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MIHI

Whakataka te hau ki te uru
Whakataka te hau ki te tonga
Kia mākinakina ki uta
Kia mātaratara ki tai
E hī ake ana te atakura
He tio; He huka; He hau hū
Tīhei mauri ora!

Feel the changing northerly and southerly winds
Watch shifting ebb and flow of the tides
See the red-tipped light of dawn
The ice, and frost and a fresh breeze
Behold, alas the breath of life!
FOREWORD

Messages from the Board Chairs and Chief Executive

Our Strategic Health Services Plan sets the scene for what we need to focus on to support our communities to be healthy and thriving. Most of our population enjoy good health and have good access to health services. The health needs of our communities are changing, and our population is growing, and we need to be able to respond to that. This plan will guide us over the next ten years to provide health services which better support people to stay well and manage their own health. We plan to strengthen our focus on providing integrated health services, intervening as early as possible, bringing health services closer to the patient, and providing the right mix of health support in the right place.

As part of developing the Strategic Health Services Plan, we completed a health profile of Bay of Plenty District Health Board communities. This health profile identified five priority groups: Māori, young children (the first 1000 days of life), vulnerable children and youth, vulnerable older people, and people with severe long-term mental health needs and/or addiction issues. The plan gives these groups a particular focus to improve their health in the next ten years. Our Rūnanga will continue to work in partnership with our Board to improve and enhance the health and wellbeing of Māori, so Māori can achieve the same level of health as non-Māori. Improving Maori health is everyone’s responsibility and in everyone’s best interests.

Our patients, families and whānau are at the heart of the Strategic Health Services Plan. Our aim is for people to live well, stay well, and get well. We want people to be empowered to live healthy lives, receive care closer to home so they can stay well, and we want people to get well as quickly as possible. Going forward we want to strengthen the way our hospital services and community based health services work together.

The development of this plan has involved our staff, community based health services, other support agencies, and patient advocates. We will continue to work all-as-one-team as we embark on its implementation. We will build on our efforts to collaborate with our partners and stakeholders across the health system who are caring for our communities, such as GPs, aged care facilities, Kaupapa Māori providers, mental health and addiction providers, pharmacies, and midwives, and our patients, to ensure our communities achieve the best health they can. We look forward to travelling on this journey together to achieve our vision of Healthy, Thriving Communities - Kia momoho te hāpori oranga.

Sally Webb,
Chair,
Bay of Plenty District Health Board

Punohu McCausland,
Chair,
Te Rūnanga Hauora Māori ō te Moana ā Toi

Helen Mason,
Chief Executive Officer,
Bay of Plenty District Health Board
Executive summary

Over the next 10 years, the Bay of Plenty health system will be recognised as a sector-leading, high performing health system. This will be achieved through implementation of the Bay of Plenty Strategic Health Services Plan (SHSP), with a focus on the key actions that will be taken over the next three years to build momentum for our long-term journey.

Development of the SHSP has been led by the Bay of Plenty DHB (BOPDHB), reflecting our overall stewardship role in the local health system, and has involved many stakeholders. It is in alignment with the government’s priorities and policies, and has been designed to address the unique needs and circumstances of the Bay of Plenty. It is strongly evidence-based, building upon information from the Bay of Plenty’s Health and Service Profile 2016.

Most of our population enjoy good health and have good access to services...

As the Bay of Plenty’s Health and Service Profile 2016 demonstrates, our local health system already performs well. Our population has relatively good health and good access to health services, compared to others in New Zealand. Likewise, our health system performs well overall compared with other DHB districts.

... but the needs of our communities are increasing at a time when our ability to respond is being challenged...

Our population is growing and ageing, and the prevalence and complexity of long term conditions (such as diabetes, cardiovascular disease and lung disease) are increasing. Our workforce is ageing alongside the people we serve, with the risk of future shortages. New health technologies mean more can be done to support our people in need, and often at a higher cost. Our health system acknowledges and is responding to the persisting health inequities experienced by some population groups - such as Māori and those living in higher deprivation areas - and more needs to be done. In the face of these challenges, the funding we receive from government to address our population’s growing health needs must be used in a way that optimises value from our available resources.

...so we now need to take a fresh approach that builds on our strengths

In looking to the future, the Bay of Plenty health system has two broad options for how to respond to these challenges in planning, funding and providing services:

1. **Carry on as we are**, doing reasonably well and working in relative isolation across professions, settings, organisations and sectors

2. **Take a new approach**, recognising our strengths and seeking to build a more cohesive and resilient system where people work more effectively together with the needs of the people we serve at the forefront.

Our concern is that if we take the well-trodden path of responding to demand growth by expanding increasingly expensive hospital services and facilities, which we then struggle to fund, we will put the continued good performance of the Bay’s health system at risk. Taking such an approach would limit our ability to invest in prevention and early intervention services in the community.

Through this SHSP, the Bay of Plenty health system commits to the second option - a ‘new approach’ that is focused on wellness, being more proactive towards addressing needs, and enabling care to be delivered as close to home as possible.
The government has reached a similar conclusion on the need for change in the New Zealand health system, as described in the *New Zealand Health Strategy (2016)*:

> The cost of providing health services through the current model is unsustainable in the long term. The Treasury estimates that, if nothing were to change in the way we fund and deliver services, government health spending would rise from about 7 percent of GDP now, to about 11 percent of GDP in 2060. It is essential that we find new and sustainable ways to deliver services, investing resources in a way that will provide the best outcomes possible for people’s health and wider wellbeing.

**The New Zealand Health Strategy: Future Direction**

We have already been advancing innovations in how we plan, fund and provide care for our population through the *Bay of Plenty Integrated Healthcare Strategy (2014-2020)* as well as recent work on improving patient flows within our hospitals. It is now time to take the learnings from these innovations, from equivalent work elsewhere in New Zealand and internationally, and from patient feedback and apply them more widely. This large scale application of innovative strategies will help us be recognised as a sector-leading health system.

**Our fresh approach is evolutionary, with strategic objectives focused on wellness, care close to home and system efficiency...**

Stakeholder workshops and the findings of the *Health and Service Profile 2016* have led to the development of three objectives to guide our strategic direction (see Figure 1), each with major ‘headline’ actions for implementation. Each objective reflects the SHSP’s focus on population health and wellness (live well), care closer to home and more responsive (stay well), and short-term hospital care (get well). As we deliver on these objectives, the way in which we fund our services needs to change in response to our change in focus.

**Figure 1. The SHSP’s three strategic objectives**

<table>
<thead>
<tr>
<th>Live well</th>
<th>Stay well</th>
<th>Get well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Empower our populations to live healthy lives</td>
<td>2 Develop a smart, fully integrated system to provide care close to where people live, learn, work and play</td>
<td>3 Evolve models of excellence across all our hospital services</td>
</tr>
</tbody>
</table>

Working collaboratively, we will create healthy, thriving communities by proactively addressing the needs of our family and whānau with services that are well-coordinated, holistic and provided as close to home as possible.

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3 Available at: [http://www.bopdhb.govt.nz/media-publications/a-z-publications/](http://www.bopdhb.govt.nz/media-publications/a-z-publications/)
While each strategic objective can be pursued independent of the others, when implemented together they will have a much bigger impact. For example, Strategic Objective 1 includes a focus on improving the well-being (‘wellness’) of our population through concentrating on factors that impact on the health of the population, such as land-use planning, housing, transport, and community networks. Strategic Objective 1 will therefore be significantly enabled through the achievement of Strategic Objective 2 – a smart, fully integrated system that works cohesively to provide health services that help people stay well in community settings. Likewise, our ability to invest in the health of our population and community based care will be dependent on how efficient and effective our hospital services are in helping people get well when they require highly specialised care (Strategic Objective 3).

In delivering on our strategic direction, we will prioritise the needs and aspirations of populations with the greatest need...

Five population groups have been identified as priorities for SHSP implementation based on the findings of the Health and Service Profile 2016, as well as engagement with stakeholders. In everything we do, we will make sure that the needs and aspirations of the following populations are prioritised in the way we design and deliver services:

- Māori
- Young children (‘the first 1000 days’)
- Vulnerable:
  - children and youth
  - older people
- People with severe long-term mental health needs and/or addiction issues.

We recognise the special place of Māori in the Bay of Plenty, and that addressing the needs and aspirations of Māori requires acknowledgement of a world view that includes Māori practices, traditional healing, knowledge, beliefs, values and experiences. The implications of this world view for health are set out in He Pou Oranga Tangata Whenua (Tangata whenua determinants of health). He Pou Oranga is a holistic model of healthcare which will be central to the new approach in relation to how we plan, fund and deliver services in the Bay of Plenty.

Our first objective is to empower our populations to live healthy lives...

**Strategic Objective 1:**
Empower our populations to live healthy lives

**Headline actions:**

- Increase our focus and investment in health improvement and prevention activities
- Work more collaboratively to quicken the pace and scale of health in all policies’
- Target investment to improve the lives of the most vulnerable
This objective is about helping our populations to live healthy lives for as long as possible. It is also about reducing health inequities, particularly between Māori and non-Māori. A partnership approach with Iwi, hapu and whānau is an important part of addressing inequity. To achieve this objective we will pursue the three key headline actions, as shown above, over the next three years. In pursuing these actions, we will:

- Focus on the major risk areas that will have the biggest impact on health outcomes and equity, and which will support our delivery on government priorities - smoking, nutrition and physical activity, and housing
- Close the gap on Māori health inequities by prioritising the Good to Great Māori Health Strategy
- Collaborate across public, private and community sectors to build the breadth and scale of initiatives needed to tackle the societal factors that impact on people’s health such as income, employment, education, housing and environment
- Adopt a mix of approaches that address both the whole population as well as those that target the priority populations - for example, supporting our population with long term conditions to self-manage and be able to understand their health needs.

By delivering on this objective, we will be able to say:

- Our population live healthy lives, irrespective of their ethnicity, where they live, or their age
- Our health system is recognised for being focused on community well-being
- We have made a significant contribution to helping our communities build their resilience.

We will know we’ve been successful when:

- All of our children and youth have great starts to life in healthy, thriving communities
- We have significantly reduced the inequities experienced by our priority population groups through a clear improvement in their health and social outcomes
- Māori achieve the same level of health as non-Māori.

Our second objective is to develop a smart, fully integrated system to provide care close to where people live, learn, work and play…
This objective is about improving the capability of the Bay of Plenty’s health system to provide care for people and their families/whānau in community settings. To achieve this objective we will pursue the three headline actions, as shown above, over the next three years. In pursuing these actions, we will:

- Put people and families/whānau at the centre of our services
- Use evidence-based approaches for responding to people’s health needs
- Help people and families/whānau to self-manage their health and well-being
- Break down the barriers that have been limiting our ability to work together across professions, organisations and sectors.

**By delivering on this objective, we will be able to say:**

- Our population has early access to care in the community, which anticipates and meets their needs before they become acute crises
- Our health system is person and family/whānau centred because we understand and cater to family/whānau with a ‘one team’ approach to care that ensures the right person, in the right place, at the right time, delivering the right intervention
- People can access care more conveniently in a wide range of community settings that are closer to home.

**We will know we’ve been successful when:**

- Māori have improved health outcomes and the health system can report a reduction in health inequities between Māori and non-Māori
- More of our population can self-manage their health and have their needs met in community settings
- Our hospital services are working as ‘one team’ with primary and community care services, in integrated care models based on the needs of our populations and communities
- We have substantially reduced acute hospitalisations through timely interventions in community settings.

**Our third objective is focused on evolving models of excellence across all of our hospital services ...**

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**Strategic Objective 3:**
Evolve models of excellence across all of our hospital services

**Headline actions:**

- Strengthen working relationships across care providers to manage demand for hospital services
- Improve patient flows through the hospital
- Define the future scope and mix of hospital services in the Bay of Plenty
This objective is about ensuring that all of our hospital services are person-centred, well-connected to other parts of the health system, and focused on delivering responsive, short-term care that enables our patients to return home as quickly as possible. To achieve this objective we will pursue three headline actions, as shown above, over the next three years. In doing so, we will:

- Deepen working relationships between care providers across the system
- Emphasise the importance of patient experience, through designing our services based on contemporary principles such as ‘valuing the patient’s time’
- Place the delivery of highly reliable services, characterised by exceptional quality and safety, at the centre of everything we do
- Develop the hospital and community infrastructure needed to deliver ambulatory health care and coordinated follow-up care
- Create a culture of teamwork, innovation, and excellence across all of our hospital services.

We will know we’ve been successful when:

- We have achieved one of the lowest acute hospital bed-day-rates per capita in New Zealand
- Our hospital services are widely recognised for their high reliability and patient-centred care
- Our staff report high levels of engagement and professional satisfaction
- Our patients report high levels of satisfaction.

To achieve our strategic objectives we will develop the necessary supporting infrastructure...

We will build on work already underway through the Bay of Plenty Integrated Healthcare Strategy (2014-2020) to develop the supporting infrastructure necessary for achieving our strategic objectives. There are seven components to this infrastructure, as shown below. Each component has a number of actions delivered as part of our objectives, with these actions reinforcing or complementing actions already implemented or planned through the Integrated Healthcare Strategy (2014-2020).
We will take a disciplined and structured approach to implementing the SHSP...

This SHSP outlines an ambitious programme of work, and one that we consider essential for building momentum towards the goal of being a sector-leading health system. We recognise that it will take commitment and effort on all our parts to achieve the objectives, frank and honest conversations regarding capability and resourcing across our system, and a structured and disciplined approach to implementation.

While we wish to achieve tangible results quickly, we will not rush implementation. Hence the Roadmap for action over the next three years takes a phased approach, building momentum over time.

Key elements to be addressed during implementation will include:

- Monitoring of key performance indicators and targets
- Board governance and executive management
- Clinical leadership and clinical governance
- Programme management
- Communications and engagement
- Alignment with the DHB planning cycle.
Our fresh approach for the Bay of Plenty Health System

**PRIORITY POPULATIONS**
- People with long term severe mental health and addiction issues
- Vulnerable older people
- Vulnerable children and young people
- First 1000 days of life

**PATIENT AND FAMILY CENTRED CARE – WHĀNAU ORA**
- Live well: Empower our population to live healthy lives
- Stay well: Develop a smart fully integrated system to provide care close to where people live, learn, work and play
- Get well: Evolve models of excellence across all of our hospital services

**Technology**
- Contracting
- Information
- Workforce
- Facilities

**Maori**

**CARE**
Manaakitanga
The structure of the SHSP...

**Section 1**
Describes the purpose of the SHSP and how it has been developed.

**Section 2**
Summarises the current performance of our local health system and highlights opportunities to improve our performance.

**Section 3**
Sets out the broad choices we face given increasing demand, resource constraints, and trends in models of care and technology.

**Section 4**
Describes our vision for the Bay of Plenty health system, and presents how we will respond to the challenges we face.

Features of the national and local policy and planning environment that the Bay’s health system operates in, are summarised in Appendix 1. Appendix 2 provides further detail on how the SHSP has been developed. Appendix 3 provides a summary Key Performance Indicator dashboard for monitoring the success of the SHSP.
SECTION 1

INTRODUCING THE BAY OF PLENTY STRATEGIC HEALTH SERVICES PLAN
1. Introducing the Bay of Plenty Strategic Health Services Plan

1.1 Purpose

The Bay of Plenty Strategic Health Services Plan (SHSP) provides our local health system and the communities we serve with a clear direction for the next 10 years. The SHSP describes the outcomes and priorities we will be pursuing, key actions we will be taking, and the infrastructure that will support our efforts.

The SHSP provides the strategic direction for further planning and action to improve the performance and sustainability of the Bay of Plenty’s health system. The SHSP also involves the enhancement of partnerships with agencies from other sectors, to address the wider factors that determine people’s health and well-being.

Development of the SHSP has been led by the Bay of Plenty District Health Board (BOPDHB), reflecting our overall stewardship role in the local health system, with the engagement of many stakeholders, including:

- The BOPDHB Board and Runanga, representing the 18 iwi in the Bay of Plenty
- The Bay of Plenty’s three primary health organisations (PHOs)\(^4\) who are funded by the BOPDHB to manage the health of their enrolled population by supporting the provision of health care services through general practices, and ensuring these services are well connected with other health care services
- Patients
- BOPDHB staff
- Health service provider organisations (including Non-Governmental Organisations and the private sector)
- Agencies from other sectors, including local government.

The SHSP is aligned with the government’s priorities and policies, and designed to address the unique needs and circumstances of the Bay of Plenty. It is strongly evidence-based, building upon information from the Bay of Plenty’s Health and Service Profile 2016\(^5\).

1.2 Why develop this SHSP?

The BOPDHB has overall responsibility for the planning and performance of the Bay of Plenty’s health system, including the funding and provision of the health and disability services in the district. As a whole, our health system performs well, thanks to the hard work of the committed health workforce and our partner agencies.

However, our operating environment is changing and challenges are intensifying. Our communities’ health needs are growing as the population increases and ages, and the prevalence and complexity of long term conditions increases in parallel. Our workforce is ageing alongside the people we serve, with the risk of future shortages. New health technologies mean more can be done to support our people in need,

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\(^4\) The three PHOs include Eastern Bay Primary Health Alliance, Western Bay of Plenty Primary Health Organisation and Ngā Mataapuna Oranga.

\(^5\) Available at: [http://www.bopdhb.govt.nz/media-publications/a-z-publications/](http://www.bopdhb.govt.nz/media-publications/a-z-publications/)
and often at a higher cost. Our health system acknowledges and is responding to the unacceptability of the persisting health inequities experienced by some population groups, such as Māori and those living in higher deprivation areas. Last but not least of these pressures is determining the best way to deliver healthcare to address our population’s growing health needs, with the resources available.

In responding to these challenges, the SHSP points to a future in which the emphasis is on prevention, earlier intervention when it’s needed, and health care provided in community settings. Upgrading and expanding hospital capacity has occurred in both Tauranga and Whakatāne over the past decade, and our hospital facilities are now fit for the present and 10-year future. Scarce and high cost hospital services will be conserved for those who need them most.

Through initiatives such as the Bay of Plenty Integrated Healthcare Strategy (2014-2020) we have worked collaboratively to devise, test, and evaluate new ways of working. It is now time to take the learnings from these innovations, and from equivalent work elsewhere in New Zealand and internationally, and apply them on a larger scale, with greater pace. This momentum will help reorient our health services in line with the directions described in this SHSP.

We need to become more deliberate and disciplined in how we use our resources to deliver care in a sustainable way that enables us to achieve the best health outcomes and value for our people, family/whānau and communities.

To achieve this, the Bay of Plenty health system must have a clear vision of the future, that is shared by all our workforce, organisations, and partners involved in the planning and provision of care, and is supported by the communities we serve. This future direction is summarised in Figure 2 (overleaf).

We also recognise the special place of Māori in the Bay of Plenty health system and that addressing the needs and aspirations of Māori requires acknowledgment of a world view that includes Māori practices, traditional healing, knowledge, beliefs, values, and experiences. The implications of this world view for health are set out in He Pou Oranga Tangata Whenua (Tangata whenua determinants of health). This has been developed to ensure traditional values are recognised as key indicators of toiora (optimum health and wellbeing) for Māori.

He Pou Oranga Tangata Whenua provides key principles and outcomes that have shaped the development of the SHSP and which will guide its implementation:

- Wairuatanga: Understanding and engaging in a spiritual existence.
- Rangatiratanga: Positive leadership and self-empowerment
- Manaakitanga: Show of respect or kindness, and support.
- Kotahitanga: Maintaining unity of purpose and direction.
- Ūkaipōtanga: Place of belonging, purpose and importance.
- Kaitiakitanga: Guardianship and stewardship over people, land and resource.
- Whānaungatanga: Being part of and contributing collectively.
- Pūkengatanga: Teaching, preserving and creating knowledge.

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Figure 2. The Bay of Plenty health system’s strategic direction

**New Zealand Health Strategy**  
*All New Zealanders live well, stay well, get well*

**Midland Region Strategic Direction**  
*Improve population health & eliminate health inequalities*

**Bay of Plenty Strategic Direction**  
*Healthy, Thriving Communities - Kia Momoho Te Hāpori Oranga*

### WHY?

**Healthy individuals - Mauri Ora**
- All people live healthy with a good quality of life
- All children have the best start in life
- People die in their place of choice

**Healthy families - Whānau Ora**
- Family/whānau live well with long-term conditions
- People are safe, well and healthy in their own homes and communities

**Healthy environments - Wai Ora**
- All people live, learn, work and play in an environment that supports and sustains a healthy life
- Our population is enabled to self manage
- All people receive timely, seamless and appropriate care

### WHAT?

- Empower our populations to live healthy lives
- Develop a smart, fully integrated system to provide care close to where people live, learn, work and play
- Evolve models of excellence across all of our hospital services

### HOW?

- Embedding patient and family centred care/Whānau Ora
- Building effective partnerships
- Developing our workforce
- Developing our facilities
- Using information to improve value
- Making the most of new technologies
- Redesigning funding & contracting models to better match care with need

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**CARE**

*Manaakitanga*
2. Current system performance and future needs

2.1 How are we doing?

The Bay of Plenty health system generally performs well. Insights from the *Bay of Plenty’s Health and Service Profile 2016* and discussions with stakeholders reveal that in the Bay of Plenty:

- Nine out of 10 adults rate their health as good, very good, or excellent
- Our population has a higher life expectancy than New Zealand as a whole, despite having higher average deprivation levels
- 99% of residents are enrolled with a PHO, suggesting engagement with primary health care services is high
- Our elderly population (age 75+) has good access to home-based care, residential care, and hospital and community-based health services
- The BOPDHB has the second highest level of investment in kaupāpa Māori health care providers in New Zealand.

However, there are still significant opportunities for improvement:

- A large inequity exists in the majority of health indicators for Māori. For example, compared with non-Māori:
  - Māori are twice as likely to develop diabetes
  - Māori have higher rates of hospitalisation for chronic obstructive pulmonary disease (COPD, or ‘smoker’s lung’)
  - Cancer registrations for Māori are higher, particularly for lung cancer
  - Māori have a higher need for and use of mental health and addiction services
- Smoking and obesity are the largest areas of potential health gain, as 19% of Bay residents (35,000 people) are smokers; 32% (57,000) of adults are obese (of whom 10,000+ are morbidly obese); and 9% (4,000) of the Bay’s children are obese
- 28% of residents report experiencing unmet need for primary health care
- Primary care performance on national health indicators show poorer results for Māori compared with non-Māori and national targets
- Our population has a higher rate of suicide than the New Zealand average, with approximately 35 deaths per year and 150 self-harm hospitalisations amongst young people
- Hospital Emergency Department utilisation rates are high in the Bay, both during the day and after-hours, suggesting difficulty in accessing same day care in general practice
- Children (0-14 years) and youth are generally at higher risk of experiencing unplanned hospital admission than their national counterparts
- We have the highest rate of head injuries for under two-year-olds in New Zealand
- Unplanned (acute) hospitalisation rates in the Bay are higher than the New Zealand average, with a high ambulatory sensitive hospitalisation (ASH) rate in children
- The average length of hospital stay for our residents is longer than for New Zealand as a whole.

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7 Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting. Refer: http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/adult-ambulatory-sensitive-hospitalisations/
2.2 What are our challenges?

Our health system could improve its current performance in a number of areas, such as those listed above. However, the pressures placed on the system to improve performance will become even greater in the future. The Bay of Plenty’s health services are already experiencing the early impacts of demand and supply pressures, similar to those facing local health systems throughout New Zealand, and indeed across all developed countries (Figure 3). These are set to threaten the clinical and financial sustainability of health services.

Figure 3. Pressures on the sustainability of health systems

The form that these pressures will take in the Bay of Plenty over coming years reflects our demographic, geographic and economic characteristics. Over the next 20 years these pressures will include:

- Significant demographic changes, such as:
  - **Population growth:** Statistics NZ’s medium projection is for the Bay of Plenty’s population to increase 16% (a rate similar to New Zealand as a whole) with much of this growth occurring in the next 10 years. However, growth could trend towards the high projection, which is for a 29% increase
  - **Uneven distribution:** The Western Bay (including Tauranga City) is predicted to experience significant population growth, while the Eastern Bay’s population is expected to decrease or stay about the same
  - **Diversification:** The Bay of Plenty has a higher proportion of Māori than New Zealand overall, and this is projected to grow. The Asian population is also expected to double to around 12% of the total Bay of Plenty population
  - **Significant ageing:** The Bay’s population is older than the New Zealand average, with 8.7% of residents aged over 75 years. Projections suggest this proportion will roughly double in the next 20 years. Use of health services is higher amongst older people, and the Bay’s ageing will require increased clinical capacity and supporting services
• Growth of the health burden associated with long term conditions arising from population ageing, a high prevalence of risk factors (smoking, drinking, obesity), low levels of physical activity, and poor diets in almost 50% of the population

• Increasing demand for general practitioner (GP) consultations, with most of this growth expected to occur in the Western Bay. In particular, consultations for people aged 65+ could grow by 35% at a time when the GP workforce is both ageing and becoming increasingly likely to work part-time. It is expected that demand growth will also be strong for other health services

• Demand for support services for older people is forecast to grow substantially given the projected doubling of the 75+ years population

• Increasing demand for mental health and addiction services

• Hospital bed capacity will need to increase if current models of care and utilisation rates continue, with a projection of between two and three wards of additional hospital bed capacity required due to population growth and ageing over the next 10 years. This growth would primarily be at Tauranga Hospital.
3. What are the choices for our future?

Increasing demand for health services is already evident in the Bay and is expected to intensify significantly over the next 20 years. In looking to the future, the Bay of Plenty health system has two broad options for how we plan, fund, and provide services.

OPTION 1
‘Carry on as we are’

Our current health care system largely reflects structures, functions, and ways of working that have their roots in 1950s England – a very different world to the one we now live in.

The English National Health Service (NHS) today provides an example of what is likely to happen in the Bay if we carry on as we are. The NHS is at a critical breaking point as it struggles under the weight of acute demand associated with increasing prevalence and complexity of long term conditions (chronic disease), largely because it has not been able to evolve sufficiently to respond to changing health needs and social conditions.

The Bay could seek to maintain today’s service delivery system that generally provides timely and high quality care to our population, but remains comparatively fragmented in professional and organisational silos of activity. Our concern is that the significant demand growth that is expected, will put at risk our current good performance. If we do not prepare for the growth in demand, we may not be able to continue to provide access to services, and the needs of an increasing number of vulnerable people and whānau may not be met.

In particular, demand pressure on primary care would begin to outstrip its capacity. The system would become more hospital-dependent, with our two acute hospitals (Tauranga and Whakatāne) consuming an increasing share of the BOPDHB’s resources as their capacity is increased to meet acute demand. The Bay’s health workforce would experience increasing signs of burnout from coping with the stress of relentless growth in the number of people seeking urgent care. The quality and safety of care would be compromised as the system struggled to keep pace with the increasing needs of the people, family/whānau, and communities it serves.

This pattern is essentially what is happening today within the English NHS; we see it as critical that we avoid the risk of this happening in the Bay of Plenty.
We would place emphasis on significantly reducing health inequities for Māori and developing an integrated and cohesive system within which local and national agencies work together to address the needs of the most vulnerable. Greater emphasis would be placed on creating a health literate system/workforce in support of wellness and self-care, and lifestyle behaviours that reduce health risk factors (particularly smoking and obesity).

Primary health services would be the ‘home’ for care and support for individuals and families, and would provide proactive and structured care for people with long-term conditions. The scope and capacity of services for older people would be increased, with an emphasis on the care and support needed to maintain independent living in the community for as long as possible. Specialist services would provide stronger interdisciplinary support for care in the community in conjunction with primary health care providers, restricting hospital admissions to those people for whom there is no viable community solution. Roles within the care team would be broadened to improve access to services for vulnerable patients and families and to allow health professionals to practice the skilled clinical work they have been trained for.

New digital technologies would be used to foster better ‘virtual’ links between patients and health professionals, share health information across members of the care team, and allow remote monitoring of physiological markers.

Constraints on the growth of health system capacity (most notably in workforce and in funding) to match increasing demand, mean that the Bay of Plenty’s health system cannot sustain its current patterns of resource allocation and ways of working. Through this Strategic Health Services Plan, the Bay of Plenty health system therefore commits itself to the second option – the ‘new approach’.

The government has reached a similar conclusion on the need for health system change for New Zealand as a whole, as described in the New Zealand Health Strategy (2016)\(^8\).

The cost of providing health services through the current model is unsustainable in the long term. The Treasury estimates that, if nothing were to change in the way we fund and deliver services, government health spending would rise from about 7 percent of GDP now, to about 11 percent of GDP in 2060. It is essential that we find new and sustainable ways to deliver services, investing resources in a way that will provide the best outcomes possible for people’s health and wider wellbeing.

The New Zealand Health Strategy: Future Direction
SECTION 4
OUR STRATEGIC DIRECTION FOR THE NEXT 10 YEARS
4. Our strategic direction for the next 10 years

The strategic direction outlined in this SHSP has been developed in response to:

- our current operating environment
- the anticipated future health needs of the Bay of Plenty’s population
- the opportunities identified to improve system performance
- local, national and international trends in models of care.

This direction is framed by the Triple Aim, an internationally recognised approach that underpins both the New Zealand Health Strategy (see Appendix 1) and how we plan, fund, and deliver care in the Bay of Plenty health system. Its use ensures population health, patient experience of care, and value for money perspectives are considered simultaneously in health system planning and decision-making (Figure 6).

**Figure 6. The New Zealand Triple Aim framework**

Three strategic objectives for the Bay of Plenty’s health system will build momentum towards achieving our vision: Healthy, Thriving Communities – Kia Momoho Te Hāpori Oranga.

<table>
<thead>
<tr>
<th>These are:</th>
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<tbody>
<tr>
<td>1</td>
<td>Empower our populations to live healthy lives</td>
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<tr>
<td>2</td>
<td>Develop a smart, fully integrated system to provide care close to where people live, learn, work and play</td>
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<tr>
<td>3</td>
<td>Evolve models of excellence across all of our hospital services.</td>
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Headline actions and activities to support these objectives have been identified and are summarised in a ‘roadmap’ for the initial period from 2017/18 to 2019/20.

While each strategic objective can be pursued independently of the others, when implemented together they will have a more substantial impact. For example, Strategic Objective 1 includes a focus on improving the well-being (‘wellness’) of our population through concentrating on factors that impact on people’s health, such as land-use planning, housing, transport, and community networks. This approach will also be significantly enabled through achieving Strategic Objective 2 – a smart, fully integrated system that works cohesively to provide health services close to home, helping people stay well in community settings. Likewise, our ability to invest in the health of our population and community-based care will be dependent on how efficient and effective our hospital services are in helping people get well when they require specialised care (Strategic Objective 3).

As we deliver on these objectives, we expect that the allocation of funds will reinforce this change in focus, as illustrated in Figure 7. Figure 7 displays expected resourcing trends over the next 10 years, in line with our vision and strategic objectives. This should not be interpreted as a reduction in spending on hospital care. Rather, it is the preferential direction of additional funds that will become available from government (in large part because of the Bay of Plenty’s growing population), to primary and community services, rather than hospital-based services.

By integrating service delivery models, increasing investment in prevention and early intervention, and expanding the role of primary and community services, we will reduce the rate of acute (unplanned) hospital admissions. This will allow timely access to more complex care, increased specialist advice and support to primary care, and additional planned activity – such as increased elective procedure volumes and shorter wait times for diagnostic and outpatient services.

*Figure 7. Stylised illustration of planned changes in resource allocation to support achievement of this SHSP’s vision and strategic objectives. The blue line reflects the current state, and the yellow line the intended future balance of investment*
The Triple Aim approach helps us to understand which populations in the Bay of Plenty are more likely to benefit from the changes we are proposing as part of this SHSP. Five population groups have been identified as priorities based on the findings from the Bay of Plenty’s Health and Service Profile 2016 and engagement with stakeholders. While the SHSP covers all our population, we will make sure that the needs and aspirations of these priority populations are considered first and foremost. The five priority populations are:

1. **Māori** in the Bay of Plenty have long experienced persistent inequities in access to health services and health outcomes. Significant progress has been made in addressing these inequities, and much work remains to be done. For example, evidence shows that Māori are still much more likely to die early (before 75 years of age) from conditions that could have been avoided. The Good to Great Māori Health Strategy provides the framework to strengthen our efforts to change the drivers of these inequities, and work alongside Māori to ensure that both specifically tailored services (such as those delivered by kaupapa Māori providers) and more responsive ‘mainstream’ services, better meet the needs and preferences of Māori so that health equity can be achieved.

The Good to Great Māori Health Strategy also recognises the importance of taking a holistic, well-being approach for improving Māori health, in-line with He Pou Oranga (see Appendix 1) and ‘Pae ora – healthy futures’, the government’s vision for Māori health. Pae ora is a holistic concept that includes three interconnected elements:

- Mauri ora – healthy individuals
- Whānau ora – healthy families
- Wai ora – healthy environments.

All three elements of Pae ora are mutually reinforcing, and will be considered in all aspects of SHSP implementation.

2. **The first 1,000 days of life** is a critical time in every child’s life - from the time of conception, through pregnancy and birth, and through to the child’s second birthday. This is the period in which development occurs at a rapid pace, and a trajectory is established for the remainder of life. Evidence shows that investment in these early years provides the greatest opportunity to prevent health problems later in life.

3. **Vulnerable children and young people**: Most children grow up happy, healthy, and loved by their families, whānau, and caregivers. However, too many children don’t have adults who keep them safe and put their needs first. There are many reasons for this, including parental capacity, poverty, welfare dependency, drug and alcohol abuse, and mental health issues. Investment in making our children and young people healthier will lead to healthier adults, reduced inequities, and avoided future costs.

4. **Vulnerable older people**: Our population is ageing significantly. As we age, we are more likely to experience long term and complex health conditions, and make greater use of both clinical and support services. Spending is particularly high during the last year of life. The Bay of Plenty population is already older than the New Zealand average and this difference is forecast to grow further. As such, we need to invest more of our resources in preventing the onset and worsening of long term conditions, intervening early when acute episodes occur, and providing the integrated care and support that will enable our older people to live independently and with dignity in their own homes for as long as possible. Particular emphasis must be placed on the needs of the frail elderly as they are at risk of increased admissions, longer lengths of stay in hospital, and need for long-term institutional care.

5. **People with long-term severe mental health and addiction issues**: People with severe mental health and addiction issues are among some of our most vulnerable community members. They have complex needs that generally involve multiple health and social services. Demand for mental health and addiction services has been increasing in recent years. With the new Substance Abuse Compulsory Assessment and Treatment Act bringing additional responsibilities for services to offer longer term care to the most severely affected, it is becoming evident that new approaches are needed to help people with severe issues to live well in community settings.
Strategic Objective 1: Empower our populations to live healthy lives

What is this strategic objective about?
This objective is about helping our population to live healthy lives for as long as possible. It is also about reducing health inequities, particularly between Māori and non-Māori. As shown in Figure 7, to achieve this objective we will pursue three key headline actions over the next three years. In pursuing these actions, we will:

- Focus on the major risk areas that will have the biggest impact on health outcomes and equity, while supporting our delivery on government priorities - smoking, nutrition and physical activity, and housing
- Collaborate across public, private and community sectors to build the breadth and scale of initiatives needed to tackle the factors that impact on people’s health
- Adopt a mix of approaches that both address the whole population and target the five priority populations (see pages 19 to 20) - for example, support people with long term conditions to self-manage and support improvement in health literacy.

Why does this matter?
If we empower and support our population to live healthy lives - particularly early in life - we will reduce the burden of disease. Today in New Zealand, around 80% of deaths are attributable to long term conditions. These include diabetes, cardiovascular disease and COPD, with many of these conditions being preventable as they are linked with factors such as obesity and tobacco consumption.

Unfortunately, while the Bay’s population generally has good health compared to others in New Zealand, it still ranks relatively highly on the prevalence of the key health risk factors that contribute to long term conditions. These population health risk factors contribute to a higher proportion of our population dying early for reasons that could have been avoided – such as respiratory conditions linked to smoking.

Sadly, we also know that while we have been working hard to reduce health inequities - particularly between Māori and non-Māori - a large gap remains in key outcomes, such as life expectancy. The causes of this gap are almost exclusively preventable and require broad-based health, social, and community interventions.
Moreover, data integrated across government-funded health and social services shows that our children and young people are more at-risk of poor long term social outcomes, with Māori being much more likely to be at-risk. We recognise that this is unacceptable, and that the Bay of Plenty health system has a part to play, alongside other social services, in addressing these risk factors.

The following headline actions will move us forward on our journey to turn this strategic objective into reality.

**Headline action 1: Increase our focus and investment in health improvement and prevention activities**

The *Bay of Plenty’s Health and Service Profile 2016* identified that significant health gains and equity improvements could be made through tackling major health risk factors. Most notably the Profile found that:

- 35,000 people in the Bay of Plenty continue to regularly consume tobacco (a prevalence rate significantly higher than the New Zealand average)
- 57,000 adults are obese, with 10,000 adults estimated to be classified as morbidly obese (with opportunities to improve nutrition and physical activity)
- Over 4,000 children are obese, indicating significant risk of them developing long-term conditions as adults
- Housing availability and poor conditions continue to contribute to poor health outcomes. For example, many of our family/whānau live in households that lack insulation and heating, with this contributing to preventable hospitalisations for respiratory and other conditions.

Within these risk factors, Māori tend to fare worse than non-Māori — with two to three times the risk of smoking tobacco, and twice the risk of being obese or hazardously consuming alcohol. More positively, self-assessed physical exercise and fruit and vegetable intake are comparable to non-Māori.

Smoking is also more common among youth and young adults, partly reflecting the Bay of Plenty’s age profile of the Māori population, which is disproportionately younger. Similarly, smoking prevalence is higher in the Eastern Bay than the Western Bay, with the Eastern Bay having a higher proportion of Māori residents.

We have been taking a range of actions to address major health risk factors, and these actions are generating positive results. We believe that the pace and scale of our actions needs to increase, to make significant gains in health outcomes and equity for our priority populations. In doing so, we will focus on:

- Tobacco consumption (‘smoking’)
- Risk factors linked to obesity
- Housing for our most vulnerable populations.

**Headline action 2: Work more collaboratively to increase the pace and scale of ‘health in all policies’**

Both this SHSP and our *Integrated Healthcare Strategy* recognise that there are many factors outside the health system that influence our community’s health. Health status is closely linked to social determinants, which are the conditions in which people are born, grow, live, work and age. As a health system, we need to work with agencies from other sectors – such as local government, education, housing, justice, and social development - to tackle the complex and long term challenges that some New Zealanders and their family/whānau face.
Working with other sectors is at the heart of the ‘health in all policies’ (HiAP) approach we have been developing over recent years. Our Planning & Funding and Toi Te Ora - Public Health Service have developed a HiAP workplan, which has been endorsed by the BOPDHB Board. This workplan will enable us to build momentum to tackle intersectoral issues related to health.

As part of the SHSP implementation, we will continue and accelerate our HiAP approach. Key activities in Western and Eastern Bay of Plenty will be:

- Membership on the SmartGrowth Governance Group and members of SmartGrowth partner forums
- Collaborating with SmartGrowth and Tauranga City Council on urban planning for social infrastructure and liveable environments in the major growth corridors, including Eastern Papamoa
- Reviewing DHB and council policies for their impacts on health, both on invitation and proactively, using approaches such as health impact assessment (HIA), as we have already done in the Eastern Bay of Plenty (Beyond Today - a 50-year spatial plan for the Eastern Bay)
- Leading implementation of actions in the Eastern Bay - Beyond Today Implementation Plan
- Continuing the development of an HIA for the Western Bay's Public Transport Blueprint, which is providing a significant opportunity to influence the provision of public transport
- Undertaking a number of specific initiatives and project work areas that contribute to improved population health (eg, working with Tauranga City Council on addressing homelessness)
- As part of further developing HiAP capabilities in the Bay of Plenty, we will review workforce development needs within the health sector, as well as helping our intersectoral partners to understand what capabilities they may need to develop.

**Headline action 3: Target investment to improve the lives of our most vulnerable people**

This headline action is focused on the Bay of Plenty’s most vulnerable people and how we can better meet their needs. The New Zealand Productivity Commission’s 2015 report More Effective Social Services (Appendix 1), identified the need for health and social services in New Zealand to take a different approach to supporting our most disadvantaged people to improve their lives. This links strongly with the purpose and vision for the Bay of Plenty’s health system (Figure 1). Additionally, persisting health inequities in the Bay of Plenty show that current approaches are not working as they should, resulting in negative impacts for society, associated with the high use of resource-intensive services by our most vulnerable people and families/whānau.

We will build our capabilities to contribute to the government’s social investment approach, by working collaboratively across agencies. As our partnerships mature, the Bay of Plenty health and social service agencies will share data more effectively to identify individuals and families with the greatest needs, better understand what approaches are likely to work, and co-invest in adopting new service and funding approaches. This work will build on our experiences with social sector trials and multi-agency collaborations like the Eastern Bay Children’s Team. It will also build on learnings from the three ‘place based’ social investment pilots underway in Northland, Counties Manukau, and Tairawhiti, as well as other social investment initiatives across the country.

The 10,000 highest-cost clients of the New Zealand health and social services system are each expected to generate lifetime budgetary costs of $0.5M or more, involving a total cost of $6.5 billion.

Productivity Commission
How will we know we’ve been successful?

We will know we’ve been successful when we have:

- Curbed the growth in the prevalence of risk factors and diagnosed long term conditions
- Provided every child in the Bay of Plenty with the opportunity for a healthy start in life
- Made support available for parents, children, families, whānau, and older people to lift and maintain their wellbeing
- Supported kaupapa Māori models, such as Whānau Ora, that empower whānau to identify their needs and aspirations, plan for the future, and access coordinated services in areas such as primary health care, education, and employment
- Significantly reduced the inequities experienced by the priority population groups, through a clear improvement in their health and social outcomes
- Significantly reduced rates of ambulatory sensitive hospital (ASH) admissions in children and young people.

How are we going to get there?

Progress has already been made in the Bay of Plenty over recent years, in improving population health approaches focused on health improvement, prevention and working intersectorally. Through this SHSP we will build on the accomplishments to date, by:

- Taking a well-being approach that uses positive messages to foster individual, family/whānau and community commitment to improving health
- More actively working with our family/whānau and communities to understand the best approaches for promoting good health and well-being, including mobilising communities to take greater self-responsibility, making better use of social media, and using technology to support health literacy
- Reviewing our investments in population health activities and identifying opportunities to improve the effectiveness of this spending in our key focus areas (tobacco consumption, obesity, and housing) and priority populations
- Using the System Level Measures Framework to drive better alignment between personal health and public health activities
- Continuing to develop intersectoral governance, management, and delivery mechanisms to support HiAP and social investment approaches
- Establishing workforce development activities that enable personal health and support workers to better understand population health needs and approaches, helping them to lift the health literacy of their patients.
Strategic Objective 1: Empower our populations to live healthy lives

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<tr>
<th>Activities / outcome description</th>
<th>2017/18 Key actions</th>
<th>2018/19 Key actions</th>
<th>2019/20 Key actions</th>
<th>What are measures of success?</th>
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**Headline Action 1: Increase our focus and investment in health improvement and prevention activities.**

1. Reduce tobacco uptake by young people.
2. Increase the number of successful smoking cessation attempts.
3. Reduce inequities in smoking rates for Māori and Pacific.
4. Reduce smoking rates in pregnant women and mothers of young children, and their whānau.

1. Expand programmes to reduce the normalisation of smoking in public spaces:
   a) Strengthen current smokefree environment policies;
   b) Promote smokefree cars;
   c) Promote smokefree marae, whānau and hapu through the Hapu Hauora programme.
2. Enrol and promote at least ten smokefree retailers.
3. Enrol at least 1520 people in the Hapainga regional stop smoking service, with a focus on Māori, Pacific and pregnant women.
4. Develop a smokefree social housing programme.

1. Promote legalisation of the sale of e-cigarettes as a tool to help smokers quit.
2. Develop and deliver key initiatives to reduce smoking rates amongst people with mental illness.
3. Extend existing initiatives that are having success in reducing smoking rates.
4. Enrol and promote at least ten smokefree retailers.
5. Strengthen current smokefree environment policies.

1. Enrol and promote at least a further ten smokefree retailers.
2. Review and evaluate initiatives that have begun in the past two years, and implement recommendations arising from that work.
3. Encourage Lead Maternity Carers to be advocates for smokefree pregnancies.
4. Work with NZ Police to assist with monitoring a voluntary smokefree cars programme.

Amenable Mortality
- Improve smoking cessation rates.
- Ambulatory Sensitive Hospitalisations 0 – 4 year olds
  - Improve housing conditions for children currently living in housing that is adversely affecting their health.

Improve the proportion of babies who live in a smokefree household at six weeks post-natal.

% of regular smokers enrolled in the Hapainga regional stop smoking service.

Reduce the prevalence of Māori women smoking by 5%.

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% of regular smokers enrolled in the Hapainga regional stop smoking service.

Reduce the prevalence of Māori women smoking by 5%.
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<tr>
<td>5. Increase the emphasis on reducing obesity in children.</td>
<td>1. Develop an evidence base around childhood obesity. 2. Implement actions from the First 1000 days project, focussing on maternal and child nutrition. 3. Develop service interventions for reducing obesity in children. 4. Implement actions from Toi Te Ora – Public Health Service Childhood Obesity Prevention Strategy on sugar-sweetened beverages and sugary food.</td>
<td>1. Implement two further obesity prevention programmes. 2. Review service interventions for reducing obesity in children.</td>
<td>1. Review obesity prevention programmes and implement recommendations from review.</td>
<td>Obesity prevalence at Before School Checks. 60 more homes insulated. Increased number of referrals to the current Healthy Homes Initiatives programmes.</td>
</tr>
<tr>
<td>6. Increase the emphasis on improving the quality of housing.</td>
<td>1. Increase referral rates to current Healthy Homes Initiatives programmes for 0-4 year olds. 2. Insulate 60 more homes through the community-based insulation and healthy housing programmes. 3. Support the Our Community Project interagency group to develop an integrated programme to reduce homelessness in the western Bay of Plenty. 4. Contribute to research into housing preferences for older people and options for rental tenure security for older people.</td>
<td>1. Increase scale and efficiency of healthy housing programmes. 2. Based on the outcomes of the housing research in Year 1, advocate and promote improvements in quality and the supply of different housing options to cater for demographic changes.</td>
<td>1. Monitor and review the healthy housing programmes. 2. Explore extension of homelessness programmes into the eastern Bay of Plenty.</td>
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<td><strong>Headline Action 2: Work more collaboratively to increase the pace and scale of Health in all Policies.</strong></td>
<td>1. Increase the pace and scale of implementing the Health in all Policies workplan.</td>
<td>1. Assess options for the DHB’s role in population health.1. Participate with SmartGrowth partners, Councils, Ministry of Education, and New Zealand Transport Authority on planning for social infrastructure, liveable environments and health services in urban growth areas.3. Participate in Tauranga City Council’s structure planning process for the Wairakei/Te Tumu area, to ensure adequate health services are provided for.4. Participate in the implementation of actions in the Eastern Bay-Beyond Today development plan.</td>
<td>1. Review and evaluate current workplan activities and make recommendations for further collaboration to foster Health in all Policies.</td>
<td>Proportion of people over 65 living independently. Percentage of the population with access to public transport. Memorandum of Understanding signed between Tauranga City Council, Ministry of Education, and New Zealand Transport Authority on collaborative liveable community planning and implementation.</td>
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- Assess options for the DHB’s role in population health.
- Participate with SmartGrowth partners, Councils, Ministry of Education, and New Zealand Transport Authority on planning for social infrastructure, liveable environments and health services in urban growth areas.
- Participate in Tauranga City Council’s structure planning process for the Wairakei/Te Tumu area, to ensure adequate health services are provided for.
- Participate in the implementation of actions in the Eastern Bay-Beyond Today development plan.
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</table>
| **Headline Action 3: Target investment to improve the lives of our most vulnerable.** | 1. Work collaboratively across agencies to build our capabilities to contribute to the government’s social investment approach. | 1. Continue to build capacity and capability in the Eastern Bay Childrens Team.  
2. Ensure 80% of our workforce is trained in engaging effectively with Māori.  
3. Continue to work with iwi and community agencies to develop a medium and long-term effective psychosocial response in Edgecumbe.  
4. Introduce incentives into the DHB’s contracts for the achievement of outcomes that improve Māori health equity. | 1. Keep abreast of progress made with the social investment place-based pilots underway in Northland, Counties Manukau and Tairawhiti, and other social investment being undertaken across New Zealand.  
2. Ensure 95% of our workforce is trained in engaging effectively with Māori.  
3. Continue to introduce incentives into the DHB’s contracts for the achievement of outcomes that improve Māori health equity. | 1. Dependent on outcome of social investment place-based pilots underway in Northland, Counties Manukau and Tairawhiti, and other social investment being undertaken across New Zealand.  
2. Review use of incentives to achieve outcomes that promote Māori health equity. |
Strategic Objective 2: Develop a smart, fully integrated system to provide care close to where people live, learn, work and play

Headline actions:
- Enhance general practice as our population’s health care home
- Promote and progress interdisciplinary community teams to enable people to stay well, and get well
- Implement care coordination for people with complex needs

What is this strategic objective about?
This objective is about:

- More conveniently delivering services closer to where people live, learn, work and play
- Emphasising prevention, self-management and early identification of when care is needed
- Being much more coordinated in how care is provided, particularly for people with chronic and complex needs, and those who have more difficulty managing their health and accessing services
- Creating a more ‘joined-up’ system through connecting primary, community, specialist and social services into larger networks supported by care pathways and shared care approaches – a ‘one team’ approach
- Supporting our hospitals to focus on high-end, specialised care that cannot be safely and effectively provided in community settings
- Increasing the proportion of health care that is provided ‘virtually’ so that patients can have more timely access to information and advice, and our health professionals can make best use of their time.

Why does this matter?
More people are living in the Bay of Plenty with long term conditions, such as diabetes, cardiovascular disease, COPD, and dementia. In addition, our population is growing and ageing - increasing demand for our health services. The pressures on our services are expected to intensify over the next 20 years. Unless we work more effectively, our resources will be increasingly focused on acute hospital care to cope with this burgeoning demand. This will mean fewer resources available to improve population health outcomes and reduce inequities for our most vulnerable populations (Strategic Objective 1).

9 Integration can have many different meanings in health care. In this SHSP, we use the term ‘integration’ to describe a system in which there are smooth patient journeys through the health system regardless of the patient’s needs or point of referral.
10 One of the strategic themes from the New Zealand Health Strategy.
11 One of the strategic themes from the New Zealand Health Strategy.
We know that there are better options for use of our limited funding, which are evidence-based and more effective in meeting population health needs. This does not mean limiting access to our valuable hospital services; these will continue to provide high quality care for people with high clinical needs. Instead, through this strategic objective, the Bay of Plenty’s health system will build greater capability and capacity in community settings, to enable more patients and families to have their health care needs met in a timely manner, closer to home.

By further building the capability of our highly skilled community-based medical, nursing and allied health workforce, supported by the non-registered workforce, our population will have continued access to good quality health care. In addition, people with more complex needs will receive team-based care, and our most vulnerable populations will experience health and social services working together more effectively.

To achieve this strategic objective, the Bay of Plenty will build on learnings from the Integrated Healthcare Strategy, with its vision that by 2020:

Bay of Plenty health services will be centred on the needs of people, their families and whānau. People will be able to easily access services when required and health care workers will be able to seamlessly transfer care between settings when needed. People will be empowered to manage their own health and to share in decision making.

The following headline actions will move us forward on our journey to turn this strategic objective into reality.

**Headline action 1: Enhance general practice as our population’s health care home**

A successful, integrated health system is built on a foundation of strong primary and community health services, which work cohesively with each other, and with specialist and social services. The concept of the ‘health care home’ (or ‘medical home’) is emerging internationally, as a key platform for enhancing general practice as the foundation of the wider health system – the place patients identify as their first point of contact in the system, and the source of holistic and continuing care.

In health care home models, general practice capacity and capability is enhanced through development of new roles, skills, and capabilities. New clinical and non-regulated workforce roles are introduced to support the traditional practice team members (GPs, practice nurses, and receptionists) so that they can work at the top of their scopes of practice. Broad-based interdisciplinary teamwork is built on the principle that while the GP maintains overall clinical leadership, care for the patient is delivered by the most suitable team member who can cost-effectively maximise the patient’s health outcomes and experience.

Health care home models also have a strong focus on making the best use of digital technologies, through promotion of ‘virtual health’, system generated patient contacts, and use of data to risk stratify populations and design new tailored care models (see Supporting Infrastructure, sections 5.3 and 5.4). Virtual care can include using technologies like Skype instead of face-to-face consultations with GPs, nurses, and allied health staff. Similarly, it can include email consultations and/or access to advice through ‘smart phone’ applications. These models support patients having enhanced access to information and advice closer to home and making best use of both the clinician’s and patient’s time. System generated contacts also make use of these new technologies through enabling practices to send alerts to patients regarding preventive health services (eg, reminders for flu vaccinations or cervical screening notifications). They can also be used to support self-management through prompts/reminders (eg, reminders for adhering to Green Prescriptions or checking blood glucose levels).
Focus areas for enhancing general practice in the Bay of Plenty include:

- Designing and applying a risk stratification approach to support ‘stepped care’ for patient cohorts that match resources to severity of need; this includes shared care planning; and team-based ways of working
- Extending the scope of the general practice team through increased use of the non-registered workforce (eg, physician assistants, health care assistants, health coaches and care navigators), and strengthening the roles of nursing (eg, nurse practitioner) and allied health (eg, clinical pharmacist)
- Encouraging practices to be more proactive in their engagement with their registered and casual populations through system-generated contacts
- Increasing the use of virtual consultations and non-traditional ‘patient contacts’ to improve access and enable greater service capacity
- Enhancing the use of technology through patient portals, shared patient records, shared care plans, and remote monitoring of patients
- Redesigning ways of working in practices to make best use of the patient and practice team’s time
- Enabling practices to undertake or more easily arrange an increasing range of ambulatory medical and diagnostic procedures, which historically have been provided by referral to our hospital services.

**Headline action 2: Promote and progress interdisciplinary community teams to enable people to stay well, and get well**

In order to expand the capacity, capability, and integration of primary and community health care services and to reduce the current levels of reliance on hospital services, we will increase support for the Bay’s general practices through interdisciplinary community teams. This will help us to deliver better coordinated care closer to home, supporting our hospital services to focus on high-end, specialised care that cannot be safely and effectively provided in community settings.

The aim of the team will be to build stronger links between local general practices and community health services, as well as secondary services where appropriate, to meet the needs of the practice population. Each interdisciplinary team will support a ‘cluster’ of general practices to generate the workload needed to sustain viable community services, and to serve natural communities of interest across general practices. Over time, teamwork may be further enhanced by co-location of the interdisciplinary team in a ‘community hub’. Where the size of the general practice patient population and facility supports it, the team could be co-located with the practice.

There are four key categories of services that will evolve to operate within the interdisciplinary community team framework:

1. BOPDHB Community Health Services personnel (eg, district nursing, allied health including dietetics, social work, Māori health, occupational therapy, clinical pharmacy, physiotherapy, psychology, and podiatry)
2. BOPDHB specialist services personnel working in community settings (eg, mental health workers, clinical nurse specialists, Māori health, and community medical specialists)
3. BOPDHB-funded NGO services (eg, home-based support workers, staff in kaupapa Māori services, and community mental health)
4. Social services funded by other sectors (eg, housing, education, social development).

Focus areas for creating interdisciplinary community teams include:

- Building stronger operational relationships between general practices and community services, to work collaboratively to address population needs
- Consolidating significant primary and community health workforces that serve a local population, to deliver the benefits of critical mass, interdisciplinary teamwork, local responsiveness, and shared care for patients and family/whānau
• Building stronger and more explicit relationships with BOPDHB specialist services, with particular emphasis on defined care pathways and shared care models, and supporting ongoing professional development
• Supporting community step-down models of care (mental health, older people, and lower acuity medical needs) – as developed through Strategic Objective 3
• Promoting interdisciplinary cooperation and clinical quality improvement.

Headline action 3: Implement care coordination for people with complex needs

Care coordination is a function that deliberately organises, communicates, and shares information among patients, family/whānau and a range of health and social care agencies, to support the patient and family/whānau in their health and wellbeing. It involves helping patients to navigate health and social services, to access appropriate care as early as possible. Often the support that a person and family/whānau need will not be health services alone, but also other social services. Therefore, effective care coordination approaches relate to the broader aspects of individual and family/whānau well-being, including social, environmental, and spiritual and cultural elements (as envisaged by He Pou Oranga and Pae Ora).

A care coordination approach will be developed to support ‘joined up’ working across general practices, interdisciplinary community teams, and secondary services - and potentially social services, as the model evolves. The main focus of the approach will be people with complex needs, since the higher the level of patient and family/whānau need, the greater the range of services involved, and therefore the greater need for coordination.

Care coordination will be provided through the person's preferred general practice (their health care home) and supporting interdisciplinary team, with the most appropriate service provider filling the role of care coordinator. Sometimes a general practice worker will best fulfil this role; in other cases, it may be a member of an interdisciplinary community team, a Kaupapa Māori health provider, or in some instances, an empowered family/whānau member.

The focus areas for developing a care coordination approach will include:

• Building on work undertaken and learnings from the Bay's Integrated Community Nursing initiative and the New Zealand and international experience of care coordination approaches
• Using the risk stratification and stepped care model to develop the principles and design features of care coordination in the overall integrated system of care, including pathways for referral into care coordination
• Developing a competency framework for defining the necessary skills and experience for undertaking care coordination, particularly for people with more complex needs
• Tailoring care coordination approaches to balance the needs and aspirations of communities across the Bay of Plenty, Māori and non-Māori, urban and rural, and enrolled, non-enrolled, and transient communities
• Supporting development of service directories attached to care pathways to support efficient coordination of care.

12 The care coordination approach envisaged in the Integrated Community Nursing initiative seeks to establish, re-establish, and strengthen whakawhānaungatanga with patients, whānau, local communities, and service providers.
How will we know we've been successful?

We will know we've been successful when:

- Primary care services, community care services, and our hospital services are working cohesively as ‘one team’ in integrated care models based on the needs of our populations and communities
- Services are much more person-centred, having been designed and improved through patient engagement and specialist advice
- Patients report that it’s quicker and easier to get the care they need
- General practice has evolved into health care homes, supported by interdisciplinary community teams, that together deliver planned, structured, and responsive care, with strong linkages to secondary care
- A greater proportion of the population is enabled to effectively self-manage their health
- A much greater proportion of care is delivered virtually, enabling patients to access information and advice more quickly, supporting the long-term viability of our primary and community health sector
- Less administration for health professionals, with quick access to the support they need to provide care for patients
- Slowed acute admission growth for hospital services
- A rebalanced local health system, which is less hospital-dependent.

How are we going to get there?

Integrated models of care across professions, settings, organisations, and sectors are at the heart of Strategic Objective 2. To enable the implementation of enhanced general practice through the health care home, interdisciplinary community teams, and care coordination approaches, the actions outlined in the roadmap below include, and are not limited to:

- Defining an approach for thinking about populations and communities of interest in localities, so that we can work with patients, family/whānau, and care providers to redesign care models to better meet local health needs
- Analysing health need, service availability, and system performance, including a focus on Māori health, to support the enhancement of general practices as health care homes, and design and implementation of interdisciplinary community teams and care coordination approaches
- Designing and implementing a risk stratification approach and patient-centred models of care, in line with contemporary leading practice, for different risk cohorts, including:
  - The enhanced general practice, as the health care home for patients and communities
  - Self-management models of care
  - Interdisciplinary community teams to support shared care planning and delivery for patients and their family/whānau
  - Stepped responses to increasing levels of patient risk, with responses tailored to personal circumstances
  - Care coordination approaches that help patients with more complex needs access the services they require across settings and sectors
- Identifying efficient resourcing models in line with population health needs, with a particular focus on community nursing and allied health services, and enhanced linkage between ‘mainstream’ and kaupapa Māori providers
- Encouraging the use of virtual health approaches by primary and community care providers, and by specialist services
• As part of the model of care and care coordination design, applying a whānau ora approach to enable further opportunities for practitioners to fill the care navigator role – as envisaged through He Pou Oranga

• Designing and implementing funding and contracting models (see Supporting Infrastructure, Section 5.7) that support:
  - A focus on outcomes and achievement of health equity
  - Person-centred and directed care
  - A one team approach
  - Cost-effective delivery through new workforce models and virtual health approaches.

Given the unique circumstances of the Bay of Plenty’s communities and varying aspirations of the local providers, it is likely that a phased approach to model of care change will prove most effective. This will include establishing demonstration sites for new models of care in prioritised services and/or communities, evaluating implementation and care outcomes, and dedicated resources to support the spread of innovation. The length of demonstration will vary according to the scope and scale of change being undertaken, and may last up to 12 months. A PDSA/action learning approach will be used, with timely results informing fine-tuning of the model. Evaluation learnings will be shared across services and/or communities as roll-out of the new models of care spreads across the Bay of Plenty health system.
## Strategic Objective 2: Develop a smart, fully integrated system to provide care close to where people live, learn, work and play

<table>
<thead>
<tr>
<th>Activities / outcome description</th>
<th>2017/18 Key actions</th>
<th>2018/19 Key actions</th>
<th>2019/20 Key actions</th>
<th>What are measures of success?</th>
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<tbody>
<tr>
<td><strong>Headline Action 1: Enhance general practice as our population’s health care home.</strong></td>
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<tr>
<td>1. Define the features of a health care home.</td>
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<tr>
<td>1. Work with PHOs and interested parties to define options for business models and features of a health care home, including need for a locality approach.</td>
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<td>2. Using the locality approach, carry out service and resource mapping and gap analysis.</td>
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<tr>
<td>3. Work with PHOs and interested parties to trial health care homes (up to 4) using a mix of general practices to support learning.</td>
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<tr>
<td>1. Continued expansion (up to 8) of healthcare homes across the Bay of Plenty.</td>
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<tr>
<td>1. Evaluate health care home progress and develop more, dependent on progress.</td>
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<td><strong>Patient Experience of Care</strong></td>
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<tr>
<td>• Increased availability of Patient Portals</td>
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<td>• Improved management of DNA rates for specialist appointments for ENT and Maternity.</td>
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<td>• Active participation in Patient Experience of Care Surveys (PES).</td>
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<td><strong>Amenable Mortality</strong></td>
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<tr>
<td>• Improve breast and cervical Screening rates for all eligible women.</td>
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<td><strong>Ambulatory Sensitive Hospitalisations 0 – 4 year olds:</strong></td>
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<td>• Improved childhood immunisation, with a focus on reducing the equity gap between Māori and non-Māori 8-month immunisations</td>
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<td><strong>Headline Action 2: Promote and progress interdisciplinary community teams to enable people to stay well, and get well.</strong></td>
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<td>1. Using information from risk stratification processes, design shared care planning approaches and deploy technologies that enable shared planning and care delivery (see also Supporting Infrastructure 5.4).</td>
<td>1. Complete the Whānau ora Access Pathway.</td>
<td>1. Evaluate the outcome of the shared care planning trial, and adopt a solution for Bay-wide rollout.</td>
<td>1. Roll out shared care planning.</td>
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<tr>
<td>2. Test and trial options for shared care planning approaches eg. Whānau Tahi.</td>
<td>2. Identify requirements and establish the capability to support a shared care planning approach.</td>
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<tr>
<td>Activities / outcome description</td>
<td>2017/18 Key actions</td>
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<tr>
<td>2. Increase community step-down models of care (mental health, older people, lower acuity medical needs) to enable lower complexity care to be provided in non-hospital settings.</td>
<td>1. Design and establish an interdisciplinary team transitional care programme in the community.</td>
<td>1. Review and expand the transitional care programme.</td>
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<td>Acute Bed Days</td>
</tr>
</tbody>
</table>
* Reduce the number of day's spent in hospital by people with COPD. |
* Increase the use of ambulatory care for patients presenting with cellulitis. |
| 1. Review and expand the transitional care programme. | | | | |
| 1. Develop, trial and implement a Common Assessment Form to enable the development of an integrated model of care. | | | | |

See also related actions around risk stratification under Using Information to Improve Value in the Infrastructure section

**Headline Action 3: Implement care coordination for people with complex needs.**

| 1. Implement a care coordination approach. | 1. Begin to develop community care coordination services starting with Community Nursing and expanding to include Allied Health, NASC, and the Community Response Team. | 1. Review and evaluate community care coordination services. | 1. Bay-wide roll out of model of care. | Increase % of patients with a long term condition who have a shared care plan. |
Strategic Objective 3: Evolve models of excellence across all of our hospital services

Headline actions:

- Strengthen working relationships across care providers to manage demand for hospital services
- Improve patient flows through the hospital
- Define the future scope and mix of hospital services in the Bay of Plenty

What is this strategic objective about?

This objective is about re-defining the roles of our two hospitals, and our Te Kaha, Kawerau, Murupara and Opotiki health centres, in the context of a joined-up health system partnership. It is also about ensuring that the services that must be provided by our hospitals are delivered safely, sustainably and in an exemplary way. Our hospital services include specialist inpatient, outpatient, emergency and supporting services. They provide clinical care through specialist teams, as well as accommodation for patients.

The simplest measures of success are that:

- Patients say that they had a great experience of our services, where they were listened to, treated with care and respect, and their individual needs were met
- Staff feel supported and empowered to flourish in their unique roles, have manageable workloads, and have the resources they need to deliver excellent care and support services
- We successfully work within, and make the most of, the funding that is available to us, spending wisely and effectively.

The three headline actions outlined above summarise our intent during the next 10 years to:

- Grow partnerships within the health and social care sectors, so that we can work together to redesign and deliver services in ways that work well for our patients and communities, across the Bay
- Re-think how we work within our hospitals, involving our staff and patients in helping shape exemplary services, and systematically working through issues that get in the way of achieving this. Much of this is about making the patient’s journey through hospital care as quick and easy as possible, with minimal bottlenecks and all of our services working together as ‘One Team’
- Carefully consider which services could be delivered in a much better way without being constrained by our traditions if the evidence demonstrates changes could be better for patients, better for staff, and more efficient.

In summary, this is about working together to deliver excellent, safe care in ways that work best for our communities and staff, within the resources we have available to us.
Where are we now?

Our hospital-based services provide great clinical care and support services. However, growth in our population and the increasing expectations on health service providers, means that it is becoming increasingly challenging for our services to manage demand within the constraints of the available workforce, infrastructure, and funding. Examples of the challenges we are facing are:

- **The use of our Emergency Departments** is relatively high and is growing, with specific surges in attendances on certain days of the week and during cold spells. This suggests difficulty in accessing or affording urgent care in the community. Initial review of recent attendances suggests at least 25-35% of these could have been cared for much more quickly by GPs or specialist nurses and allied health professionals. Emergency Departments were originally set up for major injuries or health problems, such as fractures and heart attacks, but have evolved to be a replacement GP service for many people. This means large queues and often long waiting times, which frustrate patients and stress staff. Addressing this will require a radical re-think of our whole health system’s acute care service model and require increased access to seven day services in the community so that patients are less dependent on the hospitals’ services. We have to make sure that current funding arrangements do not get in the way of designing a much better model of care for the future and we would expect quite different approaches to this in our two hospitals. Equally we want to make sure that Te Kaha and Opotiki are well supported to provide for urgent local care needs as well as increasing the range of services provided - where it is clinically appropriate.

- **The Bay of Plenty has a higher unplanned (acute) hospitalisation rate than the New Zealand average**, with relatively high ambulatory sensitive hospitalisations (ASH) for children. This means that more people are being admitted to hospital than would be if other systems of earlier intervention and support were utilised. These issues are complex and multi-factorial, with no single solution. Addressing them requires robust, integrated responses to all parts of the local health and social care system. However, our hospital services need to play their role in securely connecting patients and family/whānau with other care providers, to avoid unnecessary admissions to hospital wherever we can.

- **The average length of hospital stay for Bay of Plenty residents is longer than the national average.** This is particularly the case at Tauranga Hospital; Whakatane Hospital has a generally shorter length of stay and in some cases (e.g., orthopaedics) is deemed to be an Australasian exemplar site. At Tauranga, tighter multidisciplinary management of hospital admissions and length of stay is one component of the solution, accompanied by enhancement of community services to care for patients with complex needs who do not need hospital level care. Over the next 10 years we would expect to see developing models of step-down care in community beds for those patients who have longer length of stays, but do not need the full services of the hospital.

Over the past 18 months, our hospital and service improvement teams have begun to explore alternative, more sustainable models of care to reduce length of stay in hospitals and provide increased ambulatory health care (which means a patient doesn’t require an overnight stay) at Tauranga Hospital. There are several reasons why we want to reduce the length of stay in hospital:

- Older patients deteriorate from their normal levels of function very quickly when confined to a hospital bed
- There are risks of acquiring an infection in hospital, often unrelated to the patient’s presenting medical condition. The busier our hospitals are, the higher this risk
- It costs about $400 for one night in hospital and benchmarking data suggests that we have
over 8,000 nights a year of unnecessary stays. These costs could be much better invested in faster frontline (ambulatory) care. Many of our patients are in hospital overnight because they are waiting for something rather than because they need hospital care. We want to change this.

- There are robust, evidenced based models of care for treating medical patients as efficiently as possible during the daytime on the day they arrive and then going home, rather than being admitted to hospital. This is what we mean by the term ambulatory care. However, many patients can also receive treatment within community health services or by their GP and don’t need to come into hospital at all.

- We need our hospital beds for patients who medically need to be in hospital; we don’t want to be short of beds because this means patients coming in for surgery are more likely to have their operations cancelled.

We know that by continuing this re-design work alongside the initiatives outlined in Strategic Objectives 1 and 2 of this SHSP, we will be able to better manage demand within the limitations of supply. These principles apply to both hospital sites.

• **Dental services** provided by our hospitals include our community child dental service (delivered in mobile units from schools across the Bay) and our hospital dental services (currently outsourced). Delayed access to early intervention (for example with dental abscesses) is leading to a notable increase in avoidable hospital admissions. During the next 10 years we plan to review the current model and test whether a Hospital Dental Department would provide an improved, more efficient model of care.

• **Mental health**

Nationally, mental health and addictions services are coming under considerable scrutiny. While we have excellent teams within our services, there are some fundamental issues that it is imperative we resolve, including:

- Significant growth in need, especially in child services (CAMHS)
- Accommodation which is inadequate and is constraining best models of care
- The rise and future expected trends in need for dementia care
- The way services are commissioned (primarily on an input [numbers] model rather than outcomes); this does not always fit with best clinical care
- How we work with other mental health care providers to provide earlier, and ongoing support for patients, rather than being a last resort for people in crisis
- How we can better understand the impact of childhood trauma and configure a system of support for our most vulnerable children and adolescents, who statistically become high users of mental health and medical services throughout their lives.

• **Surgery**

Our hospitals have three operating theatres at Whakatane Hospital and eight at Tauranga Hospital. Over recent years the number of elective operations have continued to grow – both to meet increased targets for the number of operations (discharges) and reduced waiting time imperatives. However, we are also seeing year on year increases in urgent surgery, for example, for cancer and traumatic injuries, which have now exceeded the number of routine operations we perform. As a result, our operating theatres are close to full capacity. It is imperative that we use our current theatre
capacity as efficiently as possible and work is currently underway in this area. However, we will need access to additional theatre time for surgery within the next two years; determining how we do this will require a dedicated piece of work. We would expect that out of hours acute surgical demand growth will require a theatre night staff team within the next 1-3 years, rather than the current on-call arrangements.

- **Management and administration**

Our management and administration teams are often forgotten about in the context of clinical demand growth. However, these groups are critical to a successful organisation. While our clinical teams have grown in size over the past 10 years, our management and administration resources have largely remained fixed. Although it is not our intention to significantly increase the size of our management teams, we do need to make their roles manageable to ensure they have the capacity to provide the necessary leadership and support to our teams, as we evolve our service models in the years ahead. Key to this is becoming more agile and less bureaucratic in the way we work, ensuring managers have time to plan, time to work on co-design of new models, and time to implement change successfully.

Our Service Improvement Team has been essential to the many developments that have been achieved over the past 10 years. We would expect this team to evolve into, and form the starting point of, a whole of system re-design network, linking primary and secondary care teams into the implementation of actions within, and in support of this plan.

Professional development of our administration support teams is progressing under our Recognising Administration Professionals (RAP) programme, with the aim of having an NZQA accredited Health Administration training and certification programme for certain roles. However, navigating changes around reduced paper-based systems, electronic referral systems, and patient records, will require careful thought as new skills will be required. In the short-medium term, it is important that as services grow (for example when recruiting new consultants) we ensure that our administration teams are appropriately resourced.

- **Community nursing and allied health services**

A specific joint BOPDHB and PHO programme is underway to reconfigure how our hospital-based district nurses work in conjunction with primary care-based community services. It will be important to also review community allied health team roles, functions, and services provided as part of the proposed interdisciplinary models of care in Strategic Objective 2.

- **Outpatients**

Many of our outpatient clinics are close to full capacity and will not be able to accommodate any more growth within current models. This means that we have to decide whether to build or rent more physical space, or to revisit the traditional outpatient concept completely and look for new alternatives. We currently have a failed appointment (DNA) rate of around 6.2%, but this is approximately 16% for Māori patients overall (except at Te Kaha where we have the highest Māori population rate but the lowest DNA rate). Some specialty clinics have DNA rates of over 20% historically and in total we have thousands of failed appointments each year, where all the administration work has been done but with no outcome.

Creating additional physical space at significant extra cost on our hospital sites does not seem to be the best way forward, not least with the additional impact on car parking, local traffic, and the developing discussion about what consultations might look like over the next 10 years. We
propose a radical re-think of outpatient appointments to bring this 1940s model into a 21st century environment, while recognising the individual needs and preferences of our diverse population groups.

- **IT systems and informatics**

The use of technology in our hospitals is many years behind the best in the international healthcare industry, with the current focus still on implementing a basic Midland Regional IT programme (eSPACE). However, a roadmap is under development to propose a sequenced approach over the next 10 years to the implementation of new technological solutions. Our concept roadmap includes:

- Information applications for staff
- Patient Health application functionality to manage appointments
- Smartphone check-in to clinics.

Given the smaller scale of Whakatane Hospital, this could be a very useful test site for progressing towards a digital hospital concept.

**Why does this matter?**

Every day our hospital and specialist services provide safe, high quality care to enhance the lives of Bay of Plenty residents and visitors. We need this critical health system function to continue. However, given the increasing severity, complexity and population growth our hospital services are in high demand and are the most expensive part of our local health system. This means we must ensure that these services are used only by people who are medically required to be in hospital. We also need to ensure that the hospital services are as efficient, streamlined and well managed as possible.

The Bay of Plenty’s health system is at a critical point where we need to ensure that any further investments in hospital facility capacity are stringently assessed against alternative investments in prevention and out-of-hospital models of care. If we do not do this, we will not be able to:

- Adequately resource essential frontline secondary services
- Address issues related to unmet need
- Afford to invest in improving access and care in community settings.

Ultimately, the performance of the Bay’s health system would deteriorate – compromising our achievements over the past 10 years.

However, the hospital alone cannot achieve these improvements. Health systems are complex and interconnected and the actions relating to Strategic Objectives 1 and 2 in this SHSP will have a significant impact on moderating growth in hospital demand – including through specialist services working more effectively in community settings.

In summary, our aspirations for how we want to provide care through our hospital services include:

- Redefining the role of our hospital services so our community and other health providers understand that enhanced general practice is the first point of contact for health care (the health care home)
- Our hospital services working ‘All as one team’ with primary and community care services in integrated care models based on the needs of our populations and communities (Strategic Objective 2)
- Making sure we appropriately resource the services we provide, but checking that these services cannot be provided more efficiently in the community
- Developing approaches that value the patient’s time so people:
- Only come to the hospital when they really need to and only spend as long in our hospital as required by their clinical needs
- Can access specialist advice, care, and diagnostics much quicker and in the easiest way possible. For example, by reducing waiting times for people who need hospital specialist consultations from the four month national target to just a few weeks, where possible; reducing the time to access radiology services; and by exploring smartphone use for simple consultations and advice
- Receive ambulatory models of care wherever possible, supported by general practice and interdisciplinary community teams.

• Re-designing how we provide services by including patients, clinical staff and management teams working together and contributing their ideas for how our system could work better.

The following headline actions and areas of exploration will move us forward on our journey to turn this strategic objective into reality.

Headline action 1: Develop closer working relationships across health care providers to manage demand for hospital services

We will always need specialist services provided in the hospital for clinically complex care. Innovations in skills and technologies have meant a continuing move internationally of care from hospital admission to day case and from hospital to community settings. The pace of this transition is likely to accelerate over the next 10 years, allowing us to continue to provide services in lower cost settings, closer to home, or via technology such as smartphones.

Minor surgical procedures and treatment for serious skin infections are now available from general practices rather than specialists in hospitals and more nurse-led ‘hospital in the home’ models of care can be used for lower acuity medical patients. New anaesthetic and surgical techniques allow procedures to be performed as day cases, in theatres or even in ‘lower specification’ procedure rooms. Some specialist assessments can be held in clinics in the community, rather than on a hospital campus and some follow-up assessments can be undertaken by GPs and other healthcare professionals, rather than specialists. Some rehabilitation for older people can be moved from the hospital to community settings – either to a residential care facility or into the home.

We will promote these and other such moves of services where they do not compromise safety and quality, as they are more convenient for patients and more clinically and financially sustainable for the health system.

An important tool for improving access and quality of care, and optimising the use of hospital capacity, is through the use of defined care pathways for the more common conditions and patient types. Care pathways should support timely diagnosis, treatment of the patient in the most effective and convenient location, earlier discharge, more effective reconnection of patients with primary and community services, and reduced variation and increased reliability across the whole system. Care pathways will be a critical component of delivering on Strategic Objective 2, as well as development of closer working relationships across health care practitioners to manage demand for hospital services.
Opportunities for exploration

The focus areas for developing closer working relationships across the health system, to manage demand for hospital services, will include:

- Identifying services or patient cohorts that can have their care delivered safely and conveniently in community settings, and partnering with others to implement the necessary supports to enable this to happen
- Reviewing existing care pathways operating in the Bay to ensure they work effectively across the whole continuum of care (Strategic Objective 2), enabling our hospital services to increase their focus on providing care for more complex patients
- Being more active in establishing expectations for pathway use and monitoring adherence to them
- Encouraging more shared professional development activities between primary and secondary clinicians
- Designing shared care planning approaches and deploying technologies that enable shared planning and care delivery (see Supporting Infrastructure, Section 5.4). The concept of care co-ordination in Strategic Objective 2 will have a significant impact on how we provide care in the future, and pave the way for a range of services to provide care in the community rather than in the hospital
- Exploring the concepts of bringing some hospital, community and NGO services together as whole of system services. This could be through amalgamation or networking and may include a Child Health and Wellbeing Network, where community health, CAMHS, and hospital-based children's services work as a single team. A similar model could be explored for Mental Health Services - where better linked GP, NGO, and hospital functions may together be able to provide a much more proactive and supportive mental health care approach, that reduces crisis admissions to hospital.

Headline action 2: Improving patient flow through our hospitals

Fundamentals of excellence

Excellence in the performance, delivery, and patient experience of hospital-based services is dependent on many factors. How patients flow through our hospitals is not just about the development of streamlined models of care, but how all of our hospital services and teams work together. Table 1 is a starting point on what we believe are the essential characteristics for delivering exemplary hospital based services, where patients have an efficient, well supported journey and receive safe, high quality person-centred care.
Table 1. Essential characteristics for delivering exemplary hospital based services (initial starting point)

<table>
<thead>
<tr>
<th>Our people and teams</th>
<th>Our performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaged, empowered staff who feel valued and appreciated</td>
<td>A top quartile performer in the New Zealand health sector on the most important target measures</td>
</tr>
<tr>
<td>Manageable, stimulating workloads</td>
<td>Consistently achieving National Health Targets</td>
</tr>
<tr>
<td>Increased delegated responsibilities and accountability</td>
<td>Closing health disparities</td>
</tr>
<tr>
<td>Recruiting the best people, supporting their development and dealing effectively with inappropriate behaviours</td>
<td>Continually improving against safety and quality standards</td>
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<table>
<thead>
<tr>
<th>How we do business</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within a CARE* values ethos and culturally safe environment</td>
<td>Authentic, mature and expert leadership</td>
</tr>
<tr>
<td>With minimal waste and duplication of effort</td>
<td>A robust clinical leadership structure which empowers specialists through distributive leadership</td>
</tr>
<tr>
<td>Always listening to feedback, learning and evolving</td>
<td>Agile management and streamlined decision-making</td>
</tr>
<tr>
<td>Working in effective partnerships across the DHB and wider health and social care system</td>
<td>Carefully selected leaders who role model our CARE values</td>
</tr>
<tr>
<td></td>
<td>Inclusive and focussed on bringing out the very best in our people</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our environment and infrastructure</th>
<th>The services we provide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal use of paper, with optimal use of IT</td>
<td>Reliable and sustainable services</td>
</tr>
<tr>
<td>Appropriate accommodation that meets our needs without being excessive</td>
<td>Evidence based models of care with minimal variation</td>
</tr>
<tr>
<td>Increasingly environmentally friendly</td>
<td>Well-designed systems and models of care based on efficient flow and valuing the patient’s time</td>
</tr>
<tr>
<td></td>
<td>Evolving through patient and staff feedback and co-design</td>
</tr>
<tr>
<td></td>
<td>Robustly monitored by our clinical governance framework to ensure safe, quality care</td>
</tr>
</tbody>
</table>

*CARE stands for Compassion, All-one-team, Responsiveness, Excellence
Making sure we're delivering safe, quality care

Adoption of a continuous improvement philosophy by all disciplines and services will progressively reduce unwarranted variation, errors, and cost in the delivery of services, improving patient experience. This in turn will allow us to deliver better and more extensive services within our available resources.

We have recently commissioned work to better understand opportunities to improve the efficiency of our hospital services, starting with our acute emergency, medical and surgical services.

Work to date has demonstrated we can improve:

- Timeliness of services in our Emergency Departments for patients
- Flow and efficiency of patients using ambulatory hospital services
- Earlier identification and assessment of frail and elderly patients to prevent deconditioning and improve patient quality of life
- Timely access to acute surgery.

Through the SHSP we will implement the actions identified for improving acute flows through our hospital services and build on our experience to improve other parts of our hospital services. A key aspect of this will be developing and instituting clinical, professional standards within the hospital.

We will also support ongoing improvement through analysis of clinical practice patterns and provision of regular feedback to clinicians, that compares their practice with best practice and/or to that of their peers. Unwarranted variation in clinical practice can result in harm for patients, create waste through inefficiency, and increase the overall cost of health care with little or no benefit. As part of SHSP implementation, we will explore opportunities to provide more clinically meaningful benchmarking information to our clinicians, to support their pursuit of highly reliable care.

The focus areas to improve patient flows through the hospitals will include:

- Implementing the actions arising from our current work programme, to improve patient flows for acute and urgent care and for the elderly
- Identifying and actioning ways to improve the quality and efficiency of care for patients with more complex needs
- Developing and instituting clinical, professional standards within the hospital to ensure patient flow and standards of practice are formalised and measured, in line with best practice capacity and demand management standards
- Using a quality improvement perspective, providing timely, robust clinical practice data to our hospital services so they can identify opportunities for improving the reliability and efficiency of care.

Headline action 3: Define the future scope and mix of hospital services in the Bay of Plenty

Population growth, redistribution and ageing, and new technologies mean we must regularly review the configuration of specialist services to ensure that it best balances access, quality, and cost across our:

- Tauranga and Whakatāne hospitals
- Community clinics at Te Kaha, Opotiki, Kawerau, and Murupara, and
- Three major out-of-district specialist referral centres (Waikato Hospital, Auckland City Hospital, and Middlemore Hospital).
Our aim in planning of specialist clinical services is to ensure that patients have timely and cost-effective access to high quality services in their local hospital or, when required, at a more specialised hospital with higher clinical capability. Moving to a three-year plan approach for clinical streams (described further below) will provide the opportunity for clinical and managerial leaders to be more explicit about how the principles of the ‘one service, two sites’ model underpinning the Bay of Plenty’s hospitals, can be best operationalised within each specialist service, and balanced in the context of Eastern and Western Bay integrated healthcare localities.

Specifically in the Eastern Bay:

- Our clinic at Te Kaha services a large geographical area with a true interdisciplinary and unique rural model of care. This must be supported to be sustainable, with future potential for expansion to local services and telehealth as a critical part of this model.
- The evolving collaboration at Opotiki is similarly an essential part of the local community and must develop into an effective and sustainable service. Many small communities along the coast see Opotiki as their safety blanket for urgent healthcare, especially when the travel time to Whakatane Hospital can be two hours or more.

It will also support those leaders, as they work with their colleagues across the Midland Region on regional service planning and with their colleagues in the Auckland hospitals, as they plan for Bay of Plenty residents’ access to highly complex services.

Key focus areas will be:

- The model of care for each major service delivered from the two hospital sites (Tauranga and Whakatāne), including the intersection between specialty and sub-specialty, definition of care pathways, use of telehealth, and the case complexity to be managed at each site.
- How our rural clinics fit with hospital based services to provide joined up models of care as close to home as possible.
- The mix of acute and elective inpatient, day case, and outpatient activity on each site (including visiting clinics).
- Opportunities to encourage patients living in Papamoa and the Eastern Corridor areas to receive outpatient services at Whakatāne Hospital, supporting timely access and best use of resources.
- Explore the potential and feasibility of future health services in the Wairakei/Te Tumu area.
- Arrangements for patient transport and appointment scheduling when travel is required.
- Arrangements for clinician travel where required for visiting clinics and the respective responsibilities of visiting clinicians and the ‘host’ hospital.
- Explore the potential for more appropriate resourcing of transport services between the two sites and where necessary, between Bay of Plenty hospitals and referral centres.
- The specialist staffing complement for each site including clinical leadership positions and cover for key staff during planned and unplanned leave.
- How to ensure equitable patient access and how that is aligned with production planning.

We will also consider:

- The role of public/private partnerships to further support service development and expand overall capacity for the Bay of Plenty’s health services. Recent examples of such developments to enhance service access are development of the Kathleen Kilgour Centre (radiation oncology) and PathLab’s new diagnostic centre.
• The timing and need of further Intensive Care Unit and High Dependency Unit capacity to manage increasing patient complexity and clinical capability development in the Bay of Plenty, with consideration of patient transport service capacity being critical

• The timing and need of further investments in diagnostic capacity (eg, echocardiography, ultrasound, CT, and MRI) to enable efficient patient flows

• The benefits and cost effectiveness of having an in-house hospital dental unit

• Consideration of the cost-effectiveness of current arrangements for provision of more specialised secondary and tertiary services for Bay of Plenty residents through referrals to Waikato, Auckland City, and Middlemore hospital services funded by the BOPDHB. Areas identified to explore for potential clinical capability development in Tauranga, which could be supported by sub-regional arrangements with Lakes and Tairawhiti DHBs, include:
  - Vascular surgery; which will require increased 24/7 infrastructure to meet sector standards over the next 3 years
  - Cardiology; where we are developing a sector model of excellence and have capacity to grow
  - Renal medicine; some of which is delivered locally and some at Waikato DHB; increased Eastern Bay provision is the number one request from communities and politicians
  - Gynaecology
  - Neonatal care.

• Mental health and addictions services will be considered through an in-depth, targeted review to ensure that demand growth is met in the most effective way and that community services are enmeshed in integrated models of care. This will be undertaken as a special stream of work, with potential linkages to other regional DHBs.

How will we know we’ve been successful?

We will know we’ve been successful when:

• Our hospital services are widely regarded as an integral part of the Bay of Plenty’s response to the health of our population, while also providing efficient and highly reliable individual health services

• Patients say that they had a great experience of our services, where they were listened to, treated with care and respect, and their individual needs were met

• Specialist services will be managed within 2016 hospital bed capacity:
  - A strong focus on ambulatory models
  - Patients will be receiving more services in community settings
  - Senior clinicians are providing whole-of-system leadership
  - By achieving one of the lowest acute bed-day rates in New Zealand, while also improving health outcomes and experience of care

• The ‘single service, two site’ model working effectively across all hospital services, with strong operational relationships developed with local services in the Eastern and Western Bay areas

• Additional clinical capability developed in the Bay of Plenty in line with the population’s health needs, regional planning, and affordability – improving local access

• Hospital clinicians and support staff report high levels of engagement and professional satisfaction, and feeling valued and supported to provide high quality care

• Non-clinical time for Senior Medical Officers is in place in all specialties and being used effectively for clinical governance, quality development, and system improvement.
How are we going to get there?

Clinically-led and evidence-informed specialist strategic service planning and quality improvements are at the heart of Strategic Objective 3. To develop a focused, efficient and highly reliable hospital service in the Bay of Plenty, the actions outlined in the roadmap include, and are not limited to:

- Determining the budget principles for hospital services over the next three years, in-line with expected revenue growth and SHSP and government priorities, with the expectation that these principles contribute to modifying hospital cost as a share of total BOPDHB revenue
- Clinical streams to identify opportunities:
  - For improving hospital quality/efficiency
  - Reconfiguring services to support care in community settings
  - Working closely with primary and community care to manage acute demand
  - Supporting the whole system to improve population health outcomes
- Working with the BOPDHB’s clinical streams to assess and rank proposed priorities and opportunities, within the overall budget
- Tasking clinical streams with developing and implementing three-year service and capacity plans based on agreed priorities and opportunities, with activity, resourcing, and timeframes clearly identified.

Hospital clinical leaders will also be engaged in design and implementation of the headline actions in Strategic Objectives 1 and 2, with the expectation that this informs the clinical streams’ three-year service and capacity plans.
### Strategic Objective 3: Evolve models of excellence across all of our hospital services

<table>
<thead>
<tr>
<th>Activities / outcome description</th>
<th>2017/18 Key actions</th>
<th>2018/19 Key actions</th>
<th>2019/20 Key actions</th>
<th>What are measures of success?</th>
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</thead>
<tbody>
<tr>
<td><strong>Headline Action 1: Strengthen working relationships across care providers to manage demand for hospital services.</strong></td>
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</table>
| Support the hospitals and community services to work in a more integrated way through technology, funding mechanisms, systems and processes (see also actions under Strategic Objective 2: Develop a smart, fully integrated system to provide care close to where people live, learn, work and play). | 1. Identify and connect innovators and change agents in primary and secondary care.  
2. Review Provider Arm community delivered services to identify and connect critical linkages with Primary Care and third party providers.  
3. Review the DHB’s quality and clinical governance structure and develop a quality and clinical governance framework. | 1. Begin a systematic review of Bay Navigator pathways, including pathways for COPD, respiratory and cellulitis, to ensure the top 10 pathways are based on best integrated care models and are fully implemented including full uptake by primary care.  
2. Ensure relevant in-hospital pathways align with integrated Bay Navigator pathways. | 1. Determine funding and infrastructure required to channel appropriate BOPDHB professional development and education through the clinical school to enable access by the health system. | Ambulatory Sensitive Hospitalisations 0 – 4 year olds  
• Improve oral health for children, with a focus on reducing inequity for Māori children.  
Acute Bed Days  
• Reduce the number of day’s spent in hospital by people with COPD.  
• Increase the use of ambulatory care for patients presenting with cellulitis.  
• Support Aged Residential Care.  
• Acute demand management within community based services.  
• Better Integration with St John.  
• Acute Flow Programme.  
Influenza vaccinations for people over 65. |
<table>
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<tr>
<th>Activities / outcome description</th>
<th>2017/18 Key actions</th>
<th>2018/19 Key actions</th>
<th>2019/20 Key actions</th>
<th>What are measures of success?</th>
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</table>
| Identifying hospital services or patient cohorts that can have their care delivered safely, efficiently and conveniently in community settings. | 1. Review the range of outpatient services provided in the hospital to determine a list of potential community based (including DHB community health centres) alternatives across the Bay. 2. Undertake DHB wide initial stocktake of outpatient services, efficiency, issues and opportunities. 3. Implement small tests of change to alternative models of consultations. 4. Undertake community consultation on outpatient experiences and appetite for alternative models of care. 5. Assess the scale of social admissions that do not require full hospital level care and consider alternative community options. | 1. Develop two-year outpatient model plan. 2. Identify and action necessary workforce development, infrastructure and technology actions needed to support more patients to be delivered care in community settings. (refer also to Infrastructure actions). | 1. Commencement of home-based video consultations trials for appropriate patients/specialties. | Patient Experience of Care  
• Improve management of DNA rates for first specialist appointments for ENT and Maternity.  
• Record elective decline rates for all surgical elective specialties.  
Hospital patient experience survey. |
### Section 4: Our Strategic Direction for the Next 10 Years

<table>
<thead>
<tr>
<th>Activities / outcome description</th>
<th>2017/18 Key actions</th>
<th>2018/19 Key actions</th>
<th>2019/20 Key actions</th>
<th>What are measures of success?</th>
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<tbody>
<tr>
<td>Explore whole of system integrated models of mental health care, particularly for children.</td>
<td>1. Commence a whole of sector review of Mental Health and Addictions Services to determine new ways of providing integrated care, particularly for children. Review to include service location, capacity, capacity and demand for inpatient mental health services, current funding models and total system investment in Mental Health and Addictions services. Begin with concept discussions with providers.</td>
<td>1. Undertake community consultation on future state model for Bay of Plenty’s Mental Health and Addictions Services. 2. Finalise future state model for Bay of Plenty’s Mental Health and Addictions Services and develop an implementation plan.</td>
<td>1. Progress future state model for Bay of Plenty’s Mental Health and Addictions Services.</td>
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<tr>
<td>Optimise the roles of Te Kaha, Kawerau, Murupara and Opotiki health centres and explore potential to address local unmet need.</td>
<td>1. Finalise collaborative model, leadership arrangements and integrated linkages with Te Kaha clinic and Whakatane Hospital. 2. Expand Te Kaha’s clinic footprint.</td>
<td>1. Test new model and revise as required. 2. Establish Te Kaha as a Rural Model of Excellence. 3. Explore further opportunities for local clinics at Kawerau and Murupara.</td>
<td>1. Review scope of service provision to determine additional local care opportunities.</td>
<td></td>
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<tr>
<td>Designing Emergency Department Models of Excellence for the future.</td>
<td>1. Define desired future state models and service scope at both Whakatane and Tauranga Hospitals. 2. Explore the benefits of a rapid script service alternative to the use of ED. 3. Develop plans for the transfer of GP level attendances into primary care settings at Tauranga.</td>
<td>1. Commencement of transfer of GP level attendances out of the hospital environment (15% target) at Tauranga.</td>
<td>1. Stage 2 transfer of GP level attendances out of the hospital environment (cumulative 35% target) at Tauranga.</td>
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<td>Activities / outcome description</td>
<td>2017/18 Key actions</td>
<td>2018/19 Key actions</td>
<td>2019/20 Key actions</td>
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<tr>
<td><strong>Headline Action 2: Improve patient flows through the hospital.</strong></td>
<td>1. Improve the flow of the acute medical patient through the hospital.</td>
<td>1. Review status of care co-ordination and determine next steps for connecting in Allied Health services.</td>
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<td></td>
<td>2. Improve the timeliness for patients during their journey through the Emergency Department.</td>
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<td></td>
<td>3. Improve the early identification and assessment of frail and elderly patients.</td>
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<td></td>
<td>4. Improve timely access to acute surgery.</td>
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<td></td>
<td>5. Enable timely transfer of care to the community after hospital treatment.</td>
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<tr>
<td>Implement the tests of change arising from the Acute Flow Improvement Programme and align with other work streams focussed on care outside the hospital environment.</td>
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<tr>
<td><strong>Optimising the role of Community and Hospital Allied Health professionals.</strong></td>
<td>1. Explore the desired future state model of care for allied health and how this might best meet patient needs, linking with the integrated community nursing project.</td>
<td>1. Review status of care co-ordination and determine next steps for connecting in Allied Health services.</td>
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<tr>
<td><strong>Developing Exemplary Customer Services.</strong></td>
<td>1. Review 2016 roadmap and first stage pilot Patient Information Centre learnings to define next three-year plan.</td>
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### Activities / outcome description

| Headline Action 3: Define the future scope and mix of hospital services in the Bay of Plenty. |
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<table>
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<tr>
<th><strong>2017/18 Key actions</strong></th>
<th><strong>2018/19 Key actions</strong></th>
<th><strong>2019/20 Key actions</strong></th>
<th><strong>What are measures of success?</strong></th>
</tr>
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<tbody>
<tr>
<td>1. Explore the potential benefits of a future elective orthopaedic centre in Wairakei/Te Tumu area following the completion of structure planning as referred to in Strategic Objective 1.</td>
<td>1. Explore the potential benefits of a future elective orthopaedic centre in Wairakei/Te Tumu area following the completion of structure planning as referred to in Strategic Objective 1.</td>
<td>1. Assess the benefits and cost effectiveness of having an in-house hospital dental unit.</td>
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<tr>
<td>2. Conclude work on developing a model for hospital food and implement outcomes.</td>
<td>2. Conclude work on developing a model for hospital food and implement outcomes.</td>
<td>2. Conclude work on developing a model for hospital food and implement outcomes.</td>
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<td>1. Undertake a formal HDU and ICU demand review and define future capacity options.</td>
<td>1. Undertake a formal HDU and ICU demand review and define future capacity options.</td>
<td>1. Undertake a formal HDU and ICU demand review and define future capacity options.</td>
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<tr>
<td>1. Assess the timing and need for further Intensive Care Unit capacity to manage increasing patient complexity and clinical capability development.</td>
<td>1. Assess the timing and need for further Intensive Care Unit capacity to manage increasing patient complexity and clinical capability development.</td>
<td>1. Assess the timing and need for further Intensive Care Unit capacity to manage increasing patient complexity and clinical capability development.</td>
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<tr>
<td>1. Refer to peri-operative capacity review.</td>
<td>1. Refer to peri-operative capacity review.</td>
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<tr>
<td>1. Implement bowel screening in the Bay of Plenty.</td>
<td>1. Implement bowel screening in the Bay of Plenty.</td>
<td>1. Implement bowel screening in the Bay of Plenty.</td>
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<td>1. Review the case for an MRI scanner in Whakatane.</td>
<td>1. Review the case for an MRI scanner in Whakatane.</td>
<td>1. Review the case for an MRI scanner in Whakatane.</td>
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<tr>
<td>2. As part of regional capacity planning, determine the timing of a second Cath Lab requirement.</td>
<td>2. As part of regional capacity planning, determine the timing of a second Cath Lab requirement.</td>
<td>2. As part of regional capacity planning, determine the timing of a second Cath Lab requirement.</td>
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<tr>
<td>3. Develop eight-year diagnostic capacity and demand resource plan.</td>
<td>3. Develop eight-year diagnostic capacity and demand resource plan.</td>
<td>3. Develop eight-year diagnostic capacity and demand resource plan.</td>
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<tr>
<td>1. Review the case for an MRI scanner in Whakatane.</td>
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| Consider the cost-effectiveness of current arrangements for the provision of more specialised secondary and tertiary services, including vascular surgery, plastic surgery, renal medicine, gynaecology and neonatal care. | 1. Determine impact of new national standards for vascular surgery and develop implementation plan.  
2. Undertake a review of renal care in the Bay and develop a 10-year plan in conjunction with Waikato DHB.  
3. Collect patient feedback and commence a review of ophthalmology service provision to determine desired future state model. | 1. Undertake a review of gynaecology service model and capacity/demand.  
2. Undertake a review of neonatal care and capacity/demand.  
3. Undertake a review of plastic surgery capacity/demand in conjunction with Waikato DHB. | 1. Assess outflow trends to other DHBs to determine any other specialty services where changing volumes require consideration. |
SECTION 5
INFRASTRUCTURE TO SUPPORT SHSP STRATEGIC OBJECTIVES
5. Infrastructure to support SHSP strategic objectives

This section of the SHSP describes the infrastructure that will support the Bay of Plenty health system in delivering on the strategic objectives described in Section 4. It builds on the actions already undertaken and planned through the Bay of Plenty’s Integrated Healthcare Strategy. There are seven components of this infrastructure, as shown in Figure 8. Each component has a number of actions to be undertaken, reinforcing or complementing actions already implemented or planned through the Integrated Healthcare Strategy. The action tables for each of the seven components are still being developed.

Figure 8. The SHSP’s enabling action areas

- Embedding patient and family centred care/Whānau Ora
- Building effective partnerships
- Using information to improve value
- Making the most of new technologies
- Developing our workforce
- Developing our facilities
- Redesigning funding and contracting models to better match care with need
5.1 Embedding patient and family centred care/Whānau Ora

We want to make the government’s desire for ‘people-powered care’, as presented in the *New Zealand Health Strategy*, a reality. To do this we will:

- Involve patients, whānau, and colleagues as equal partners
- Involve patients in planning, review, and co-design of new service models
- Evaluate the efficacy of current health-related information provided to patients and family/whānau, with the intention of gaining patient insights on improvement opportunities
- Engage with patients and communities on best mechanisms for improving health literacy and self-management, including through digital apps, online portals, information pamphlets, and peer group support
- Strengthen preventive and self-management models of care, including wellness plans, health coaching and peer group sessions
- Build practitioner skills and confidence to engage older people and their families in the important conversations that will support widespread uptake of future care plans.

The *Integrated Healthcare Strategy* identified health literacy as one of seven key priorities for improving health outcomes, experience of care and value. While some progress has been made on realising the actions and outcomes envisaged by the *Strategy*, we acknowledge that further work is required. The four actions we have prioritised to increase health literacy in our population are targeted towards:

- Improving health literacy of our populations
- Putting patients at the centre of designing our health literacy initiatives, so that we can best understand their information needs and how we can best communicate with them
- Ensuring that our health professionals have the right skills to effectively communicate with our increasingly diverse population, whilst acknowledging that our health workforce is also diverse
- Encouraging increased emphasis on preventive and self-management approaches in primary health care - for example, through access to health coaches for people with more complex needs who require help understanding their health and why, when, and how to access services
- Providing more opportunities for people and their family/whānau to learn from each other in group environments and through peer support workers (eg, in mental health services).

The strategic objectives and headline actions presented in this SHSP envisage significant changes in models of care to improve outcomes, patient experience, and resource use. Patients will be engaged in review of existing services and planning of new service configurations at both district-wide and locality levels, to ensure that their needs are at the heart of service redesign.

In addition, as our population continues to age, health practitioners will support older people and their families to plan for future end of life care. Future care planning helps people understand what the future might hold and to be clear what treatment they would and would not want. This makes it much easier for families and health professionals to understand what the person would want when the time comes - particularly if they can no longer speak for themselves.
### 5.2 Building effective partnerships

This SHSP recognises that if we are to achieve our vision and mission, and make a real difference to population health outcomes, the Bay of Plenty’s health system needs to have strong partnerships with our communities and other agencies in place. We can’t do it on our own. We will:

**Effective partnerships**  
• Continue to enhance the BOPDHB’s partnership with iwi, with the shared aim of lifting Māori health outcomes and reducing health inequities

• Collaborate across public, private and community sectors to build the breadth and scale of initiatives needed to tackle the societal factors that impact on people’s health

• Work with key agencies from other sectors to determine the outcomes, service models, and funding and contracting approaches that will deliver the best results

• Strengthen the BOPDHB’s relationships with the other Midland Region DHBs, to support alignment of service and capacity planning

• Explore opportunities for further public/private partnerships in service and infrastructure development that will make the best use of scarce funding and workforce.

Partnership arrangements between the BOPDHB and the Bay of Plenty’s three PHOs are established and will be built upon as part of the SHSP implementation. These arrangements include:

• The Bay of Plenty Alliance Leadership Team (BOPALT), which is comprised of the chief executives of the three PHOs and the BOPDHB, clinical leaders, other BOPDHB executive members, and an independent chair. As described in Section 6, BOPALT will be a crucial mechanism for driving implementation of the SHSP, most notably, Strategic Objective 2

• The Bay of Plenty Strategic Partnership Group, which is made up of the BOPDHB’s Chair and Chief Executive, and the Chairs and Chief Executives of the three PHOs. This group meets every eight weeks and will continue to play an important strategic role in oversight of activity undertaken by the organisations, including implementation of the SHSP.

Foundational relationships are already established between the BOPDHB and other agencies from other sectors. Examples include partnerships with local government in the Western Bay for joint population and community planning and ‘health in all policies’; and with social development for the Children’s Team operating in the Eastern Bay.

To give effect to Strategic Objectives 1 and 2 of this SHSP, the BOPDHB will seek to build on and formalise the relationships developed so far with local and central government agencies, through agreeing memoranda of understanding (or similar documents) that describe how we will work together and the shared initiatives we will pursue. We will also use a partnership assessment tool to continually evaluate and strengthen these relationships. As described in Strategic Objective 1, we are particularly interested in exploring the use of the alliance model as the basis for aligning planning and action across sectors, to jointly focus on the needs of the five priority populations identified and to address the social determinants of their health.
A strong relationship also exists between the Board of the BOPDHB and the 18 iwi of the Bay of Plenty through the Māori Health Runanga. Both parties are committed to continue building their partnership, with the shared aim of lifting Māori health outcomes and reducing health inequities. The Board looks to the Runanga and its 18 mandated iwi health representatives to provide both strategic direction and connection to the Māori community on issues of importance to Māori. While individual iwi representatives are not expected to make decisions on behalf of their constituents, they act as a conduit for information between the BOPDHB and iwi.

In the context of SHSP implementation, this will mean:

- Continuation of support for the strong network of kaupapa Māori providers across the Bay of Plenty
- Emphasis on amplifying the Māori voice and supporting that closely with resourcing and implementation
- Increased focus on how mainstream service providers can contribute to improving the experience and outcomes for Māori patients
- In the context of the post-Treaty settlement environment, how the health system can best respond to the aspirations of individual iwi.

Structures are also in place to support collaborative DHB planning across the Midland Region, which embraces Bay of Plenty, Lakes, Tairawhiti, Taranaki, and Waikato DHBs. Renewed energy is now going into building more effective regional relationships, which will be of fundamental importance in agreeing the distribution of specialist services within the Region over the next 10 years, in the context of demand growth and new technologies. This will be a key enabler of Strategic Objective 3, as well informing facility and information technology planning and development.

The BOPDHB is party to a number of public/private partnerships relating to both service delivery and facility development. We will explore opportunities for additional public/private partnerships where these offer the potential for effective use of scarce funding and workforce.

### 5.3 Using information to improve value

Understanding opportunities to improve access and quality of care across the system requires robust data and sophisticated analytical approaches, complemented by funding and contracting arrangements that encourage attainment of agreed outcomes. To support delivery on the SHSP’s three strategic objectives, we have identified four actions for using information to improve value:

- Implementing system-wide risk stratification to support better targeting of resources to population and individual needs
- Create a whole-of-system dataset, with analytics undertaken by a shared health intelligence function across BOPDHB, PHOs, kaupapa Māori providers, and other relevant stakeholders
- Institute Patient Reported Outcome and Experience measures
- Strengthening ethnicity data collection and integrity
Risk stratification

As envisaged in the *Bay of Plenty's Integrated Healthcare Strategy*, risk stratification will be a core component of better coordinating care across the system. As described in Strategic Objective 2, risk stratification will be foundational for the design and implementation of:

- Health care homes
- Interdisciplinary community teams
- Care coordination for people with complex needs.

Clinicians have always assessed patient needs to determine the best course of action. Over recent years, this traditional approach has been strengthened through a population approach to assessing risk. This approach uses data and clinical judgement to assess the number of people that are at higher and lower levels of risk for particular health outcomes, such as being acutely admitted to hospital. Taking a population approach to risk stratification helps to be more responsive to health needs, in increasing the intensity of care to match increasing severity of the patient’s condition, and thereby reducing the risk of poor health outcomes.

Figure 9 displays a typical risk profile for a population and the type of care approach and resource intensity (e.g., range of health professionals involved in care) at each risk level. As shown, approximately 10% of the population are generally at high risk of poor health outcomes and require more intense engagement with health (and social) services.

We anticipate that as the population ages and the prevalence and complexity of long term conditions increases, the proportion and number of people at risk of poorer outcomes will also increase. This means we will have to become even better at cost-effectively matching services to population needs and, wherever possible, empowering individuals and family/whānau to self-manage their health and well-being.

*Figure 9. Stylised risk stratification profile and associated intervention model*¹³

Population risk stratification is a key enabler of integrated models of care, as it allows proactive planning of the most appropriate care approach (‘stepped care’) for each risk group. In turn, this supports a patient-centric approach to care, as the needs and aspirations of individuals and their family/whānau become central to how the care approach is tailored and delivery is coordinated.

While some aspects of population risk stratification are in place in the Bay of Plenty, these efforts remain marginal. Implementing an appropriately scaled, relevant and systematic approach to population risk stratification and stepped care, based on registered general practice patient populations, will support more proactive care planning, better coordination of services, and matching of resources to needs.

**Whole of system data analytics**

New Zealand, and the Bay of Plenty, has the key building block for whole-of-system data collection and analytics: the National Health Index (NHI). The NHI can be used to link patient information across care settings and providers longitudinally and in real-time, providing opportunities for population, cohort and individual patient analysis.

Building on the progress we have made in sharing data and clinical information through the Integrated Healthcare Strategy, during implementation of the SHSP we will create a shared whole-of-system dataset across the Bay health system. This dataset will initially comprise the BOPDHB hospital, specialist, and community health data integrated with the newly created primary care data set. Over time, health and support data from kaupapa Māori providers and other NGOs will also be incorporated into the dataset (including social care where possible).

A key aspect of analytics is understanding how we compare with other health systems and how access, quality, and outcomes vary across the Bay of Plenty. Locally we have already developed innovative ways of looking at data, such as Trendly. In preparing the SHSP, we have also developed a Health and Service Profile 2016 that compares the Bay of Plenty to other DHBs on a range of population level measures. We will continue and extend this work while also developing more localised benchmarking methodologies using the proposed whole-of-system dataset. This will allow us to understand areas of greatest opportunity for improvement, and to share learnings across practitioners, organisations, services, and communities.

To fulfil the full potential of whole-of-system analytics, we will also explore opportunities to develop a shared health intelligence function across key organisations in the Bay of Plenty system. The health intelligence function may be virtual or take a more formal structure.

**Using patient-centred data to improve performance**

To support our continued shift to patient-centred care, as part of improving data and analytics in our health system we will progressively institute Patient Reported Outcome and Experience measures (PROMs and PREMs). These measures will enable us to better understand and monitor how well we are doing in improving outcomes for our population and patients’ experience of care. They will also support our need to maximise value for every dollar we spend.
5.4 Making the most of new technologies

We have made significant progress on gaining the benefits from information technology in the Bay of Plenty. Many of our clinicians can now quickly access relevant patient information across care settings, improving their ability to provide high quality care. Our primary health care workforce can also access a wide range of clinical pathways and referral guidelines online through Bay Navigator, helping them make timely, evidence-based decisions for their registered populations. Through the Midlands Regional Information Systems Plan (MRISP) we are also progressing the implementation of information technologies, which will improve the efficiency and reliability of the care we provide. It is expected that these existing initiatives will continue to be advanced. To support them and build on benefits already gained, we have prioritised three areas of technology that will support the SHSP’s strategic objectives:

- Identify and implement an electronic shared care planning approach to enable interdisciplinary planning and care across primary, community, and specialist services
- Encourage uptake of technologies for virtual consultations, home monitoring, and point of care testing
- Within hospital services, further advance demand forecasting and workforce resourcing tools to make best use of capacity

The SHSP Strategic Objective 2 envisages a more integrated system of care in the Bay of Plenty, with interdisciplinary approaches used for patients and family/whānau with more complex needs. While we have made progress on improving clinician access to patient information and aspects of clinical communication, we have yet to fully develop the information technology infrastructure to support shared care planning and care delivery. Other parts of New Zealand and leading international examples, have shown significant benefits for patients, clinicians and the system as a whole. As we progress the new models of care to support a more integrated system, we will need to identify and implement an appropriate electronic shared care planning approach, which allows our clinicians to:

- Develop a personalised care plan for a patient and/or whānau
- Access the personalised care plan
- Make modifications to the care plan, with read and write access rights defined in the plan
- Securely and conveniently communicate with other clinicians involved in the care plan and delivery
- Monitor patient and family/whānau progress on the care plan including through outcome and experience measures.

A key action for improving access to services while maintaining the sustainability of our local health system is the use of new technologies to deliver more efficient services. Approaches to virtual health, such as through smart phone, video and email consultations are rapidly being implemented internationally and in New Zealand. Some of our specialised clinical services already use these approaches to provide access to our rural populations. We will encourage much more significant use of virtual health in the Bay of Plenty as this will make better use of patient, family/whānau and clinician time. For example, there are successful models of online video consultations for a range of common conditions that help patients obtain more timely clinical advice. Similarly, a greater number of follow-up visits with health professionals can be undertaken virtually, including for lower risk post-operative patients.
We will also encourage more use of new technologies that enable patients to safely care for themselves in their own homes, with support from their health care home team and interdisciplinary teams. This can include patients with chronic disease monitoring and management of their physiological markers, or health professionals monitoring patients receiving care such as chemotherapy, so that they can intervene quickly to reduce risk. Studies from a number of countries suggest that these approaches can improve patient satisfaction and clinical productivity, and reduce demand pressures on hospital services.

5.5 Developing our workforce

Delivering the SHSP’s strategic objectives will require development of new workforce models and capacity within the Bay of Plenty’s health system, particularly given the risk of future workforce shortages and the changing demographic of our resident population. It will also require active promotion of the values, objectives, and outcomes of the SHSP including:

- Reduced health inequities (access, quality, and outcomes)
- Person and family/whānau-centred care
- A collaborative ‘All as one team’ approach
- A focus on population health as well as individual experience of care.

Workforce planning is currently undertaken on a relatively ad hoc basis in the Bay of Plenty, with little coordination across services and organisations. As part of implementing the SHSP, key enabling actions include conducting a stocktake of workforce capacity across the system (public and private) and developing a Bay of Plenty workforce development plan which builds on actions from the Integrated Healthcare Strategy and identifies a staged pathway for:

- Developing a workforce across the health system that is representative of its resident population and is appropriately skilled, resourced and change-ready to support achievement of the SHSP values, objectives, and outcomes
- Addressing critical workforce gaps in the context of demand growth, demographic changes, and workforce ageing
- Promoting recognition that reducing health inequities is everyone’s responsibility
- Developing competencies and educational goals for all health care workers, to incorporate training that considers the impacts of the social determinants of health
- Workforce training for engaging effectively with Māori
- Further promoting Māori participation in the health and social workforce, and partnering with education institutions to address recruitment, retention, and barriers to access
- Achieving the expectation that all health professionals will have achieved defined health literacy competencies appropriate to their role and that all provider organisations are accountable for ensuring that this is achieved
- Through Strategic Objective 2, using a risk stratification and competency framework approach to determine workforce roles and capability requirements in primary and community care settings, to build the workforce to deliver enhanced primary care, interdisciplinary care approaches, and enhanced quality of care
- Through Strategic Objective 3, determining workforce capacity requirements through clinical stream service and capacity plan development; and developing a person-centred ‘handbook’ for clinicians, to support a culture of collaboration and professional standard adherence
- Making best use of the non-regulated and volunteer workforce across all care settings.

The Bay of Plenty’s health workforce plan will be developed within the context of the New Zealand Health Strategy, the national 20 DHB Workforce Strategy Group’s Strategic Workforce Services Programme,
Midland Region service and capacity planning, and initiatives undertaken by Health Workforce New Zealand. It will also support delivery of our recent work that was intended to support our clinical and non-clinical workforce to realise their aspirations, through a supportive and innovative workplace culture founded on our core values of compassion, all one team, respect, and excellence (CARE), and enhanced by our tangata whenua values within He Pou Oranga framework: Kaitiakitanga, Kotahitanga, Manaakitanga, Pūkengatanga, Rangatiratanga, Wairuatanga, Whānaungatanga and Ukaipōtanga.

Through the Bay of Plenty Clinical School, the Bay of Plenty has an existing education and training facility located in both Tauranga and Whakatāne, which can be developed to coordinate appropriate professional education and development activities across the system. Bringing these together under a single coordination structure will help to promote increased collaboration across professions, prioritisation of development and education activities, and administration savings.

To achieve the above, we will:

- Develop a workforce development plan to support achievement of SHSP strategic objectives and desired outcomes
- Deliver on the recommendations of our recent Staff Engagement and Culture work programme.
- Determine funding and infrastructure required to channel appropriate BOPDHB professional development and education through the clinical school.

### 5.6 Developing our facilities

The SHSP’s strategic objectives are intended to support better management of acute demand growth for hospital services, which is already exerting pressure on workforce, equipment, and facility capacity. While successful achievement of these objectives will assist with managing capacity pressures, there will continue to be capacity issues that will require investment in facility changes and development by the DHB, and/or encouragement of private sector and community development of additional capacity. In particular, SHSP development has identified the following key issues:

- The need to meet new seismic building standards over the next 10 years, with a number of existing facilities not meeting these standards
- The current fragmentation of outpatient, capacity across the Tauranga Hospital campus, impacting on efficiency
- Limited outpatient capacity to undertake interdisciplinary assessment and care
- Mental health assessment, outpatient and inpatient facilities that impact on the DHB’s ability to deliver safe, contemporary models of care at both Tauranga and Whakatāne hospitals
- Appropriate configuration of renal dialysis capacity
- Potential to improve office space for clinical staff to enable co-location and associated efficiencies
- Significant population growth is occurring in the Papamoa and Western Corridor areas.

Given these issues, four major facility enabler actions have been identified.
Facility development

- Review and refine Tauranga and Whakatāne site master plans based on actions to right-size capacity and improve patient flows, with a focus on:
  - Outpatients, mental health, ‘one-stop shop’ hub models for major clinical services, and renal dialysis
  - Consideration of the capacity requirements of services being targeted for clinical capability development
- Build capability in community settings to enable lower complexity care to be provided in non-hospital settings, with this to include and not be limited to:
  - Increasing the capability and capacity of aged residential care providers to provide step-up or step-down care for older patients, in line with Strategic Objectives 2 and 3
  - Working with the NGO sector, government, and community agencies to invest in an increased range of accommodation options (including respite) for people with mental health and/or addiction needs, across the Bay of Plenty
  - Encouraging further private sector or community development of primary maternity birthing capacity to enable Tauranga Hospital to focus on more complex pregnancies, births, and postnatal care
- Explore opportunities to develop a ‘health precinct’ in Papamoa and the Western Corridor as a ‘proof of concept’ site for the new model of enhanced primary care and interdisciplinary community teams
- Develop comprehensive travel plans for each site.

5.7 Using funding and contracting to better match resources with need

Stakeholders have consistently signalled that current funding and contracting models in the Bay of Plenty lead to duplication, and restrict collaboration and innovation. They also acknowledge that successfully implementing the SHSP will require:

- Rebalancing investment across the system
- A stronger focus on measuring value
- Encouragement of collaboration and integration across care providers, professions, and settings.

Stakeholders also consider that Māori health funding and contracting arrangements in the Bay are a unique approach targeted to meeting the aspirations of lifting outcomes for the Māori population and supporting kaupapa Māori services.
In this context, the key enabling actions for funding and contracting are:

| Funding and contracting | • Regular evaluation of spending across PHO, NGO, and DHB Provider Arm services to identify areas of duplication in effort, or lower value spending  
| • Work with intersectoral partners to identify areas of duplication between health, education, and other social agency spending in the Bay of Plenty, and develop action plans to better align roles, responsibilities, and funding as part of Strategic Objectives 1 and 2  
| • Create a Strategic Investment Fund through a combination of prioritising new annual funding growth to SHSP priorities, tight cost control in Provider Arm services, and disinvestment from lower value spending  
| • In combination with improved data and analytics (see Section 5.3), implement a new whole-of-system procurement approach that will shift funding and contracting models towards a stronger focus on achieving outcomes, within the context of supporting increased collaboration and integration across providers, managing within existing resources. |

Our approach to data and analytics, outlined in Section 5.3, will enable us to take a stronger investment approach to reviewing our existing spending and prioritising proposals for new spending, in line with the SHSP. We know we can invest our funding better than we do now. We may be maintaining spending on programmes and interventions that do not represent the best value, or that overlap with services supported by other funding agencies. Similarly, we may invest in new programmes and interventions without a clear understanding of how they compare with other options for investment and in isolation from other agencies.

Population growth and ageing in the Bay of Plenty is likely to mean that the funding the DHB receives from government will continue to grow – given current policy settings and trends. This will allow ‘top-slicing’ of funding to create a Strategic Investment Fund to support reorientation of the balance across the Bay of Plenty’s health services, as described in Figure 7, combined with tight cost control within hospital services and disinvestment from lower value services.

We believe that by bringing together data from across the system and instituting more patient-centred measures, we will lay the key foundations for better prioritisation of our existing and new investments. We will do this in an open and transparent way, using evidence-based approaches, to build public and clinician trust and confidence in our investment decisions.

As we build our analytical and investment expertise, we will progressively shift our funding and contracting models to have a much greater emphasis on achieving agreed outcomes. This will build on our learnings to date in taking an outcomes-based approach to funding and contracting for mental health services from NGO providers.

A key priority for us will be developing appropriate funding and contracting models to support enhanced primary care and interdisciplinary teams in community settings, and working with funding agencies in other sectors. To achieve this, we will be more flexible and less bureaucratic in our stewardship role of public funding, by removing unnecessary barriers that limit the ability for care providers to provide the right type and level of care for patients at the right time (‘funding will follow the patient’). We will achieve this through specification of the outcomes we want for our population, rigorously monitoring achievement of these and allowing providers to be more flexible and innovative in how they achieve these outcomes – in line with contemporary models of care.
Infrastructure Actions to Support SHSP Strategic Objectives

Notes:
1. The timeframes for the actions in this section are less certain and will require regular review, so they have been tagged with an indicative timing of short, medium or long-term, rather than specifically year by year.
2. The BOPDHB is participating in the Midland Region eSPACE programme which aims to provide a consolidated clinical information system for the Midland Region DHBs. While predominantly intended to support secondary care service provision, the eSPACE programme also aims to provide enablers for cross-healthcare settings (e.g., primary/secondary/tertiary integration). The actions outlined below are outside of the eSPACE programme but will align with and leverage that programme where appropriate.

<table>
<thead>
<tr>
<th>Infrastructure 1: Embedding Patient and Family Centred Care/Whānau Ora.</th>
<th>Short-term</th>
<th>Medium-term</th>
<th>Long-term</th>
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<tbody>
<tr>
<td><strong>Activities / outcome description</strong></td>
<td><strong>Key Actions</strong></td>
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</tr>
<tr>
<td>1. Involve patients, whānau and colleagues as equal partners.</td>
<td>1. Implementing the action plans for the two work streams: Communication within and between teams, Embedding our CARE* values, within the Staff Engagement and Culture work programme.</td>
<td>1. Surveillance of staff engagement and culture measures against work plans and patient outcomes.</td>
<td>1. Embedding the staff engagement and culture work programme as business as usual.</td>
</tr>
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<td></td>
<td>2. Develop a Strategic Health Services Plan communication strategy.</td>
<td>2. Implement the Strategic Health Services Plan communication strategy.</td>
<td>2. Review the Strategic Health Services Plan communication strategy.</td>
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<td></td>
<td>3. Ensure 80% of our workforce is trained in engaging effectively with Māori.</td>
<td>3. Ensure 90% of our workforce is trained in engaging effectively with Māori.</td>
<td>3. Involve patients in planning and review of service improvements.</td>
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<td></td>
<td>4. Identify and adopt patient co-design methodology to underpin the development of a healthcare home.</td>
<td>4. Test patient co-design methodology.</td>
<td>4. Increase the use of Future Care Planning (FCP) in targeted populations and strengthen community awareness about the value of FCP.</td>
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<td>5. Adopt a health services directory to assist people to navigate around the health system.</td>
<td>5. Increase the use of Future Care Planning (FCP) in targeted populations and strengthen community awareness about the value of FCP.</td>
<td>5. Review consumer council.</td>
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<tr>
<td></td>
<td>6. Increase the use of Future Care Planning (FCP) in targeted populations and strengthen community awareness about the value of FCP.</td>
<td>6. Involve consumer council in service improvements.</td>
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<td>7. Establish a consumer council or similar group to improve consumer engagement.</td>
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*CARE stands for Compassion, All-one-team, Responsiveness, Excellence
### Infrastructure 2: Building Effective Partnerships.

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<th>Activities / outcome description</th>
<th>Key Actions</th>
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<tr>
<td></td>
<td><strong>Short-term</strong></td>
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<tr>
<td>1. Collaborate across public, private and community sectors to build the breadth and scale of initiatives needed to tackle the societal factors that impact on people’s health.</td>
<td>1. Participate with SmartGrowth partners, Councils, Ministry of Education, and New Zealand Transport Authority on planning for social infrastructure, liveable environments and health services in urban growth areas.</td>
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<td>2. Develop a joint workplan with Tauranga City Council in areas of mutual benefit.</td>
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<td></td>
<td>3. Continue to build capacity and capability in the Eastern Bay Childrens Team.</td>
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### Infrastructure 3: Using Information to Improve Value.

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<tr>
<th>Activities / outcome description</th>
<th>Key Actions</th>
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<tr>
<td></td>
<td><strong>Short-term</strong></td>
</tr>
<tr>
<td>1. Create a whole-of-system dataset, with analytics undertaken by a shared health intelligence function across BOPDHB, PHOs, kaupapa Māori providers, and other relevant stakeholders, to better target resources to need.</td>
<td>1. Adopt risk stratification to identify priority patient groups for co-ordinated care planning.</td>
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<td>2. Complete delivery of integrated primary and secondary data to DHB, primary and community users.</td>
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<td>3. Develop a smart system for collecting and sharing data to support the System Level Measures Framework.</td>
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</table>
## Infrastructure 4: Making the Most of New Technologies.

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<tr>
<th>Activities / outcome description</th>
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<tr>
<td></td>
<td><strong>Short-term</strong></td>
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<tr>
<td>1. Encourage uptake of technologies for shared care planning, virtual consultations, home monitoring and point of care testing.</td>
<td>1. Scope virtual health platform options to support electronic shared care planning.</td>
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<tr>
<td>2. Develop a strategic IT and informatics roadmap to underpin excellence.</td>
<td>2. Promote Health Navigator.</td>
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<td></td>
<td>3. Develop a strategic IT and informatics concept roadmap.</td>
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<td></td>
<td>5. Scope first hospital smartphone application functionality for patient feedback.</td>
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<tr>
<td></td>
<td>6. Scope first hospital smartphone application functionality for staff.</td>
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## Infrastructure 5: Developing our Workforce.

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<th>Activities / outcome description</th>
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<td></td>
<td><strong>Short-term</strong></td>
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</table>
| 1. The workforce across the health system will be representative of its resident population and appropriately skilled, resourced, and change-ready to support achievement of the SHSP values, objectives, and outcomes. | 1. Conduct a stocktake of workforce capacity and capability across the system and develop an appropriate Workforce Development Plan, incorporating:  
   - Safe Staffing, Healthy Workplaces  
   - An equitable approach to workforce education  
   - Strengthening union partnerships  
   - Upskilling of Home and Community Support Service staff, in line with the recent pay equity settlement. | 1. Implement the Workforce Development Plan.  
2. Surveillance of staff engagement and culture measures against work plans and patient outcomes.  
3. Achieve appropriate levels of quality improvement capability.  
4. Conduct an annual stock-take of employee qualification levels as part of monitoring Home and Community Support services. | 1. Review the Workforce Development Plan.  
2. Embedding the staff engagement and culture work programme as business as usual.  
3. Maintain an appropriate level of quality improvement capability. |
| 2. Implementing the action plans for the two workstreams: Tackling Inappropriate Behaviour and Performance Development including Appraisal within the Staff Engagement and Culture work programme. | 3. Develop appropriate quality improvement capability using the IHI Model for Improvement. |
## Infrastructure 6: Developing our Facilities.

<table>
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<tr>
<th>Activities / outcome description</th>
<th>Key Actions</th>
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<tbody>
<tr>
<td></td>
<td><strong>Short-term</strong></td>
</tr>
<tr>
<td>1. Review and refine Tauranga and Whakatane site master plans based on actions to achieve right-size capacity and improve patient flows.</td>
<td>1. Following the clinical services review detailed site master plans will be completed for both campuses and services located in off-site premises.</td>
</tr>
<tr>
<td>2. Consider the role of public/private partnerships to further support service development and expand overall capacity.</td>
<td>1. Scope the potential and feasibility of a future collaborative integrated healthcare hub/health care home in the Wairakei/Te Tumu area.</td>
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## Infrastructure 7: Using Funding and Contracting to Better Match Resources with Need.

<table>
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<tr>
<th>Activities / outcome description</th>
<th>Key Actions</th>
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<tbody>
<tr>
<td></td>
<td><strong>Short-term</strong></td>
</tr>
<tr>
<td>1. In combination with improved data and analytics (see Section 5.3), implement a new whole-of-system procurement approach that will shift funding and contracting models towards a stronger focus on achieving outcomes.</td>
<td>1. Continue to progress the Outcomes Agreement approach with Ministry of Business, Innovation and Employment using the Streamlined Contracting for NGO’s Framework with Mental Health Providers and spread the approach to other portfolios.</td>
</tr>
<tr>
<td>2. Introduce incentives into the DHB’s contracts for the achievement of outcomes that improve Māori health equity.</td>
<td>2. Continue to introduce incentives into the DHB’s contracts for the achievement of outcomes that improve Māori health equity.</td>
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SECTION 6
IMPLEMENTING THE SHSP
6. Implementing the SHSP

This SHSP outlines an ambitious programme of work. One that we consider is essential to building momentum towards our vision of Healthy, Thriving Communities Kia momoho te hāpori oranga. We acknowledge that a plan is only of real value if it is implemented, which we are strongly committed to doing. Hence, even though the SHSP has been developed with a 10-year horizon, its focus is on the Roadmap for Implementation over the next three years, with momentum being built from year one (2017/18).

A structured and disciplined approach to implementation will be of critical importance. Translation of the SHSP into action will have the following dimensions.

6.1 Key performance indicators and targets

A set of key performance indicators (KPIs) for monitoring the impact of the SHSP at a strategic level have been defined (Appendix 3). Baselines and targets for these KPIs will be confirmed during detailed implementation planning. Where relevant and possible, these will include reporting of performance by ethnicity, to ensure a focus on reducing population health inequities.

6.2 Corporate governance

The BOPDHB Board will be the primary decision-maker and owner of the SHSP in consultation with the Māori Health Runanga. The Community and Public Health Advisory Committee/Disability Services Advisory Committee (CPHAC/DSAC) will focus on monitoring Strategic Objectives 1 and 2, and providing strategic advice to the Board on these objectives. The Bay of Plenty Hospitals Advisory Committee (BOPHAC) will focus on monitoring Strategic Objective 3, and providing strategic advice to the Board on this objective. Both CPHAC/DSAC and BOPHAC will meet as a combined forum once each quarter, as a Strategic Health Committee (SHC). The purpose of the SHC is to consider the SHSP in its broadest sense, to explore disruptive initiatives, and challenge the status quo.

Strong corporate governance commitment to the SHSP is critical to supporting the Executive to ensure management and clinician time is focused on delivering on the actions. The Board will also support further development of the organisational partnerships that will be fundamental to the success of the SHSP.

6.3 Executive management

The Executive Leadership Team (ELT) of BOPDHB will carry a collective accountability for delivery of the SHSP and a subset of the headline actions will also be overseen by the Bay of Plenty Alliance Leadership Team. Individual ELT members will be accountable for leading, planning, and implementing each of the actions identified in the SHSP. They will also be accountable for ensuring the engagement of partner organisations and the clinical community.

6.4 Clinical leadership and governance

Effective implementation of the SHSP will require leaders in the Bay of Plenty health system to have the capacity and capability to manage both current business and short term imperatives, and the longer term, strategic agenda arising from the SHSP. Areas for particular focus during implementation planning will include support for the clinical leaders, who will be actively engaged in driving service improvement through an ‘all one team, one population approach’ and in actioning the strategic objectives. As part of SHSP implementation, we will explicitly link clinical governance and quality improvement to the strategic objectives and headline actions, including enhanced primary care, interdisciplinary teams, clinical stream service plans, and locality planning and action.
6.5 Programme management

We acknowledge that the Bay of Plenty health system has been less successful at implementation than strategy and plan development. To make sure we have the capability to successfully deliver on the SHSP we will start implementation by:

- Evaluating organisational capability across key partners in the Bay of Plenty and as necessary, encourage changes in organisational arrangements to enable implementation of the SHSP
- Dedicating resource allocation to each major work stream and developing clear milestones and accountabilities linked to the SHSP Roadmap
- Using Rapid Implementation Planning workshops (and similar methods) to drive progress on headline and enabling actions, with strong involvement of clinicians from across relevant organisations and services
- Establishing a clear reporting and monitoring framework for SHSP actions, which cascade from the Board level to the front-line, with regular reporting updates provided to the boards and other relevant governance parties (eg, BOPALT), to enable remedial actions to be quickly undertaken where necessary
- Building leadership capability at all levels of system and using processes for gaining ideas and insights from our front-line staff, recognising that effective implementation requires everyone to work together.

The Roadmap for Implementation in the SHSP provides an overview of the staging and sequencing of the headline actions for each of the three strategic objectives. This Roadmap will be strengthened following SHSP finalisation through more detailed implementation planning and identification of the linkages and dependencies. Implementation planning will inform the annual plan, which will be the key document for the Board’s governance purposes.

6.6 Communications and engagement

Early and effective communications and engagement with key stakeholders will be critical during SHSP finalisation and implementation. The communications and engagement process that has accompanied SHSP development will be refreshed to focus on the next three phases; consultation on the draft plan leading to finalisation, detailed implementation planning, and staged implementation. It is expected that existing alliances and partnerships (eg, BOPALT) will have key roles in the communications and engagement during the next three phases.

The objectives of the communications and engagement process will be to:

- Engage clinical and managerial leaders from BOPDHB, primary health care, NGOs and partner agencies, and the wider community, in discussion of the draft SHSP
- Obtain feedback that will inform SHSP finalisation
- Provide stakeholders with timely, relevant and targeted communication throughout the course of SHSP implementation, offering opportunities to contribute.

6.7 Alignment with the DHB planning cycle

During SHSP implementation planning, the actions related to the priorities and the supporting infrastructure will be linked with the DHB’s annual planning cycle. This will ensure that they are factored into each year’s annual plan and budget, and associated monitoring and reporting.
SECTION 7
APPENDICES
Appendix One: SHSP planning context

The purpose of the SHSP is to provide a ‘strategic umbrella’ for Bay of Plenty health system strategies, plans, and activities. Bay of Plenty stakeholders recognise that undertaking annual and service-specific planning without a clear view of how the system should best respond to demand and capacity challenges over the longer term, is insufficient to ensure a sustainable health system for our people and communities. The SHSP will provide the strategic framework for annual and more detailed service, capacity (workforce, facilities, and technology), and financial planning.

In developing a clear view of how the Bay of Plenty health system should respond to its challenges over the next 10 years, a number of important health system strategies and plans, were taken into consideration. Additionally, reference was made to broader trends in system and service design emerging in New Zealand and internationally, as well as existing Bay of Plenty strategies, plans, and activities. Figure 10 provides a summary of the relationship between national, regional and local strategies, plans, and activities.

Figure 10. Planning context for the Bay of Plenty SHSP
DHB legislative context

The BOPDHB is one of New Zealand’s 20 DHBs. Each DHB is a Crown Entity, accountable to the Minister of Health. The New Zealand Public Health & Disability Act 2000 defines the role of the DHBs and the organisation of publicly funded health and disability services. It establishes DHBs with specified geographically-defined populations and sets out the duties and roles of key participants, including the Minister of Health, Ministerial committees, and health sector provider organisations. An amendment to the Act in 2010 changed the planning framework for DHBs and emphasised the need for regional collaboration (in the Bay of Plenty’s case, with the four other Midland Region DHBs).

The BOPDHB receives funding from government to fund and provide health and disability services for our local population. As an agent of the Crown, the BOPDHB is committed to fulfilling its role as a Treaty of Waitangi partner. Central to the Treaty relationship and implementation of Treaty principles is a shared understanding that health is a ‘taonga’ (treasure). The BOPDHB and Māori 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. This is reflected by the ongoing role of the Māori Health Runanga as the Treaty of Waitangi partner to the BOPDHB in the Bay of Plenty.

In accordance with legislation, we use the funding to:

- **Plan** the strategic direction of the Bay of Plenty health system in partnership with clinical leaders, alliance partners, key stakeholders at local, regional and national levels, and our community
- **Fund** the majority of the health and support care service provided in the Bay of Plenty through our partnerships, alliances, and key relationships with service providers. Our focus is on promoting integration of services and collaboration between providers to achieve more health gain for funds invested (value for money), by making sure services are high quality, safe, responsive, coordinated and efficient, and meet patients’ expectations
- **Promote, protect, and improve** our population’s health and wellbeing through an evidence-based whole-of-system strategy that includes public health approaches such as health impact assessments, and health improvement and protection interventions
- **Provide** hospital specialist and community services for our population
- **Integrate** health service activity in our district.

DHBs are guided by the New Zealand Health Strategy, Disability Strategy, and Māori Health Strategy (He Korowai Oranga). The Ministry of Health has recently refreshed the New Zealand Health Strategy. The refreshed Strategy includes five themes and a roadmap of 26 action areas (see Figure 11). These themes and action areas have informed development of the SHSP.
Government health policy

Better, Sooner, More Convenient is the Government’s over-arching policy for health services. It seeks services that put the patient first, provide seamless integrated care closer to the person’s home, and are good value for money. Goals of this policy are:

- Increasing access to services and reducing waiting times
- Improving quality, patient safety, and performance
- Providing better value for money.

These goals are to be achieved by:

- Strengthening sector accountability
- Regional planning and action to address shared challenges
- Stronger leadership from the national agencies
- Slowing the funding growth path
- Emphasis on primary health care and providing services closer to home.

In line with these goals, a number of major health system policy and structural changes have been made by the government over the past eight years in New Zealand’s public health system. These include:

- Creation of a number of new national entities to strengthen health system leadership and support for DHB performance improvement and innovation. These include Health Workforce New Zealand (HWNZ), National Health IT Board (NHITB), the Capital Investment Committee (CIC), and the Health Quality and Safety Commission (HQSC)

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• Stronger national direction for DHBs and PHOs to deliver on policies, priorities, and expectations, most notably in respect of the national Health Targets (see below)

• Expectation that each DHB will lead and champion service integration through whole system planning involving primary and community services, as well as regional and sub-regional services, rather than focusing predominantly on its own Provider Arm

• Requirement for strengthening of clinical engagement and leadership to improve health service delivery

• National mandating of the alliance model for partnering between DHBs and PHOs and making collective achievements against a set of System Level Measures, which support improved health outcomes and system efficiency

• Requirement for collaborative DHB regional service planning, with an updated regional plan to be produced annually

• National planning and funding by the Ministry of Health for a small number of highly specialised, low volume services

• Emphasis on regional and national DHB collaboration to gain efficiencies through shared ‘backroom’ services.

Continuing emphasis is also given to delivering on the following national Health Targets:

• Shorter stays in hospital emergency departments
• Improved access to elective surgery
• Shorter waits for cancer treatment
• Increased immunisation
• Better help for smokers to quit
• Raising healthy kids.

The Minister of Health’s annual ‘Letter of Expectations’ to DHBs signals specific priorities for the health sector that link with Better, Sooner, More Convenient, and that are to be responded to in the DHB’s annual plan and statement of intent (SOI). In setting expectations for 2016/17, the Minister focused on:

• clinical leadership
• integration of primary and secondary care
• tackling the key drivers of morbidity
• and fiscal discipline and performance management.

The government has also introduced the System Level Measures Framework (SLMF) to guide actions and activities undertaken by Alliance Leadership Teams. The SLMF measures for 2016/17 are:

• Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds (ie, keeping children out of hospital)
• Acute hospital bed days per capita (ie, using health resources effectively)
• Patient experience of care (ie, person-centred care)
• Amenable mortality rates (ie, prevention and early detection).

Two further System Level Measures will be developed during 2016/17:

• Number of babies who live in a smoke-free household at six weeks postnatal (ie, healthy start)
• Youth access to and utilisation of youth appropriate health services (ie, teens make good choices about their health and wellbeing).

Alliance Leadership Teams are expected to establish Improvement Plans that detail the contributory measures they will use to set targets and monitor performance in making achievements against SLMF measures, and the actions they will take to realise these achievements.
Further national initiatives led by the Ministry of Health and other government agencies that are expected to impact on the Bay of Plenty health system over the next three years, include:

- Supporting vulnerable children (including reducing rheumatic fever cases and assaults on children)
- Social sector collaboration (across Social Development, Education, Health, and Justice)
- Youth mental health
- Whānau Ora
- National drug policy
- Shifting services
- Childhood obesity plan
- Diabetes plan
- Quality and safety of health services
- Support the health of older people
- Implementing Rising to the Challenge (the mental health and addiction service development plan)
- Smokefree 2025
- Long term strategic planning through the Treasury-run Investor Confidence Rating process (including development of a Long Term Investment Plan).
Appendix Two: The SHSP development process

The SHSP development process is shown in Figure 12. The process involved building the evidence-base for strategic direction setting through development of a whole-of-system Health and Service Profile 2016 and extensive engagement with stakeholders from across the Bay of Plenty. Through further engagement with stakeholders and reference to trends in system and service design and national, regional, and local priorities, the strategic direction was developed into the SHSP’s three strategic objectives, ‘headline’ actions, and roadmaps.

Figure 12. The New Zealand Health Strategy’s five strategic themes

Health and Service Profile 2016

The Health and Service Profile 2016 was developed from a population health and whole-of-system perspective. It brought together information from across primary, community, secondary, and social care to identify key health needs in the Bay of Plenty by age, ethnicity, socio-economic status, and place of residence. It also revealed current and potential future trends in demand for health services and the impacts on workforce and physical capacity if current trends continue. This analysis was based on best available information regarding how the Bay of Plenty’s population will likely change over the next 10-20 years, including population growth, ageing and redistribution, and disease and disability prevalence.

Key factors considered in the Health and Service Profile 2016 were:

- The demographic and socio-economic characteristics of the Bay of Plenty population
- Population health outcomes, health and social risk factors, and the prevalence of key long term conditions
- The responsiveness of the Bay of Plenty health system to health needs by key service areas
• Equity of access and outcomes by major population groups in the Bay of Plenty by age, ethnicity, socio-economic status, and place of residence

• Performance of the Bay of Plenty health system and service areas against national, regional, and local key performance indicators (eg, national Health Targets), and traditional measures of efficiency and effectiveness (eg, average length of stay).

The data and analysis developed through the Health and Service Profile 2016 was tested with stakeholders through a variety of mechanisms, including workshops, as discussed below.

Stakeholder engagement

Extensive engagement with stakeholders was undertaken as part of the SHSP development process. Key stakeholder engagement milestones included:

• Scene-setting and fact finding interviews with more than 20 stakeholders from across the Bay of Plenty health system (July – August 2016)

• Direction setting workshops with the BOPDHB Board and Māori Health Runanga (August), which determined the strategic direction for the SHSP based on early findings from the Health and Service Profile 2016, trends in system and service design, and national, regional, and local priorities

• Six focus area workshops with stakeholders from primary, community and secondary care as well as non-health stakeholders such as local government and the social sector (September). Patient representatives also participated in the workshops. The workshops considered what was working and not working so well in the Bay of Plenty, and identified opportunities to improve the system over the next 10 years. The six workshops were:
  - Population growth and change
  - Health inequities
  - Long term conditions
  - Primary and community models of care
  - Hospital models of care
  - Healthy ageing

• Participation at a hui with Māori Health providers to gain their advice on opportunities in the Bay of Plenty health system (September 2016)

• A full day strategic options workshop with over 90 stakeholders from across the Bay of Plenty to consider a ‘strawman’ framework for the SHSP’s strategic objectives, ‘headline actions’, and supporting enabling actions (September). At the strategic options workshop, participants worked in small groups to critique and refine the ‘strawman’ framework, with participant feedback then incorporated into further development of the SHSP. A survey of workshop participants was also undertaken prior to the workshop, which sought participant views on how well the Bay of Plenty system performed on key aspects of the Triple Aim and what participants considered to be the highest priorities for the next 10 years (see Figure 13 below)

• Attendance at meetings of clinical stakeholders including Eastern Bay and Western Bay primary health care stakeholders and secondary clinicians from the BOPDHB (October - November 2016)

• Presentation of the Health and Service Profile 2016 and draft SHSP to the BOPDHB Board and Māori Health Runanga (November 2016).
Figure 13. Strategic options workshop participant feedback on priorities for the Bay of Plenty health system over the next 10 years

Governance

Reflecting the whole-of-system perspective of the Health and Service Profile 2016 and SHSP, a Steering Group comprising BOPDHB and PHO representatives guided development of both documents. The Steering Group oversaw development of each aspect of the Health and Service Profile 2016 and SHSP, including approaches to stakeholder engagement.
Appendix 3: SHSP key performance indicators

Successfully implementing the SHSP’s three strategic objective will contribute to improvements across all three domains of the Triple Aim – health outcomes, patient and clinician satisfaction, and value. While each strategic objective will have its own measures of success, overall outcomes will also be measured – aligned with, and complementary to, existing accountabilities such as national Health Targets and the System Level Measures Framework. The selection of system measures, which will provide an indication as to how the Bay of Plenty health system is progressing the delivery of the strategic objectives of the SHSP, is shown below. Regular reports will allow the ELT, Board, and Rūnanga, to track progress and fine-tune the approach as appropriate.

<table>
<thead>
<tr>
<th>Population Health and Equity</th>
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<tbody>
<tr>
<td>1. Living longer</td>
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<tr>
<td>2. Keeping people healthy and out of hospital</td>
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<tr>
<td>3. Child health</td>
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<tr>
<td>4. Cardiovascular disease and diabetes management</td>
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<td>5. Reducing the impact of tobacco smoking</td>
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<td>6. Reducing the impact of obesity</td>
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<tr>
<th>Experience of Care</th>
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<tr>
<td>7. Hospital experience</td>
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<tr>
<td>8. Maintaining access to elective surgery</td>
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<td>9. Integrated care</td>
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<td>10. Customer satisfaction</td>
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# Making Best Use of Public Resources

<table>
<thead>
<tr>
<th>11. Operating efficient hospital services</th>
<th>Weighted output per FTE, inpatient and outpatient services. Increase in CWDs per theatre. Proportion of funding on inpatient services.</th>
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<tr>
<td>12. Efficient inpatient capacity use</td>
<td>DRG-weighted medical-surgical average length of stay.</td>
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<tr>
<td>13. Care in the community</td>
<td>Ratio of over-75s supported in their own homes to those in ARRC. Ratio of people receiving specialist mental health services in the community to those in inpatient care. % of outpatient clinics delivered in community facilities.</td>
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<tr>
<td>14. Balancing primary and specialist care</td>
<td>Specialist FSAs per 1000 population (age standardised). Specialist follow-ups per 1000 population (age standardised).</td>
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<tr>
<td>15. Workforce</td>
<td>Staff engagement. % of days worked/total days available.</td>
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