, and operates fairly, ethically and responsibly. (Refer [http://www.ssc.govt.nz/glossary/](http://www.ssc.govt.nz/glossary/))

Performance measures

Selected measures must align with the DHBs DSP and DAP. The use 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 (2010/11) and show intended results for the two subsequent financial years. (Refer to [www.ssc.govt.nz/performance-info-measures](http://www.ssc.govt.nz/performance-info-measures))

Priorities

Statements of medium term policy priorities.

Purchase agreement

A purchase agreement is a documented arrangement between a Minister and a department, or other organisation, for the supply of outputs. Some departments piloting new accountability and reporting arrangements now prepare an output agreement. An output agreement extends a purchase agreement to include any outputs paid for by third parties where the Minister still has some responsibility for setting fee levels or service specifications. The Review of the Centre has recommended the development of output plans to replace departmental purchase and output agreements. (Refer [http://www.ssc.govt.nz/glossary/](http://www.ssc.govt.nz/glossary/))

Regional collaboration

Regional collaboration refers to DHBs across geographical ‘regions’ for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist.

- Northern: Northland DHB, Auckland DHB, Waitemata DHB and Counties Manukau DHB
- Midland: Bay of Plenty DHB, Lakes DHB, Tairawhiti, Taranaki, Waikato DHB,
- Central: Capital and Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, MidCentral DHB, Waitemata DHB, Whanganui DHB
- Southern: Canterbury DHB, Nelson Marlborough DHB, South Canterbury DHB, Southern DHB and West Coast DHB

Regional collaboration for some clinical networks may vary slightly. For example Central Cancer Network contains eight DHBs, Taranaki DHB and Tairawhiti DHB in addition to the Central Region DHBs.
### Results
Sometimes used as a synonym for 'Outcomes'; sometimes to denote the degree to which an organisation successfully delivers its outputs; and sometimes with both meanings at once.


### Standards of Service Measures
Measures of the quality of service to clients focus on aspects such as client satisfaction with the way they are treated; comparison of current standards of service with past standards; and appropriateness of the standard of service to client needs.

### Statement of service performance (SSP)
Government departments, and those Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of objectives and statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year.


### Strategy
See Ownership


### Sub regional collaboration
Sub regional collaboration refers to DHBs working together in a smaller grouping to the regional grouping. Typically this is groupings of two or three DHBs and may be formalized with an agreement e.g. Memorandum of Understanding. Examples include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (centralAlliance), Capital and Coast, Hutt Valley and Wairarapa DHBs and Canterbury and West Coast DHBs.

### Targets
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. A target can also be in the form of a standard or a benchmark.

### Values
The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which, in turn, tend to be drawn from social norms, democratic principles and professional ethos. ([http://www.ssc.govt.nz/glossary/](http://www.ssc.govt.nz/glossary/))
The Bay of Plenty DHB
2009/10 story:

2,772 babies were delivered; 36,783 acute patients treated and discharged; 8,425 MENTAL HEALTH ACUTE BED DAYS; 3,436 mental health elderly bed days; 62,961 emergency department attendances; 841 patients seen under community primary options mental health initiative in the Eastern Bay Primary Health Alliance; **22 PEOPLE WERE SUCCESSFULLY PLACED UNDER THE FRIENDLY LANDLORD PILOT; 647,530 HOURS OF HOME SUPPORT SERVICES FOR OVER 65’S;** 197,101 people enrolled with their Primary Health Organisation; 425,519 AGED RESIDENTIAL CARE BED DAYS; 632 patients received palliative care services through our hospices; **9,687 elective discharges; 3,372 day case procedures; 4,872 diabetes annual review checks; 48,793 people admitted to hospital (treatment which took longer than 3 hours); 18,627 of those admitted, received their treatment as day cases; 4.8 days was the average length of stay for patients admitted to wards; 91,027 outpatient doctor visits; 9,632 elective surgery procedures; 5,719 acute operations; 80,058 district nurse visits; 20,546 Public Health nursing visits; 3,204,216 pharmacy items; 1,055,227 laboratory tests ordered; 1,939 preschoolers received their Before School Health (B4School) checks; 106,357 school age dental procedures