

# **Counties Manukau District Health Board**

## **Health Services Plan**

**February 2008**

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# Executive Summary

## Background

The Counties Manukau District Health Board Health Services Plan describes the future shape of health services in Counties Manukau. The Health Services Plan (HSP) is grounded in our District Strategic Plan (DSP), but differs from it in that the HSP takes a longer view (20 years, as opposed to 5 years), and has a service rather than outcomes focus.

The purpose of the HSP is to inform and support our detailed planning of services, workforce, facilities and other major capital investments, finances, and information systems. Specific HSP objectives include to:

- Translate the strategic direction of CMDHB into a 'blueprint' for integrated health service delivery across Counties Manukau to the year 2026
- Provide a clear description of future Models of Care across the care continuum, and to plan for the shape, size, setting and location of service delivery for Counties Manukau residents and inter-district patients accessing care within Counties Manukau
- Provide advice on issues arising from the HSP that relate to facility and workforce capacity, and affordability
- Support future business cases for facilities development within Counties Manukau.

Development by DHBs of long term comprehensive health services plans – as opposed to a focus on secondary and tertiary clinical services - is a recently prescribed requirement from the Ministry of Health to support facilities business cases, and better reflects the full scope of DHB accountability for population health outcomes. CMDHB is the first DHB to complete a comprehensive plan of this nature.

This document includes only the key findings from each of the service planning workstreams, with the detailed workstream reports forming appendices to this summary.

## Planning Approach

Development of the Plan has been based on a 'whole system' approach consistent with our DSP, encompassing a broad continuum of care, a population health perspective, a focus on inequalities, and consideration of the wider determinants of health. A generic planning framework – including a model of care, planning template, principles, assumptions and enablers – was devised at the outset of the 18 month planning process to inform detailed planning within each service area. This has meant that the HSP is built upon a shared understanding of the DHB's strategic approach, and a consistent foundation of common terminology and concepts.

## Our Population

Counties Manukau encompasses the territorial local authorities of Manukau City, Franklin District, and Papakura District. It has a diverse population with complex health needs and service requirements. It is the fastest growing area in New Zealand. Key features of the Counties Manukau population are:

- a high proportion of Maaori
- a high proportion of Pacific people
- a high proportion of Asian people
- the relative youthfulness of these populations, and the population as a whole
- the fast growth of the population
- a high proportion of the population who are relatively deprived in socio-economic terms.

For the year 2006 the estimated Counties Manukau population was 454,790, 10.9% of the New Zealand population. The catchment area for the CMDHB provider arm includes all of Counties Manukau plus Otahuhu, part of the Auckland DHB area, and has an estimated 2006 population of 468, 670. Population growth between Census 2001 and Census 2006 for Counties Manukau was 16%, an annual growth rate twice that of the New Zealand average. An additional 18,300 people are

projected for Counties Manukau in 2008 compared with 2006, a 2% annual increase. Growth has slowed slightly with the downturn in immigration to New Zealand, but remains significant and places pressure on health service provision. CMDHB is currently the third largest DHB by population (behind Waitemata and Canterbury). Projections suggest that by 2026 Counties Manukau will have a population of 626,000, and CMDHB will have overtaken Canterbury to become the second largest DHB.

### **Strategic Focus**

CMDHB is responsible for the planning and funding of services to meet the health needs of the local population, in addition to being a large provider of specialist inpatient and ambulatory services. Counties Manukau health services have a strong national reputation for innovation, a focus on community based (as opposed to hospital based) service delivery, and partnerships with agencies from other sectors.

The generic Model of Care continuum describes care from health promotion, through primary and specialist inpatient care. This HSP demonstrates that, wherever possible, services are increasingly focusing on health promotion and early intervention strategies with care provided in ambulatory settings. Specialist services will increasingly deliver care in community or ambulatory settings and will work collaboratively with primary and community providers to support the growing number of people with chronic conditions. Intersectoral partnerships will be used to address the determinants of health.

The HSP starts from the position that the quality of care provided to the Counties Manukau population is not as safe and reliable as it should be, and that it can be improved. This emphasis on quality improvement will pervade all facets of health services development, so that within the term of this HSP the services CMDHB funds and provides will be of high quality.

CMDHB will continue to work within a collaborative framework with the other northern region DHBs to improve regional service provision. Where services provided by CMDHB are provided nationally or for North Island DHBs, CMDHB has the responsibility to plan and consult to meet the needs of other DHBs to help achieve improved outcomes for their populations.

Workforce has been identified as a critical constraint to implementation of this HSP. CMDHB has a Workforce Development Plan that promotes the development of the local workforce, in parallel with national workforce initiatives. Caring for the growing numbers of people requiring community based support-care for age-related or chronic conditions will be particularly challenging.

### **Moving Forward**

Specific planning processes associated with the HSP that will occur through 2008 include:

- Primary maternity services
- Primary and community health services
- Community radiology
- Regional Services Planning (continued medical and surgical sub-specialty planning in association with the other northern region DHBs)
- Child & adolescent community oral health services (business case development as part of a national process)
- Smoking cessation services (part of a national process).

As noted above, the HSP is also be used as a foundation for site masterplanning, facility business cases, workforce planning, long term financial planning, and development of the Regional Information Services Strategic Plan.

As with any plan, the HSP reflects a view of the future from today's perspective, and hence will require regular review and updating. This is likely to be done in conjunction with the 3-yearly DSP review. We have already identified the following services as requiring dedicated consideration during the first review:

- Obesity

- Youth – adult transition
- Incontinence
- Sexual health
- Rural health
- Allied health
- Genetics

These services have in fact been considered in this initial HSP, but in a broader context. A more focused approach will be adopted in the future.

## 1.0 Introduction

### 1.1 Health Service Plan: Aim, Purpose and Objectives

In 2005/06 Counties Manukau District Health Board (CMDHB) developed a Clinical Services Plan outlining the clinical services to be delivered by the CMDHB provider arm until 2020. That plan provided valuable direction for the DHB through identifying:

- The provider arm services needed for Counties Manukau people in the future
- The current service delivery model and location of services
- Current service delivery challenges
- The future service delivery model and location of services
- Regional service delivery implications
- The model of care that is needed for the services to be effective, well integrated, seamless and holistic.

CMDHB has now developed an expanded approach to services planning through developing a Health Services Plan (HSP) framework that builds on the earlier version of the Clinical Services Plan (CSP V2.5) and better reflects the full scope of CMDHB's accountability for the health of the Counties Manukau community.

This expanded framework takes a 'whole of society' approach to health services planning up to 2026. The approach includes planning across intersectoral boundaries, integrating services along and across care continua, providing leadership in the provision of services within Counties Manukau, and supporting the provision of high quality clinical services by both the CMDHB provider arm and other service providers.

The HSP provides both the framework and the 'blueprint' for development and implementation of the clinical dimensions of the CMDHB District Strategic Plan through providing greater detail and specificity to the planning of health services within Counties Manukau. This 'whole of society' view is consistent with CMDHB's commitment to meeting its core accountabilities and to achieving improvement in the health status of the Counties Manukau population.

The HSP has four key objectives:

- To translate the strategic direction of CMDHB into a 'blueprint' for integrated health services across Counties Manukau to the year 2026
- To provide clear description of future Models of Care across the care continuum, and to plan for the shape, size, setting and location of service delivery for Counties Manukau residents and inter-district patients accessing care within Counties Manukau
- To provide advice where appropriate on issues arising from the HSP that relate to facility and workforce capacity, and affordability
- To support future business cases for facilities development within Counties Manukau.

A number of planning principles, planning assumptions and planning enablers were identified at the inception of HSP development. These are contained within the report in section 1.2.3.

The CMDHB HSP differs from the earlier Clinical Services Plan in a number of significant areas:

- Taking a 'whole of society' approach rather than solely a DHB provider arm view of health services
- Developing a generic Model of Care framework that is applied in the detailed planning for particular services
- Presenting a model that reflects and supports CMDHB's commitment to health promotion, prevention of ill health, early detection and intervention strategies to support improved health outcomes
- Intersectoral collaboration to support the achievement of improved health outcomes where other sectors have an important influence on health outcomes

- Promotion of community-based services delivery where these can be provided efficiently and effectively
- Strong, clear linkages to CMDHB organisational strategic direction and funding intent
- Clear linkages to background planning documents and supporting information
- Linkage to DHB workforce issues and workforce planning
- Linkages with metro-Auckland Regional Service Planning and other DHBs where appropriate
- Identifying and strengthening interfaces between services, and between components of services with the aim of promoting service integration
- Incorporating current and proposed new initiatives that will strengthen the Models of Care within Counties Manukau
- Utilising Models of Care, service configurations and demand calculations to inform facility capacity and guide development of clinical support
- Promoting service flexibility to respond to future changes in government policy, CMDHB direction, technology developments and changes in clinical best practice
- Identifying change management, and workforce issues/strategies that are relevant to Models of Care and service direction
- Meeting the 'Guidelines for Capital Investment and Clinical Service Planning Guidelines' (Ministry of Health, 2003).

The HSP is part of the broader CMDHB planning framework that includes a number of key strategic planning documents and processes:

- CMDHB District Strategic Plan (DSP)
- CMDHB District Annual Plan (DAP)
- Crown Funding Agreement
- CMDHB Statement of Intent
- CMDHB Population Health indicators
- National health strategies and plans (Ministry of Health)
- Capital Investment and Clinical Service Planning Guidelines (Ministry of Health).

## **1.2 What Guides Us?**

### **1.2.1 Policy Context**

The responsibilities of District Health Boards are established by the NZ Public Health and Disability Services Act 2001. Under this legislation it is expected that CMDHB will:

- have a population focus, addressing disparities in health and disability status
- shift the emphasis towards promotion of health, prevention of ill health and disability, and early intervention
- foster collaboration and co-operation between local providers, with services focused more on consumer needs than providers
- involve and engage with the community and other key stakeholders, and promote outreach programmes and local community initiatives
- pursue the objectives outlined in the Act to the extent that they are reasonably achievable within the funding provided.

The New Zealand Health Strategy 2000 provides overarching strategic direction for the New Zealand health sector. It identifies 13 priorities, and directs the sector to focus on reducing inequalities in health status by ensuring accessible and appropriate services for Maaori, Pacific peoples and people from lower socio-economic groups. This is particularly relevant in Counties Manukau where there are high numbers of Maaori and Pacific people, and high rates of deprivation.

The NZ Health Strategy identifies five service delivery areas for particular attention: public health, primary care, reducing waiting times for elective surgery, improving the responsiveness of mental health services, and accessible and appropriate services for people living in rural areas. It also focuses on quality including continuous improvement, individual rights, consultation, co-ordination, information management and technology, workforce development and evaluation of the Strategy as warranting focus.

Improving Quality (IQ) a systems approach for the New Zealand health and disability sector (Minister of Health 2003) sets out a strategy for the New Zealand Health service that focuses on quality improvement and safety. It draws a distinction between quality assurance and quality improvement, placing a requirement on organisations and individuals to adopt a programme of quality improvement to address issues of safety, access and equity, effectiveness, efficiency and people centred care.

### 1.2.2 CMDHB Vision

*“To work in partnership with our communities to improve the health status of all, with particular emphasis on Maaori and Pacific peoples and other communities with health disparities.”*

- *We will do this by leading the development of an improved system of healthcare that is more accessible and better integrated.*
- *We will dedicate ourselves to serving our patients and communities by ensuring the delivery of both quality focussed and cost effective healthcare, at the right place, right time and right setting.*
- *Counties Manukau DHB’s provider arm will be a leader in the delivery of successful secondary and tertiary health care, and supporting primary and community care.*

The CMDHB Model of Care is informed by the six key outcomes areas of the CMDHB District Strategic Plan 2006 that are the focus for health sector activities over the next five-ten years:

- Improve community wellbeing
- Improve child and youth health
- Reduce the incidence and impact of priority conditions
- Reduce health inequalities
- Improve sector responsiveness to individual and family/whanau need
- Improve the capacity of the health sector to deliver quality services.

(See section 2.1 for further detail.)

### 1.2.3 Planning Principles, Assumptions and Enablers

Identifying key Planning Principles, Planning Assumptions and Planning Enablers at the beginning of HSP development has been valuable in setting the planning direction and guiding the detailed planning. These principles, assumptions and enablers were consulted on with the CMDHB Community Panel, and with the HSP Reference Group which comprised clinical and managerial leaders from the CMDHB provider arm and PHOs.

#### HSP Planning Principles

The services we plan for the next 15 to 20 years will be informed by the following principles. Services will:

- Increase access to integrated community based health care that is safe, effective and delivered closer to home
- Encourage and support individuals and families to keep well, healthy and actively participate in their own care and self management
- Reflect the particular needs of discrete geographic and ethnic communities within Counties Manukau
- Be based on a collaboration between providers within the Health sector, and between sectors
- Be developed through multi-skilled teams of healthcare and support professionals
- Be of high quality when funded by CMDHB, regardless of the service provider
- Incorporate a philosophy of continuous quality improvement, focussing on safety, effectiveness, efficiency, equity, timeliness and patient centred care
- Ensure that patient/consumer flow through services is rational, seamless, timely and effective
- Offer holistic, co-ordinated care that meets the needs of individual complexity

- Foster reduction of population health inequalities.

### **HSP Planning Assumptions**

Over the next 15 to 20 years we assume there will be:

- Continued growth in population (above the national average)
- A rapidly ageing population, although Counties Manukau will continue to have a relatively young population compared with the national profile
- Significant growth in the incidence of chronic disease including doubling of the number of people with diabetes
- Development of health promotion and early intervention activities that will reduce the demand for treatment services and improve health status
- Continued ethnic diversity with a high proportion of Maaori, Pacific and Asian people
- A similarly high proportion of people who are socio-economically deprived
- A growing availability of and demand for new, and more complex technology
- More informed consumers of health services through increased internet access to information
- A cultural and organisational change in the way in which healthcare providers deliver services (e.g. moving towards integrated healthcare teams, links between secondary and primary care providers)
- Services that are tailored to meet the particular needs of population groups (e.g. Maaori, Pacific, children, older people)
- No material change in the proportion of healthcare that is DHB funded
- Funding will always be insufficient to meet all health needs and prioritisation of healthcare investment will continue to be required
- No significant change in health organisational structures
- No change to the current configuration of tertiary service providers
- Achievement of breakeven financial results by the DHB
- Continuation of the Future Funding Track (FFT), demographic adjuster and Population Based Funding
- An increased focus on patient safety, clinical effectiveness and quality improvement
- Growth in workforce numbers will not keep pace with demands of population growth and ageing
- Changes in the workforce composition and expectations of the workforce that will challenge service delivery.

### **HSP Planning Enablers**

- Workforce planning to increase capacity and capability, and to support a team approach
- Outcome based indicators and evidence-based planning
- Cross-sector and intersectoral pooled funding initiatives
- Flexible funding packages and reporting models
- Increased and consistent use of information systems
- Consistent protocols, practises and processes across providers
- Development of service 'clusters' that meet the needs of particular population groups
- Sector access to public and private capital to fund investment in facilities, equipment and IT
- System wide evidence-based clinical systems, including decision support systems
- Support from the Quality Improvement Unit
- Effective partnerships between agencies
- A communications strategy that ensures all stakeholders receive clear, open information.

#### **1.2.4 Regional Context and Collaboration**

The metropolitan Auckland region served by Waitemata DHB, Auckland DHB and Counties Manukau DHB stretches from north of Wellsford to just south of Mercer. While mostly urban, this area stretches 160km from north to south and 60km from east to west. Each of the three DHBs is acutely aware of the considerable capital and operational costs of providing services to the largest metropolitan area in New Zealand and is striving to ensure that collectively the DHBs make efficient and effective use of both staff and facility resources.

To facilitate achievement of these goals the metropolitan Auckland District Health Boards agreed in October 2002 to formalise a structure and process to enable active collaboration specifically to improve co-ordination, priority setting and planning. The primary focus of the process at that time was on provider arm services only, however the scope of regional collaboration has since evolved and extended to include all service provision. (Similarly, Northland DHB has recently actively joined in the collaboration, to strengthen its regional nature.)

There are a number of critical drivers of health service need, principally population growth, ageing, deprivation and population diversity. The sheer magnitude of these drivers within metro-Auckland has major implications for health services and facilities within the region.

### **Metro-Auckland Population Growth**

During the period from 2001 to 2026, the region's population is predicted to grow from 1.23m to 1.8m. This is an increase of 570,000 people which is a population growth equivalent to a city 3.3 times the current size of Wellington City.

The population will become more diverse with increases of 46% in the Maaori population, 66% in Pacific peoples, and 205% in Asian people, with each of these groups placing specific and often additional demands upon healthcare such as higher rates of diabetes and heart disease amongst Maaori and Pacific people.

The most graphic changes are in the ageing of the population. In particular, the over-85 years age group will increase from 13,730 in 2001 to 36,780 in 2026, a 167% increase over the period. There are similar increases in the over-65 years age group, with both of these groups being high users of health services.

The combined impact of these drivers is likely to result in need growing faster than Vote Health funding. If one takes the average age mix of people presenting to the Health system (and their age related utilisation figures) then the demand curve for health services is growing by around 4.5% per annum compared to a national average population growth figure of 1.5% for the Auckland region. Typically the demographic health funding increases relate to the national average population growth figure. Over time this would result in a large cumulative deficit in funding if one were to maintain access at current thresholds. The OECD estimates that most countries would need to spend between 12% and 15% of their GDP by 2050 to deal with this issue<sup>1</sup>. (*Projecting OECD health and long-term care expenditures: what are the main driver? OECD – 2000*). If this level of reallocation is not attainable then thresholds for access will inevitably rise.

The potential impact of the ageing population on need/demand for health services is the subject of international debate and various theories exist around the relative importance of different scenarios in different populations (increasing survival with longer periods of morbidity and increased disability; a dynamic equilibrium with better management of chronic diseases; a compression of morbidity as a result of improving health status).

### **The Need for Efficiency and Innovation**

It is imperative that we find innovative and more cost effective ways of responding to healthcare needs. A number of different strategies are being pursued currently through the Regional Service Planning (RSP) process to do this:

1. Ensure that patient care is provided in the most appropriate setting from the whole system's perspective. Often there are road blocks or administrative hurdles that drive people down less effective pathways, but there has also been a considerable change in the last 20 years and much care that was previously provided in institutional settings is now provided in the home or community.

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<sup>1</sup> Projecting OECD health and long-term care expenditures: what are the main drivers, OECD – 2000

2. Continuing implementation of the Primary Health Care Strategy to strengthen the capability and capacity of primary care. Workforce development, team work and the integration of information systems are all important parts of this strategy.
3. Locate secondary care services closer to where people live, where that can be done in an efficient manner.
4. The approach to management of chronic disease. CMDHB in particular has put a significant investment into a more focussed and cost-effective way of engaging patients and healthcare workers in dealing with long term conditions.

## **Facility Requirements**

Notwithstanding all of the measures to reduce the demand for expensive secondary and tertiary healthcare and the significant push to ensure more care is provided in primary and community settings, there will still be a significant future requirement for additional inpatient beds and theatre capacity within the Auckland metropolitan area.

Much of what has been built over the last 10 years in all three DHBs has been focused on catching up with previous population growth. Over the next 20 years, the RSP forecast is that at occupancy of 85% an additional 1549 beds will be required regionally over and above what is currently commissioned to meet expected inpatient capacity across all specialities. Of those expected beds 1037 are needed in Medicine and Surgery. The principal drivers are population growth and ageing. The forecast impact of remaining at 90% occupancy for adult medical and surgical beds only reduces the forecast Medicine and Surgery component by 126 beds – that is, an increase of 912 medical/surgical beds instead of 1037, and 1423 beds in total (instead of 1549).

Facility requirements reflect changes in the model of care, based on sound quality improvement principles. For example, facilities can promote efficient patient flow and also play a role in decreasing cross infection. Likewise, good model of care work can decrease inefficiencies and wasted resources before services move into new facilities.

## **Quality Initiatives**

The three metro-Auckland DHBs have specifically identified the importance of collaboration in the area of quality improvement. All the DHBs face similar challenges in providing access to high quality health services, with the need to improve on all the dimensions of quality: safety, access/timeliness, clinical effectiveness, improving patient involvement and centeredness, and decreasing waste of resources.

Regional collaboration in patient safety currently centres on medication safety with medication reconciliation projects in all three DHB provider arms. As the national medication safety project begins in 2008, there will be a need for further collaboration in this area, with an electronic web-based medication record planned, and electronic prescribing and bedside verification through bar coding of medications set to revolutionise the way that medications are handled in the provider arm.

Other work in the patient safety areas includes:

- The development of Early Warning Scores (EWS) in both North Shore and Middlemore Hospitals, with further refinement in this area
- The 'hospital at night' concept with improved handover of care for critically ill patients. Regional collaboration is particularly important given the fact that our junior medical force not only rotates between the three main hospitals but is also likely to continue to be a scare resource in the future
- Optimising the patient journey particularly focussing on waits and delays in emergency departments; training of staff in quality improvement skills; and improvements in communication between hospitals and primary care, and vice versa.

## **Information Technology Requirements**

A quality, customer focussed healthcare delivery system needs reliable and accessible information for two core reasons:

1. To assist healthcare professionals to deliver high quality care. In today's environment as well as into the future, information technology is increasingly the enabler of our ability to achieve a quality, responsive, effective healthcare delivery system.
2. To provide information so that the quality of healthcare can be measured and improved. IT will need to support a more extensive clinical indicator programme (e.g. be able to provide information on waiting times for lung cancer patients, from referral to treatment), and to support clinical staff as they increasingly seek improved clinical practice through critical appraisal.

As planners, funders and administrators of healthcare we cannot ignore the importance of factoring investment in IT into our prioritisation processes as being of equal importance to building physical capacity. This is particularly the case as we look to expand delivery of care into our communities and take a pro-active role in preventative care. IT investment however comes at an additional and substantial cost to the sector but one that should not be overlooked.

### **Funding and Affordability**

In addition to service provision, the RSP process is considering issues of equity of access across the three DHBs – a complex issue when consideration of need, capacity to benefit and efficiency of service delivery is applied relative to each DHB's requirement to achieve health gain within its particular demographics and competing resources and needs. The four northern DHBs are committed to the principle of equity of access, and are currently exploring the feasibility and impact of achieving this.

### **Principles and Philosophy of Regional Collaboration**

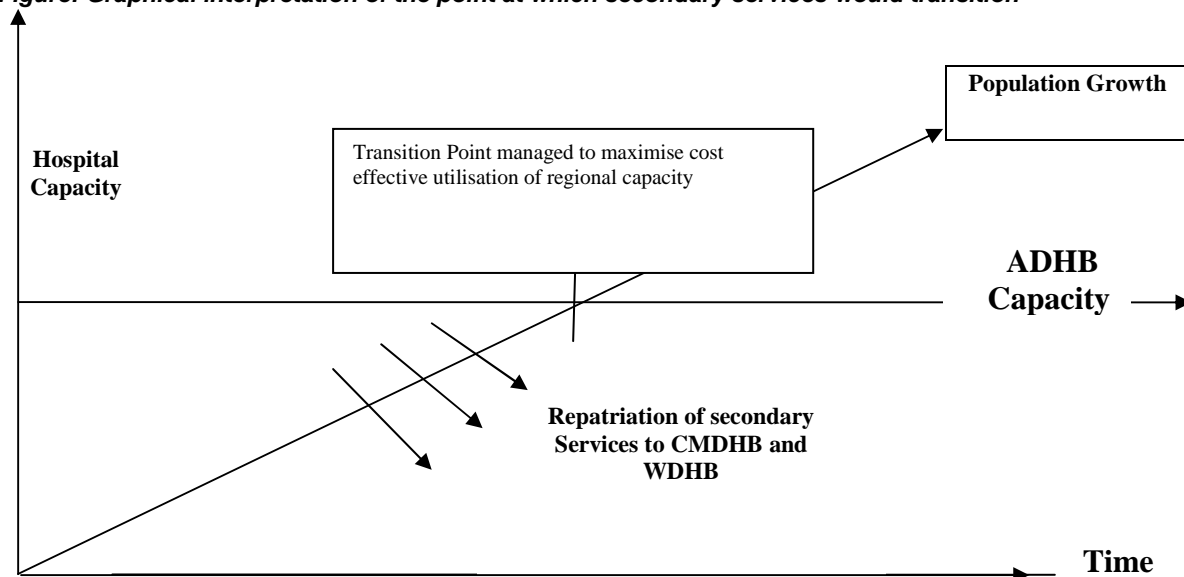
The metro-Auckland region have a set of guiding principles based on the premise that they will work together on issues where it is agreed that the population of the region will benefit from a collaborative approach. Where a DHB has a significant disagreement with the position of the other two, the group will make every effort to accommodate or at least fairly represent the dissenting view. Further, the metro-Auckland DHBs have a process of pro-actively presenting their combined case to the Government and other DHBs, to ensure that the Auckland population is not disadvantaged in funding or service provision. The DHBs recognise each other's unique accountability to the Government.

### **Regional Planning 'End Point'**

The 'end point' planning expectation is that each DHB will provide secondary services for its own population, subject to clinical and financial viability, with regional provision of tertiary services. The transition of secondary services will be determined based on cost effective utilisation of resources throughout the population growth transition. As demonstrated below, the population growth is significant and the transition of secondary services is expected to occur up to the next 20 years.

The exact transition point (i.e. the timing and viability of each transition) will be determined based on the specific circumstances for each service reflected in a full business case analysis. In the main, this involves transfer of delivery responsibility from Auckland DHB to other two DHBs for the local population, and affects DHB provider arm services only (although there are exceptions to both these generalisations).

**Figure: Graphical interpretation of the point at which secondary services would transition**



### Regional Service Collaboration Structure

The Regional Service Configuration Project was established in October 2002 to improve coordination, priority setting and linkages between Regional Planning and Funding (including inter-district flow agreements), Regional Service Planning (RSP), and Regional Capital Group (RCG) in the metro-Auckland region. The overarching aim of Regional Service Configuration is to take a strategic view of the region to ensure that any changes or decision making about service configuration in the Auckland region takes place through a planning process that is clinically and financially informed.

The Regional Service Configuration Project therefore focuses on three specific deliverables to ensure there is cost effective utilisation of service capacity:

1. Plan the future configuration of tertiary/complex or high cost services
2. Plan the future configuration of secondary services
3. Ensure the cost effective utilisation of services in their transition phase, where they have been identified for change in configuration.

The development of the CMDHB HSP has been managed consistent with the RSP process. Presentation of the workstream directions has been made to the RSP team. Specific meetings have been held with northern region DHB representatives, sharing developments and new directions for health services in Counties Manukau, and seeking a regional consensus on service development.

### Current RSP Projects

Below is a description of current and planned medical and surgical subspecialty RSP projects as at February 2008. (Note that (a) a considerable range of RSP projects have been completed and implemented prior to that date; and (b) that there is a parallel mental health RSP work also underway that is not itemised in this table.)

Project	Description of Issues	Expected Process	Timeline
Gynaecological Oncology	Issues relating to the regional service's ability to meet demand on a timely basis together with a need for clarification of referral process led to a regional process being established to agree the model of care, referral model and timeframe protocols for treatment for all gynaecological cancer groups.	A planning document from the Auckland metropolitan DHBs that identifies agreed service model, configuration of services, clinical guidelines and impact analysis.	March 2008

	<p>The issues were applicable to the northern half of the North Island, however it was felt that if metro-Auckland could streamline the models of care and pathway then these would be mapped out to provision of care to other North Island DHBs.</p> <p>This is an Auckland metropolitan project.</p>		
Chronic Pain Services	<p>Issues relating to meeting demand, low intervention rates and identification of unmet need. Opportunities to look at existing resource and whether this can be applied in a different configuration as well as opportunities to partner with ACC gave rise to this project.</p> <p>ACC engaged, then disengaged so the current direction of the project is to write a strategic plan to map how the future delivery can be achieved under current resource levels.</p> <p>This is a metro-Auckland project.</p>	A strategic plan looking at the 5 – 10 year view of provision of chronic pain services within metro-Auckland.	May 2008
Ophthalmology	<p>Issues relating to provision of service by the Auckland DHB regional service, staffing, demand, capacity, subspecialisation, and demands for local service provision.</p> <p>This is a metro-Auckland metropolitan project (however Northland have now indicated that they may need to participate)</p>	A Strategic Plan to identify future configuration of services 5 – 10 years out. Confirm model of care, staffing levels, pathways, acute demand management, impact of technology protocols and financial impact analysis. An implementation plan will also be prepared.	To be confirmed

Project	Description of Issues	Expected Process	Timeline
Sexual Health	<p>Issues relating to future configuration and models of care across the entire spectrum of services required to meet demand for sexual health services.</p> <p>The project will produce a Strategic Plan for the future delivery of Sexual Health services across metro-Auckland taking into account demand, workforce, local service delivery, impacts of technology across the continuum of care. A systems approach will be applied.</p> <p>There is a linkage here with the Ministry of Health Review of Sexual Health Services. However it is anticipated that the work by the Auckland region will be completed prior to any final work from the MOH and there is therefore the opportunity to inform the national direction.</p> <p>This is a metro-Auckland project.</p>	A full Strategic Plan detailing the provision of Sexual Health services for metro-Auckland over the next 5 – 10 years.	December 2008
Renal	<p>'A Plan for the Short and Long Term' was completed in November 2005. The Regional Renal Steering Group is now working through each recommendation (divided into work streams) contained within this plan to progress to implementation, which includes an operational and financial impact analysis as required.</p> <p>This is a Northern Region project.</p>	<p>As each workstream is completed, a plan for implementation will be presented to the Northern Region CEOs to proceed.</p> <p>A full strategic plan will also be presented to the CEO Forum.</p>	Strategic Plan June 2008

Equity of Access	<p>The Northern Region DHBs want to understand the implications of implementing equity of access for all services for its populations. The wider implications of equity of access for service delivery, future service size and configuration, access thresholds, regional decision making and funding, etc, as well as the processes required to enable equity to be achieved will be considered as part of this project.</p> <p>This is a Northern Region project.</p>	Initial output will be a review of four pilot services.	March 2008
Plastics and Reconstructive Surgery	<p>Issues have arisen over a period of time in relation to the provision of Plastic &amp; Reconstructive services across the Northern Region in relation to local delivery of service, workforce, technology, demand, production levels and timeliness of delivery.</p> <p>A full RSP process is required to look at the effective delivery, efficiency and configuration of the provision of plastic services across the region.</p> <p>This is a Northern Region project.</p>	A full strategic Plan detailing the provision of services for the next 5 – 10 years for metro-Auckland will be presented to the Northern Region CEO Form.	July 2008

### Proposed RSP Projects for 2008

Service	Description of Issues	Expected Outcome
Major Trauma	<p>A desktop exercise required in the first instance to define 'major trauma' and then look at volumes/complexity and configuration of current service configuration.</p> <p>This should include benchmarking current provision of service (eg population, FTE) against international examples.</p> <p>There is a key linkage here with work on the provision of Head and Neck services across the region.</p>	<p>The purpose of the paper will be to paint a picture of the current provision of service with analysis of any gaps, duplication, or configuration issues that we need to draw attention to for purposes of planning for future service delivery.</p> <p>The CEOs would be asked then to decide whether any further RSP actions should be taken.</p>
Radiology	<p>A full RSP process to look at the effective delivery, efficiency and configuration of radiology services, including the delivery of nuclear medicine services.</p> <p>There is a linkage here with provision of Vascular and Cardiology services in the future.</p>	A plan detailing the provision of services for the next 5 years for the Northern Region and a vision for the 10 – 20 years, taking into account the many influences of evolving technology, growth, demand and workforce.
Vascular	<p>A full RSP process to look at the future effective delivery of an efficient service, taking into account configuration of services, workforce, technology issues and demand.</p> <p>There is a linkage here with provision of Radiology services</p>	An initial paper to identify the issues and next steps prior to confirming the next steps.
Urology	<p>A full RSP process to look at the effective delivery, efficiency and configuration of the provision of Urology services across metro-Auckland that will refresh the regional plan completed in 2004.</p> <p>Of key significance is the 'medicalisation' of Urology and the implementation of a fixed Extra Corporeal Shockwave Lithotripter at ADHB which will enable management</p>	A plan detailing the provision of Urology services for the next 5 years for the metro-Auckland region and a vision for the 10 – 20 years, taking into account technology, clinical, growth, demand and workforce.

	of acute stones via ESWL. This will mean a significant change in clinical practice.	
Oral Health	A full RSP process to look at the effective delivery, efficiency and configuration of the provision of secondary Oral Health services across metro- Auckland.	A plan detailing the provision of services for the next 5 years and a vision for the 10 – 20 years, taking into account technology, growth, demand and workforce.
ORL – Head and Neck Services	A full RSP process to look at the effective delivery, efficiency and configuration of the provision of ORL services across metro-Auckland. There has already been a great deal of work done through SREA and RSP up to 2003 with respect to ORL services and it is likely that even though the current configuration needs to be challenged the outcome of the process may well confirm the existing configuration of ORL.	A plan detailing the provision of services for the next 5 years and a vision for the 10 – 20 years, taking into account technology, growth, demand and workforce.

### 1.2.5 Introduction of New Services/Technology

For the past 18 months the national New Services & Technology Review (NSTR) Committee has been in place. This is a collaborative Ministry/DHB initiative and is both guided by and supports the Service Planning and New Health Intervention Assessment (SPNIA) Framework.

The purpose of the SPNIA framework is to take a national approach in considering introductions of new technology and/or services to the New Zealand public health system. The NSTR process aims to ensure consistency across the country and takes into account access, cost, value for money, effectiveness, substitution (or additional services), acceptability and contribution to population health.

In the first phase of its implementation, NSTR has concentrated on introduction of new technologies at the request of the Minister of Health. It is noted that given the current backlog there is a greater urgency to concentrate on emerging technologies that require a national view, rather than regional or national service changes.

NSTR evaluates all national proposals as per set criteria contained in the *Proposal for Change* guide. Proposals are scored to assess the quality of the application and whether it has included all required information or whether further information is required from the applicant. Proposals that are added to the workplan proceed to development of a business case with full Health Technology Assessment (HTA), health economic evaluation, cost/benefit analysis etc.

#### Counties Manukau DHB

While promoting development of local clinical practice innovation, introduction of new technology or service, clinical practice must be carefully planned to ensure safety for staff and patients, ensure efficacy and management of financial risk.

Under the national SPNIA framework, CMDHB is able to design its own internal process for the evaluation of new technologies and/or services/clinical practice. The outcome of the local process may be to implement in-house in the first instance, or to take the matter to the region for consideration for a regional or national decision.

The criteria used by NSTR for these types of proposals have been adopted locally for CMDHB purposes. The CMDHB application form for use within CMDHB incorporates the NSTR *Proposal for Change* criteria as a guide to the type of information that would be required in an application.

The CMDHB NSTR process requires an application that requires local clinical and managerial endorsement prior to regional CEO approval for progressing for national consideration. The CMDHB process meets the requirements of the national framework and a list of items considered and implemented by CMDHB will be notified to both the region and NSTR when local decisions are made.

As an innovative provider of healthcare, CMDHB is active in the development of new services that will benefit both our population and New Zealand as a whole.

### 1.2.6 Intersectoral Collaboration

*“Intersectoral health action aims to achieve health outcomes ‘in a way that is more effective, efficient or sustainable than could be achieved by the health sector working alone’ (Harris et al, 1995:7)<sup>2</sup>*

CMDHB has a strong record of working intersectorally (e.g. Healthy Housing, PATHS, and Let’s Beat Diabetes programmes) to achieve health gain in Counties Manukau, and the HSP continues to promote development of intersectoral initiatives to achieve improved health outcomes.

In 2005 the Ministry of Health revised a literature review undertaken in 2001 that examined the ingredients for success with intersectoral health projects. This publication<sup>3</sup> provides robust evidence that both affirms the CMDHB approach to intersectoral initiatives and guides CMDHB in progressing further developments.

A range of factors were identified by the Ministry as influencing the degree to which community-based intersectoral initiatives are considered effective or successful. These factors were summarised and grouped under six headings that correspond to the six overarching requirements for effective intersectoral action identified earlier by Harris (1995). The categories are:

1. Clear agreement exists on the necessity for intersectoral action
2. Support exists in the wider community for action
3. Capacity exists to carry through the planned action
4. Relationships enabling action are defined and developed
5. Agreed actions are planned and implemented
6. Outcomes are monitored and evaluated.

With a considerable number of successful intersectoral projects underway, CMDHB staff have developed specific experience, skills and the organisational perspectives required to work with other sectors, responding to the multiple complexities that this involves.

The HSP describes CMDHB’s intent to continue:

- To recognise the strong influence of other sectors on health outcomes and the necessity of working collaboratively to achieve health gain;
- To work with other sectors to further refine the framework used to collaborate intersectorally;
- To foster the unique leadership and organisational culture behaviours required to work effectively with other sectors;
- To develop further intersectoral initiatives that will deliver health outcomes in the future.

### 1.2.7 International Challenges

In April 2002, the European Observatory on Health Care Systems released a report on “Health Care Systems in Eight Countries: Trends & Challenges”. The eight countries included in the report were Australia, Denmark, France, Germany, the Netherlands, New Zealand, Sweden and United Kingdom. Similar themes have emerged in these countries which affect future health service provision. Across these countries, major challenges have included:

- The ageing population
- Health care expenditure
- The need to reduce waiting times

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<sup>2</sup> Harris E, Wise M, Hawe P, et al. 1995. *Working Together: Intersectoral Action for Health*. Sydney: National Centre for Health Promotion and Commonwealth Department of Human Services and Health.

<sup>3</sup> Intersectoral Initiatives for Improving the Health of Local Communities, Ministry of Health, 2005

- Alternative organisational models
- Declining numbers of doctors and other health professionals
- Patients' rights
- Increased focus on public health issues and development of disease management programmes
- Equity of access
- Quality of care.

Within Counties Manukau, two further trends will continue to be key drivers within health service planning:

- Growth in chronic conditions will be a key driver of health services due to an ageing population and resultant increases in chronic conditions e.g. diabetes and renal disease.
- The emergence and re-emergence of infectious diseases will change the Models of Care for service provision, influence the development of hospital facilities (e.g. the need for isolation facilities), and challenge current occupancy rates.

### **Quality of Care: the international context**

A focus on patient safety in most developed countries has been driven by evidence of patient harm. The first study in 1991 in the US revealed a rate of adverse events (defined as harm due to medical management, not just the natural course of illness) as just over 3%. This study has been broadly replicated with rates of 16%, 10% and 13% in Australia, England and New Zealand respectively. In all these countries efforts to improve patient safety and quality generally have gathered momentum and look set to be important in the years to come.

The US Institute for Healthcare Improvement (IHI), has co-ordinated a major social movement focussed on decreasing patient harm. The first part of this, entitled the 'Saving 100,000 Lives' campaign, involved over 3000 hospitals. The IHI identified six areas of evidence-based improvements simplified into bundles of care, and participating hospitals attempted to introduce system wide changes. Some of the bundles focussed on improving care for patients after a heart attack (e.g. making sure that they were discharged on aspirin, beta-blockers and lipid-lowering therapy), while others focused on high risk areas for infection (e.g. surgical site infections). At the end of the 18 month campaign, they were able to demonstrate that 120,000 lives had been 'saved'. They are now undertaking the more ambitious programme – 'Protecting 5 million Lives from Harm'.

In the UK the National Patient Safety Agency collects and analyses patient safety incidents, in an effort to rapidly respond to emerging patterns in patient harm while also building a national culture of safety.

CMDHB's provider arm has an incident reporting system, but no in-depth analysis of it and there is no standardisation across New Zealand as to definitions, so we have not been able to galvanise action. This will need to change in the future, as major campaigns and social movements will inevitably lead to public demand for better results.

### **1.3 Development Process for the CMDHB HSP**

The HSP Project Plan was developed at the commencement of the project identifying project scope, sequencing of health services planning, the four phases of HSP development, and establishing the project structure.

The project structure was designed to ensure input from a range of stakeholders in each workstream. Input was sought at different phases throughout the project depending on the workstream.

A Project Steering Group was established involving senior managers from the DHB provider arm, DHB planning and funding team, primary care, Maaori and Pacific health managers, and PHO representatives. This Steering Group played a valuable role in maintaining project direction and in decision making on key project matters.

Two important groups provided valuable external feedback at several points in the HSP development. The **Community Panel** is a standing group of fifteen people who meet monthly with CMDHB staff to

provide a community perspective on proposed CMDHB directions. As these individuals have key areas of interest, but are not there as representatives of organisations, they provide excellent input on issues from a community perspective - rather than as a health provider or lobby group.

The **HSP Reference Group** met on four occasions between July 2006 and January 2008, receiving presentations on the HSP process, and detailed information on the workstream content as it was developed. The HSP Reference Group comprises DHB and PHO clinical and managerial leaders.

The project scope identified at the outset the need to take a “whole of society” approach that considered the DHB provider arm, primary care providers, NGOs, private health providers, and other governmental organisations. A generic Models of Care Framework ensured planning occurred across the care continuum – irrespective of whether components of care are provided by CMDHB, by other health providers, or by other agencies who directly or indirectly influence health status.

For pragmatic reasons, the HSP was developed in two stages, with Stage One concentrating on establishing the planning framework and addressing seven large workstreams which represented more than half the DHB’s responsibilities. Due to urgency regarding facility business case development for the Manukau campus, the Stage One workstreams primarily related to services that were involved with that campus.

There were four phases within Stage One of developing the HSP.

**Phase One** involved the development of the Model of Care framework and service planning tools for developing the CMDHB HSP. This Model of Care Planning Framework was to meet the following requirements:

- Ensure a whole of society approach to health planning
- Provide opportunity to identify links between all parts of the health sector
- Bring together models of care delivery that suit the Counties Manukau population
- Ensure that shared assumptions and principles inform all service planning
- Ensure a common language and understanding of key concepts
- Ensure a shared understanding of CMDHB’s strategic approach
- Be applicable to all health needs/conditions groupings
- Outline continuum of care components to be provided within the district.

**Phase Two** saw the commencement of the seven key workstreams to be completed as Stage One of the HSP. Workgroups were established for each workstream and a workstream brief agreed. Workstream project managers were appointed for each workstream and a series of meetings were held in each workstream. In many cases these meetings involved primary care, NGOs, consumers and community representatives.

**Phase Three** ensured the integration of health service developments into a cohesive ‘whole of society’ plan for health service delivery in Counties Manukau. This included the integration of service delivery changes across multiple care continua, and ensuring the robustness, efficiency and effectiveness of current and proposed services, facilities and models to deliver along and across all care continua. A number of interface meetings were held across service continua to discuss and agree directions.

**Phase Four** of the HSP involved the identification of transition issues including determining the difference between current and future services, and identifying:

1. Benefits of the new model and service configurations
2. Future facility requirements
3. Investment plan (capex & opex)
4. Future workforce requirements
5. Change management implications
6. Unresolved problems, issues or gaps in service delivery.

Stage Two workstreams generally followed a similar process with the development of a full continuum of care. However, a number of Stage Two workstreams involved a focus on specific subspecialty,

within the overall Model of Care for the specialty (e.g. respiratory medicine and the Medicine Continuum. Phases Three and Four were repeated to ensure consideration of the full range of services.

## 2.0 Environmental Scan

### 2.1 CMDHB Strategic Environment

The HSP is developed from the CMDHB District Strategic Plan (DSP) for the five-year period 2006-2011. The District Strategic Plan will be reviewed and updated at regular intervals throughout the 20-year lifespan of the HSP. The HSP in turn will be reviewed and updated as new (and unanticipated) Models of Care evolve, new health technologies are developed and introduced, national and international changes in funding models occur, and there are further changes in the workforce or changes in government policy.

In his foreword to the CMDHB District Strategic Plan (2006-2011), the Chairman of CMDHB outlined the strategic direction of CMDHB. The CMDHB District Strategic Plan is “*designed to show how we aim to make a difference to the health of Counties Manukau people in the next five years....so, in summary the key areas of focus for your DHB are:*

- *We are adopting a ‘whole of society’ approach to improving health outcomes including working with partner organisations and communities through Let’s Beat Diabetes, and with Housing New Zealand in promoting Healthy Housing. We also work with people who have been off work with sickness to get them re-employed under the PATHS programme with the Ministry of Social Development Work & Income)*
- *We are determined to reduce inequalities in health by including affected groups in DHB decision making and by working with providers to implement Maaori and Pacific Health plans*
- *We are committed to making the best use of the resources we have available: more than \$840million revenue, over 5,200 DHB staff (3,800 full-time equivalents); and significant facilities on the Middlemore and Manukau sites plus other satellite locations including Botany, Papakura, Pukekohe and Waiuku*
- *We will implement prevention strategies such as well child checks and immunisation programmes, and programmes to increase physical activity and nutrition to improve the health of children and young people*
- *We will support and value our staff within the DHB and the wider health sector by implementing workforce development strategies (particularly recruitment, retention and wellness programmes)*
- *We acknowledge the role of primary care in delivering improved health outcomes and will take a partnering approach in supporting Primary Health Organisations (PHOs) to improve quality and change the model of care to focus on these deliverables*
- *We will reduce the community’s need for hospital services for conditions that are able to be managed by community and primary care services through programmes like Primary Options for Acute Care (POAC), Chronic Care Management (CCM), integrated community based mental health services, secondary specialists holding clinics in primary care, and hospital-led training sessions in primary care*
- *We will continue to ensure the delivery of safe and effective health services, particularly focusing on reducing the number of avoidable injuries and deaths that occur in the hospital setting*
- *We will improve access to hospital based services so they match national rates, including increased elective surgical (gynaecology, cataracts, hips and knees etc) and diagnostic procedures (gastroscopy, endoscopy etc)*
- *We will develop our facilities to meet the future needs of the community.”<sup>4</sup>*

#### CMDHB Vision

*To work in partnership with our communities to improve the health status of all, with particularly emphasis on Maaori and Pacific peoples and other communities with health disparities*

<sup>4</sup> (CMDHB District Strategic Plan 2006-2011 foreword from Mr Pat Snedden – Chairman CMDHB, page 2)

- We will do this by leading the development of an improved system of healthcare that is more accessible and better integrated
- We will dedicate ourselves to service our patients and communities by ensuring the delivery of both quality focussed and cost effective healthcare, at the right place, right time and right setting
- Counties Manukau DHB will be a leader in the delivery of successful secondary and tertiary healthcare, and supporting primary and community care.

### **CMDHB Values**

CMDHB has six key values which guide the way we undertake our responsibilities to the shareholder, to our staff, and to the community.

<b>Care and Respect</b>	Treating people with respect and dignity: valuing individual and cultural differences
<b>Teamwork</b>	Achieving success by working together and valuing each other's skills and contributions
<b>Professionalism</b>	Acting with integrity and embracing the highest ethical standards
<b>Innovation</b>	Constantly seeking and striving for new ideas and solutions
<b>Responsibility</b>	Using and developing our capabilities to achieve outstanding results and taking accountability for our individual and collective actions
<b>Partnership</b>	Working alongside and encouraging others in health and related sectors to ensure a common focus on, and strategies for achieving health gain and independence for our population.

### **CMDHB Strategic Outcomes**

The CMDHB District Strategic Plan describes six outcomes it is seeking – each of these with medium and long term outcomes:

**Outcome 1:** *Improve community wellbeing*

We will work with our community and partner agencies on initiatives such as Let's Beat Diabetes, Healthy Housing and healthy schools

**Outcome 2:** *Improve child and youth health*

We will improve health during pregnancy, keep up our good Well Child check and immunisation rates, and improve access to dental care for children and young people.

**Outcome 3:** *Reduce the incidence and impact of priority conditions*

We will reduce the rates of diseases such as diabetes, heart disease, lung disease, and cancer; and improve access to mental health care.

**Outcome 4:** *Reduce health inequalities*

We will support workforce and provider development that increase the capacity of the health sector to deliver services to populations with high health needs. We will maintain our inclusive board and committee structures and fully implement our Maaori and Pacific Health plans.

**Outcome 5:** *Improve health sector responsiveness to individual and family/whanau need*

We will ensure that people have the care they need, when they need it, including respecting their culture.

**Outcome 6:** *Improve the capacity of the health sector to deliver quality services*

We want people in our community to consider health as a career choice and our facilities to be the best we can afford. We will increase the services we offer so people don't have to wait long for treatment, and we will improve the quality of health services within our hospitals and the community, and the information available to staff who provide services.

## 2.2 Our People

Counties Manukau has a diverse population with complex health needs and service requirements. It is the fastest growing area in New Zealand. Key features of the Counties Manukau population are:

- A high proportion of Maaori
- A high proportion of Pacific people
- A high proportion of Asian people
- The relative youthfulness of these populations, and the population as a whole
- The fast growth of the population
- The high proportion of the population who are relatively deprived in socio-economic terms.

### 2.2.1 Population Size

The population of Counties Manukau includes the territorial local authorities of Manukau City, Franklin District, and Papakura District.

For the year 2006 the estimated Counties Manukau population is 454,790, 10.9% of the New Zealand population. The catchment area for the CMDHB provider arm includes all of Counties Manukau plus Otahuhu, part of the Auckland DHB area, and has an estimated 2006 population of 468, 670. Population growth between Census 2001 and Census 2006 for Counties Manukau was 16%. An additional 18,300 people are projected for Counties Manukau in 2008 compared with 2006, a 2% annual increase. Growth has slowed slightly with the downturn in immigration to New Zealand, but remains significant and places pressure on health service provision.

	Manukau City	Papakura District	Franklin District	CMDHB Total
Estimated pop 2006	347,100	46,900	60,900	454,900
Forecast pop change 2006/2011	33,600	4,800	5,700	44,100

### 2.2.2 Population Demography and Needs

The *Counties Manukau Population Health Indicators (2005)* document provides detailed information on the demography and health needs of the Counties Manukau people. A summary of the demography appears here; for more detail refer to [www.cmdhb.org.nz](http://www.cmdhb.org.nz).

#### Population Composition

Notable characteristics of the Counties Manukau population are the high numbers of Maaori and Pacific people, and their relative youthfulness. In 2008 a quarter (118,000, 25%) of the population is aged 14 or under; 13.3% of the children of New Zealand live in Counties Manukau. In 2006, the 0-14 year olds are estimated to comprise around 38,300 European/Other, 28,000 Maaori, 32,540 Pacific and 16,700 Asian children. In contrast, estimated numbers of European/Other, Maaori, Pacific and Asian people in the 65-plus age group are respectively 30,000; 2,300; 4,000 and 3,600 adults.

	Population (prioritised)	% of CM pop	% of NZ for that ethnicity	Fertility (TFR)	Life Expectancy Male	Life Expectancy Female
Maaori	76,000	17%	12%	2.8	70	74
Pacific	95,500	21%	37%	3.4	73	78
Asian	73,000	16%	21%	1.7	79	84
Other	210,000	46%	7%			

Note that populations here have been 'prioritised' – that is, each person is allocated to one ethnic group only, in order: Maaori, Pacific, Asian, Other. For example there are likely to be approximately 107,000 people acknowledging Pacific ethnicity in 2006 (the difference being people who selected both Maaori and Pacific being counted as Maaori in the prioritised populations). Likewise for Asian, the figure for all Asian non-prioritised is estimated at 83,000.

Fertility is measured as the Total Fertility Rate, and gives the number of children the average female would have over their lifetime if the current age-specific fertility rates continued, and is as calculated by Statistics New Zealand. Counties Manukau Pacific women in particular are much more likely to have babies than other ethnicities – their fertility rate has been increasing in contrast to most of the rest of the New Zealand population. This rise is perhaps due to inward migration to Counties Manukau of young people intending families seeking affordable housing, and has placed pressure on the maternity and neonatal facilities.

Life expectancy is measured as the average age a newborn would reach should they experience the current age-specific mortality rates over the course of their lifetime. It is as calculated by Statistics New Zealand for their medium population projections. Maaori have a 9-year shortfall in life expectancy compared to the European and Other ethnicities, while Pacific people have a 5-year shortfall.

### Population Growth

The Counties Manukau population is growing rapidly. While young people still predominate, the over-65 years population is projected to more than double from 40,000 in 2006 to 92,000 by 2026. This group already make up 40% of the inpatient bed occupancy; by 2021 this will be over 50%.

*CMDHB projected population growth by age group<sup>5</sup>*

	<b>0-14</b>	<b>15-44</b>	<b>45-64</b>	<b>65+</b>	<b>Total</b>
2001	104,500	174,400	81,000	33,800	393,700
2006	115,500	200,900	98,500	39,900	454,800
2011	121,200	213,500	116,200	48,800	499,700
2016	126,000	223,600	130,100	61,400	541,100
2021	131,200	236,800	140,400	75,000	583,400
2026	136,700	252,300	145,300	91,800	626,100
% change 2001/26	31%	45%	79%	172%	59%

Total Maaori and Pacific populations are growing and ageing. Diabetes, obesity, smoking and other health issues will contribute to added demands as this population ages. By the age of 45 years and older, these risk and lifestyle factors will be having their effects on hearts, lungs and kidneys, placing increasing demands on health services. Excess premature mortality in Counties Manukau 45-64 year olds compared with all New Zealanders is already apparent.

*CMDHB projected population growth by ethnicity<sup>6</sup>*

	<b>Maaori</b>	<b>Pacific</b>	<b>Asian</b>	<b>Other</b>	<b>Total</b>
1996	60,800	59,000	28,200	208,900	356,900
2001	69,200	78,550	47,950	198,000	393,700
2006	76,100	95,400	73,300	210,000	454,800
2011	83,200	109,000	77,700	229,800	499,700
2016	90,100	122,200	81,300	247,500	541,100
2021	97,000	136,000	84,500	265,900	583,400
2026	104,500	150,500	87,300	283,800	626,100
% change 2006/26	37%	58%	19%	35%	38%

<sup>5</sup> Source: Statistics NZ medium projections for MoH Nov 2005

<sup>6</sup> Source: 1996 and 2001 are Census data. Remainder Statistics NZ medium ethnic-specific projections for MoH Nov 2005. Ethnicity is prioritised in the order given in the table

## Socio-economic Status

The New Zealand Deprivation Index 2006 (NZDep06) can be used to analyse deprivation by area. For domicile groups 9 and 10 (by definition the 20% of New Zealand people most deprived), Counties Manukau has around 156, 600 people - that is, 34% of the district's population are living in areas that can be classified as very deprived.

	Dep 1-2	Dep 3-4	Dep 5-6	Dep 7-8	Dep 9-10	Total
Maaori	5,300	5,700	7,400	14,700	43,000	76,100
Pacific	1,700	2,900	4,300	16,400	70,100	95,400
Asian	12,300	16,300	14,400	15,300	15,000	73,300
Other	66,400	49,100	35,500	29,400	29,600	210,000
Total	86,100	74,400	61,800	75,900	156,600	454,800

Maaori and Pacific people are highly concentrated in domicile 9 and 10 areas – 57% of all Counties Manukau Maaori and 73% of Counties Manukau Pacific people. Children are also over-represented in domicile 9 and 10 areas – for example, 45% of the 0-4 year olds in Counties Manukau live in domicile 9 and 10 areas, and around a third of all Counties Manukau domicile 9-10 residents are children (0-14). This concentration of deprivation, including some of the most deprived areas in New Zealand, has a significant impact on the health of the people living there, and health service provision for them.

Being part of a large metropolitan area creates challenges for service planning. Many people move across DHB boundaries to access services. Similarly without changing employment or other social support structures, people can move from one DHB area to another, with many people working in a DHB area outside their domicile. At primary and emergency care level, this can result in large numbers of acute patients accessing services that are closer to their place of work than their place of domicile.

There are also considerable opportunities in metro-Auckland, including the opportunity to share scarce workforce across two or more DHBs, and the opportunity for patients to link into specialist programmes or low volume services provided in another DHB. This creates options not so readily available in provincial cities or small rural DHBs.

While generally the Counties Manukau population is highly urban, 60,900 people live in the more rural Franklin District – a population larger than many small DHBs in New Zealand. There are significant population centres in Pukekohe and Waiuku and significant forecast growth in Franklin. Residents in Franklin have health service needs more akin to a rural DHB than the densely populated and high-deprivation populations in Manukau City and Papakura District.

CMDHB is responsible for ensuring that local Models of Care and service quality meet the needs of the diverse local populations.

### 2.3 Key Stakeholders

Health services have many stakeholder groups reflecting both the importance to society of robust health services, and the strong sense of ownership of publicly funded services. Key stakeholders can be grouped under main headings:

- Consumers and potential consumers
- Family/whanau and significant others of consumers and potential consumers
- Government and governmental agencies in health and related sectors
- Service providers – DHBs, NGOs, private providers (e.g. residential care)
- Health professionals
- Social agencies.

The HSP has been developed with recognition that achieving improved health outcomes necessitates understanding of the determinants of health, the competing needs and drivers for key stakeholders, and effective processes for engaging them in service planning, delivery and monitoring.

## 3.0 Current Profile of Health Services in Counties Manukau

### 3.1 Metro-Auckland Specialist Services

In addition to responsibilities for the planning and funding of health services across Counties Manukau, CMDHB is the largest provider of health services with the district.

Through its provider arm CMDHB provides a wide but not complete range of specialist secondary services, a selected range of community services, and a number of niche specialist tertiary services. A range of services are provided by other metro-Auckland DHBs, either as part of a regional service at facilities outside Counties Manukau, or using CMDHB facilities.

Table 1: DHB provided services

CMDHB Provision	Auckland DHB or Waitemata DHB Provision
<b>Adult Medicine &amp; Acute Care</b>	
<ul style="list-style-type: none"> <li>❖ Internal medicine, respiratory, cardiology, renal, gastroenterology, rheumatology, diabetes, endocrinology, infectious diseases, dermatology</li> <li>❖ Cardiac catheterisation</li> <li>❖ Respiratory laboratory</li> <li>❖ Oncology outpatient services provided by ADHB from CMDHB facilities</li> <li>❖ Visiting neurology consultation outpatient services provided by ADHB from CMDHB facilities</li> </ul>	<ul style="list-style-type: none"> <li>❖ Auckland: Tertiary services including: rheumatology, clinical haematology, neurology, endocrinology, inpatient tertiary dermatology</li> <li>❖ Auckland: Sexual health (secondary and tertiary)</li> </ul>
<b>Adult Surgical Services</b>	
<ul style="list-style-type: none"> <li>❖ Acute and elective general surgery, orthopaedics, gynaecology, plastic and hand surgery, specialist dental, ORL</li> <li>❖ Tertiary services: plastics and hands, orthopaedic oncology, burns, spinal surgery</li> <li>❖ Elective secondary services with input from Auckland DHB clinicians: ophthalmology, urology</li> </ul>	<ul style="list-style-type: none"> <li>❖ Tertiary services including: renal/ liver/ lung/cardiac transplantation, cardiothoracic surgery, neurosurgery,</li> <li>❖ Tertiary and acute ORL, ophthalmology, urology</li> <li>❖ Acute secondary services for ophthalmology and urology</li> </ul>
<b>Child Health</b>	
<ul style="list-style-type: none"> <li>❖ Services for Level I, II and III neonates</li> <li>❖ Tertiary paediatric burns (for NZ)</li> <li>❖ Secondary hospital and community services for children and young people.</li> <li>❖ Surgery for children in orthopaedics, ophthalmology, ORL and plastics</li> <li>❖ Public health nursing services, health promoting school services and vision and hearing screening services</li> </ul>	<ul style="list-style-type: none"> <li>❖ Regional public health (adults and children)</li> <li>❖ Paediatric general surgery (daycase surgery provided at Manukau SuperClinic by Auckland DHB clinicians)</li> <li>❖ Tertiary paediatric services except neonates and burns for Counties Manukau population</li> <li>❖ Quaternary services including neonatal surgery</li> <li>❖ Secondary neurology, some paediatric respiratory, endocrinology and general surgery</li> <li>❖ Paediatric inpatient dental</li> <li>❖ Community child dental services</li> </ul>
<b>Women's Health</b>	
<ul style="list-style-type: none"> <li>❖ Primary, secondary and some tertiary obstetric care</li> <li>❖ Acute and elective secondary gynaecological services</li> </ul>	<ul style="list-style-type: none"> <li>❖ Elements of foetal medicine</li> <li>❖ Fertility</li> <li>❖ Gynaecological oncology surgery</li> <li>❖ First and second trimester termination services</li> </ul>
<b>Intermediary Care</b>	
<ul style="list-style-type: none"> <li>❖ Assessment, treatment and rehabilitation services for people over 65 years</li> <li>❖ Tertiary care rehabilitation services for across most of the North Island for people with spinal cord injury</li> <li>❖ Home health care service</li> </ul>	<ul style="list-style-type: none"> <li>❖ Assessment, treatment and rehabilitation 16-64 years with traumatic brain injury</li> </ul>
<b>Mental Health</b>	
<ul style="list-style-type: none"> <li>❖ Community and inpatient adult mental health services</li> <li>❖ Community and inpatient mental health services for Older Persons.</li> <li>❖ Community child and youth services</li> <li>❖ Secure inpatient rehabilitation (regional)</li> <li>❖ Dual disability services(regional)</li> </ul>	<ul style="list-style-type: none"> <li>❖ Forensic services</li> <li>❖ Alcohol &amp; drug services</li> <li>❖ Child and youth inpatient</li> <li>❖ Eating disorders service</li> </ul>

There are two large facilities operated by CMDHB – at Middlemore campus and Manukau campus. All acute inpatient services are provided at the Middlemore Hospital campus while most outpatient elective and day surgery services are provided through ambulatory care models at the Manukau

campus. Visiting outpatient services are provided in a smaller SuperClinic at Botany, at Pukekohe Hospital, Auckland Spinal Unit (Bairds Road) and at Community Mental Health Clinics.

Most CMDHB elective surgery is provided at the Manukau Surgery Centre, with some major surgery and high-risk elective patients treated at Middlemore Hospital. Over the last two years CMDHB has continued to expand the range of major surgery on moderate-risk patients provided at Manukau Surgery Centre being supported by the development of additional clinical support services.

Currently services provided at a number of other inpatient sites within Counties Manukau include:

- Maternity – Community Maternity Units located at Pukekohe, Papakura and Botany.
- Mental Health – Tamaki Oranga is a 20-bed secure residential facility for Mental Health patients at Bairds Road, Otara.
- Rehabilitation – the Spinal Rehabilitation Unit is a 20-bed inpatient facility at Bairds Road sharing the Otara campus with Tamaki Oranga.
- Health Services for Older People – inpatient services at Franklin Memorial Hospital (Waiuku) and Pukekohe Hospital (sharing a facility with the Pukekohe Community Maternity Unit).

CMDHB provides predominantly upper-secondary care services and a number of full tertiary services:

- The National Burns Centre at Middlemore Hospital for the management of major burns for the people of New Zealand. A contract is also held with the Government of Tahiti for the treatment of patients from Tahiti
- Tertiary plastic, reconstructive and hand surgery for metro-Auckland and Northland
- Neonatal Unit for Level III neonates
- Spinal Rehabilitation Unit services for most North Island DHBs
- Orthopaedic oncological surgery

These tertiary services will continue to be provided by CMDHB while the majority of tertiary services for people of Counties Manukau will continue to be provided by Auckland DHB (ADHB). CMDHB will continue to support ADHB in ensuring that these services are provided to meet the needs of Counties Manukau residents, and to provide services that integrate well with other services required by local residents and delivered by CMDHB.

Where practicable, if a component of a continuum of care is provided by Auckland DHB it will be delivered within Counties Manukau as a component of the CMDHB Models of Care. This will promote ease of access for patients/whanau, and will support collaborative relationships between ADHB and CMDHB-referring clinicians.

A range of tertiary services is provided by Auckland DHB – either at Auckland DHB facilities, or at CMDHB facilities through ‘hub and spoke’ models. Increasingly CMDHB has repatriated secondary services provided by Auckland DHB (via the Regional Services Planning process) for those services to be provided by CMDHB, or by ADHB clinicians in CMDHB facilities.

CMDHB is now providing most of the secondary care services for the local population and this will continue to develop with growth and ageing of the local population supporting local service development, and the need to provide services through Models of Care that best meet the unique needs of the local population. Changes in service configuration will be worked through as part of Regional Services Planning processes.

## **3.2 CMDHB Specialist Services**

### **3.2.1 Specialist Inpatient Services**

CMDHB provides an increasing range of specialist inpatient services at a number of CMDHB facilities while developing Models of Care that aim to reduce demand for inpatient services. With population growth and ageing driving increased demand, and with CMDHB having relatively low inpatient bed rates/population (and hence limited capacity for improvement), CMDHB services will be challenged to control future increases in inpatient bed numbers.

### **3.2.2 Specialist Ambulatory Care**

Ambulatory care encompasses a range of activities including:

- Attendance at outpatient clinics for consultation or treatment
- Treatments or treatment programmes such as dialysis and chemotherapy that (while complex) do not require an inpatient admission
- Diagnostic investigations that can be undertaken without requiring an overnight admission
- Daypatient surgical or medical care.

Ambulatory care has increased as a proportion of CMDHB provider arm health services as more patients are diverted from inpatient to daypatient (or outpatient care), as complex diagnosis and treatment becomes available on an outpatient basis, and as a higher proportion of care is provided as specialist consultation.

Ambulatory surgery has increased with developments in short-acting and regional anaesthesia, and as minimally invasive surgical treatment and diagnostics become available. A wider range of procedures can now be undertaken without overnight admission to hospital, and many procedures are undertaken as office procedures.

### **3.3 Non-DHB Provided Service**

Counties Manukau residents have access to a wide-range of publicly-funded services from non-DHB providers, each making a valuable contribution to the delivery of local health services. Examples of these include:

- Lead Maternity Carers (predominantly midwives)
- Well Child providers (including Plunket)
- Residential care (Older Persons and Mental Health)
- St John Ambulance services
- Dentists
- Community pharmacy
- Community laboratory
- NGOs delivering a range of community health and health promotion services
- Primary Health Organisations and General Practice Services.

These and a considerable number of other NGO services are funded in whole or part either directly by CMDHB, or through centralised agencies in collaboration with other DHBs. Each is a critical component of the Continuum of Care for local health services.

Most non-DHB services are provided in primary care and delivered in community settings. Primary health care is the first level of contact with the health system where services are mobilised to promote health, prevent illnesses, care for common illnesses, and manage ongoing health problems. Primary care includes assessment, diagnosis and treatment, largely provided by general practitioners and nurses, and organised through Primary Health Organisations (PHOs).

Within Counties Manukau, general practice delivers two key district-wide programmes that support management of patients in community settings without the need for referral to hospital for further care. These include:

#### **Chronic Care Management Programme**

A recognised increase in chronic conditions resulted in the development of the CMDHB Chronic Care Management (CCM) Programme in 1999 and piloted in 2000. This programme is primary care driven and central to integrating the care of high need people with chronic medical conditions within Counties Manukau. There are now five established CCM modules within the CMDHB programme with a collective enrolment of over 11,000 patients. The aim of the programme is to have 20,000 by 2016.

Modules already in place or under development are:

- Diabetes
- Cardiovascular disease
- Congestive heart failure
- Depression (pilot underway)
- Chronic obstructive pulmonary disease
- Renal (pilot under development)
- Bariatric (pilot under development).

While CCM is primary care led with most of the clinical care occurring in the primary sector, CMDHB provider arm specialist services support the programme through scheduled or acute specialist review of CCM patients when requested. CMDHB specialists have played a prominent role in programme guideline development, and treatment plan review within each module.

### **Primary Options in Acute Care Programme**

The Counties Manukau Primary Options in Acute Care (POAC) programme provides GPs with immediate access to a range of diagnostic and care services. When a GP is of the opinion that immediate access to such a service (e.g. an investigation, specialist advice or rest home care) might lead to avoidance of hospitalisation, up to \$300 is available to the GP to spend on such services.

Modifications to each of these programmes over time will ensure that the programmes both reflect and drive changes in Models of Care. These programmes aim to reduce the need for hospital-based services, providing better access to early and appropriate healthcare that is primary care based. Each of these programmes reflects the strategic direction of CMDHB – particularly in relation to reducing health disparities and promoting the development of community based care.

### **3.4 Quality Improvement**

The HSP starts from the position that the quality of care provided to the Counties Manukau population is not as safe and reliable as it should be, and that it can be improved. This emphasis on quality improvement will pervade all facets of health services development, so that within the term of this HSP the services CMDHB funds and provides will be of high quality.

Making this progress requires understanding of what healthcare quality is, and a move away from outmoded theories of control and external inspection to development of a workforce capable of taking on quality improvement at every level.

Don Berwick has identified three preconditions to change of the healthcare system: “face reality, seek new designs and involve everyone”. His first law of improvement - “every system is perfectly designed to achieve exactly the results that it gets<sup>7</sup>” makes the point that errors and waste in healthcare are system properties, and that to improve these, we must improve how we deliver care, not ask the same system to perform better. This ‘systems approach’ to quality improvement is a core concept in the HSP.

#### **Facing Reality**

Quality improvement an integral part of the 20-year HSP because both national and international evidence demonstrates strongly that there are serious deficiencies in the quality of healthcare provided.

Studies of medical error and adverse event rates in the US, the UK, Australia, and here in New Zealand all show high rates of harm due to medical management. Peter Davis’s New Zealand study showed that nearly 13% of hospital admissions suffer some form of iatrogenic harm and that close to 40% of these are preventable<sup>8</sup>. Furthermore, analysis shows that the cost of these adverse events is

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<sup>7</sup> DM Berwick. A primer on leading the improvement of systems. *BMJ* 1996; 312:619-22

<sup>8</sup> Davis, P, Lay-Yee R, Briant R, et al., Adverse events in New Zealand public hospitals I:

increased hospital stays (average of an additional 9 days) and costs (~\$10,000 per adverse event). In fact it has been estimated that 30 cents in every health dollar goes towards managing adverse events<sup>9</sup>.

We have built in inefficiencies to the way we deliver care – estimated to be as high as 17% - money which could be more effectively spent delivering additional services. So poor quality is costing money and over the next 20 years we need to improve quality to allow these funds to be redirected.

Delivering poor quality is also demoralising for the health workforce. By paying attention to quality improvement, we aim to make Counties Manukau health services a 'magnet', attracting and retaining health workers.

### **What is Healthcare Quality?**

Quality is "the degree to which the services for individuals or populations increase the likelihood of desired health outcomes and/or increase the participation and independence of people with a disability, and are consistent with current professional knowledge"<sup>10</sup>. This definition points to a number of core themes:

1. There are both population and individual considerations which must be balanced when considering the quality of health services
2. It is important to take the patient's perspective
3. A high quality health service makes best use of current knowledge – making sure that that knowledge is actually applied.

The Institute of Medicine in its landmark report 'Crossing the Quality Chasm: a New Health System for the 21st Century'<sup>11</sup> identified six dimensions that defined healthcare quality:

1. Safety – avoiding injuries or harm to patients from care that is intended to help them
2. Clinical effectiveness – providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit (avoiding overuse and under use respectively)
3. Timeliness – obtaining needed care and minimising unnecessary delays in getting that care
4. Patient centeredness – health care that establishes a partnership among practitioners, patients, and their families, to ensure that decisions respect patients' wants, needs and preferences and that patients have the education and support they need to make decisions and participate in their own care
5. Efficiency – endeavours to avoid waste of resources in service delivery, thus giving the greatest benefit for the available resources
6. Equity – all patients should receive the same high level of care without reference to their age, gender, location or ethnicity.

These same dimensions are reflected in the Ministry of Health's 'Improving Quality (IQ) Strategy' as outlined in the diagram below. This diagram puts the patient and their family at the centre, depicts quality improvement as occurring at all levels of the healthcare system, and also incorporates the principles (as at 1987) of the Treaty of Waitangi – partnership, participation and protection<sup>12</sup>.

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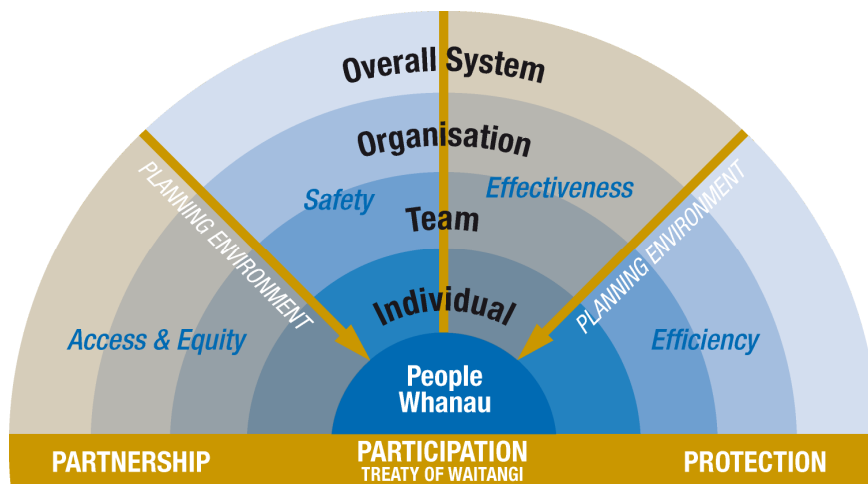
occurrence and impact. N Z Med J. 2002;115(1167). URL:<http://www.nzma.org.nz/journal/115-1167/271>

<sup>9</sup> Brown P. McArthur C. Newby L. Lay-Yee R. Davis P. Briant R. Cost of medical injury in New Zealand: a retrospective cohort study. [Journal Article] Journal of Health Services & Research Policy. 7 Suppl 1:S29-34, 2002 Jul.

<sup>10</sup> Institute of Medicine, 1990

<sup>11</sup> Institute of Medicine Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21<sup>st</sup> century. Washington DC: National Academy Press, 2001.

<sup>12</sup> New Zealand Maaori Council v Attorney-General [1987] 1 NZLR 641, 663



### Building Workforce Capability

Traditionally, strategies to assure healthcare quality have focused on standardisation of the work and reliance on external inspection. Workers were expected to conform to the standardised work flow, but not to actively participate in innovation. This approach has not improved quality to date (as exemplified by cases of poor healthcare quality in organisations that have satisfied accreditation standards). Some facets of healthcare do indeed require standardisation and inspection – such as laboratory calibration standards – but to rely on external inspection is to waste money and time, and removes the workforce from the quality improvement process. We need to identify how our workforce can own and drive the improvements that are necessary to make the Counties Manukau health system high-performing. We need a workforce that is capable of “setting bold aims, measuring progress, finding alternative designs for the work itself, and testing changes rapidly and informatively”<sup>13</sup>.

Involving the workforce is important, but they also need to be equipped with the tools to succeed. These tools are outlined in the model<sup>14</sup> for improvement that asks three central questions, which form the basis for the Plan-Do-Study-Act cycles that health workers will need to be confident to run themselves:

1. *What are we trying to accomplish?*  
The workforce has to have the skill of identifying and agreeing on what they are going to improve. This involves listening to patients and families, identifying the gap between where the organisation is and where it wants to be, and being willing to address this gap.
2. *How will we know that a change is an improvement?*  
All improvement is change, but that not all change is improvement. The only way to decide whether the changes introduced have resulted in improvement is to measure. Two types of measurement have been found to be useful to decide which changes have helped: plotting data over time in statistical process control charts; and narratives and stories, from both staff and patients.
3. *What changes can we make that will result in an improvement?*  
Alternatives to the status quo which are worthy of trial must be identified. These alternatives may come from staff, from the ‘best in class’ institutions or even from outside healthcare itself.

To enable the staff to participate in improving the quality of the health services they deliver, ongoing programmes will be needed. These include:

<sup>13</sup> DM Berwick. Improvement, trust, and the healthcare workforce. *Quality and Safety in Health Care* 2003;12:448-452. [www.qshc.com](http://www.qshc.com)

<sup>14</sup> GJ Langley, KM Nolan, TW Nolan, et al. *The improvement guide: a practical approach to enhancing organizational performance*. San Francisco: Jossey-Bass, 1996.

1. Formal quality improvement (QI) teaching, based on projects identified by the workers
2. Recruitment of QI facilitators to work with clinical units
3. Support from decision analysts in collecting data and assisting in its analysis
4. System-wide QI initiatives that have the by-product of greater awareness of QI tools.

## **Trust**

Achievement of all these efforts – measured by whether we are judged to be a high quality health delivery system, capable of attracting and retaining the best workers – is predicated on establishing and maintaining a high degree of trust with both the workforce and the community. To earn this trust we must enable the workforce to be part of the solution, demonstrate that we will deal with adverse events in a systems way rather than blaming individual workers, and demonstrate that we are committed to improving healthcare delivery without cutting the workforce or services.

We must support a 'just culture' to ensure the focus remains on service improvement when reporting and investigating complaints, incidents, other adverse events and near misses. Blaming individuals does not improve patient safety and may harm organisational learning from errors. We will need to as open and transparent as possible, celebrating our successes but not hiding our problems, to maintain the trust of the Counties Manukau community.

## 4.0 CMDHB Model of Care Planning Framework

### 4.1 Model of Care Attributes

*“A model of care is a multifaceted concept, which broadly defines the way health services are provided. It can therefore be applied to health services delivered in a unit, division or whole of District”<sup>15</sup>.*

The CMDHB Model of Care planning framework is a whole of society approach to health services planning across a population and across the continuum of health need/complexity. It is based on the HSP planning principles, assumptions and enablers developed by CMDHB in 2006 (see section 1.2.3).

The CMDHB Model of Care framework has a number of key attributes:

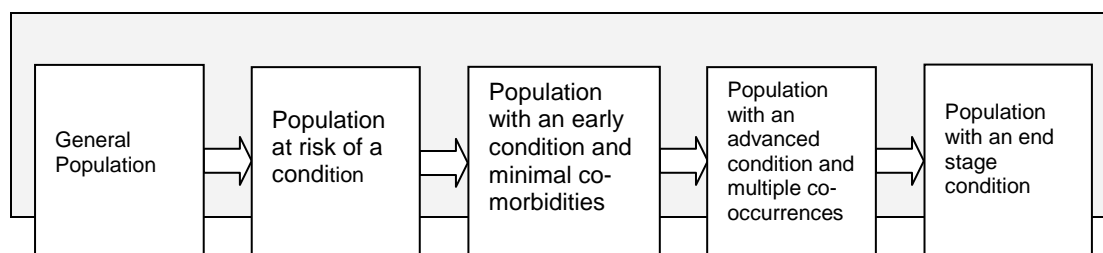
- The components of care include health promotion and illness prevention – areas where real differences to a population’s health status can be made.
- Self responsibility is encouraged through the model with ‘self and family/whanau care’ extending across all aspects of the continuum.
- The CMDHB Model of Care for planning health services focuses on the needs of the population across the components of the health care system. Through applying the generic Model of Care to a specific service stream the model identifies the components of care needed to better meet the needs of a population, and invites challenge as to whether this care is currently available, who can best provide those services, and the settings where they are best provided.
- The CMDHB Model of Care for planning health services is not a patient-flow pathway and it does not assume that an individual will move through all parts of the continuum. Rather, it is a representation of the range of services that are available to a population with a health need - depending on the type, complexity and intensity of need.
- Settings of care graphically illustrate the large volumes of healthcare that are or can be provided in the community.
- Adoption of the NSW Role Delineation Model within the framework is used to establish clarity around the levels of the services that are provided in a hospital/clinic setting.
- Where possible services should be moving to the components at the left of the framework (ie. Health promotion, early detection and supported self care).
- While specialised care is more complex, specialist services proved input in the health promotion, community based programme development, and chronic care management programmes operating in Disease/Injury specific care management.

### 4.2 Model of Care Framework

The CMDHB Model of Care framework incorporates four key concepts: Condition/Need Complexity; Components of Care; Settings of Care; and Levels of Care.

#### Condition/Need Complexity

This factor ensures that there is a population-based approach to service planning by moving across the Population Health to Personal Health continuum. There are five stages across the Condition/Need Complexity continuum:



<sup>15</sup> Queensland Health, Changing Models of Care Framework, 2000

## Components of Care

These are the dimensions of health care services that may be part of a care continuum. Many components are heavily influenced by intersectoral drivers. Review of all components that may be a part of a continuum of care is a critical component of the 'whole of society' planning approach of CMDHB.

The components of care include:

- **Self & Family/Whanau Care** – care activities that the individual or their family undertake across the continuum of need to improve their health. This type of care requires no specialised skills or professional training.
- **Health Promotion** – activities that encourage behaviours and practices that will improve health status.
- **Prevention** - initiatives and activities that will decrease the likelihood of ill-health.
- **Early Detection** – early identification screening programmes.
- **Supported Self Care** – collaboratively assisting individuals and their family/carers to develop the knowledge, skills and confidence to care for themselves and their condition.
- **Disease/Injury Specific Care Management** – care specific to the need, delivered by multidisciplinary teams using disease specific protocols and pathways. Features early identification, prompt response and proactive follow-up.
- **Specialised Care** – care that requires specialised clinician, infrastructure or other supports delivered according to specific disease or care requirement.
- **Day Stay Admission** – care involving a procedure or treatment that does not require an overnight stay but requires access to a range of clinical infrastructure and technology supports (e.g. anaesthetists, specialist surgeons, theatres, recovery rooms, or high cost specialist equipment).
- **Episodic Inpatient Admission** – care that requires a person to be bed-based overnight or longer and requires continuous or high level medical monitoring/supervision, with a capacity for immediate response to change in condition.
- **Palliative Care** – care that focuses on improving the quality of life through prevention and relief of pain and suffering.

## Settings of Care

This refers to the physical setting for the delivery of care and is divided into two broad domains:

- **Community Settings** – this includes Primary and Community Health Centres, general practices, DHB community-based sites, NGO health sites, workplaces, schools, churches, residential care, hospices, and home-based care.
- **Specialist Care Settings** – typically a hospital or dedicated outpatient facility, these are centralised health sites providing specialised facilities and/or equipment.

## Levels of Care

Health care services can be divided into levels based on the support services, staff profile, minimum safety standards and other requirements that will ensure that clinical services are appropriately supported and are provided safely. The level assigned to each service is determined by the complexity and frequency of service and facility requirements, the requisite clinical support infrastructure, and the presence of suitably qualified health care staff.

'Role delineation' provides health service planners with a valuable tool to ensure that service development is consistent with the relevant clinical infrastructure, and that it fits with other solutions where those solutions are facility-based. The New South Wales Role Delineation Model (2002 revision) has six levels and lists the clinical support services that are required to support each level of service. It supports the effective and efficient provision of health services provided the focus is on care across a continuum and innovative approaches are taken to develop non-hospital based aspects of care.

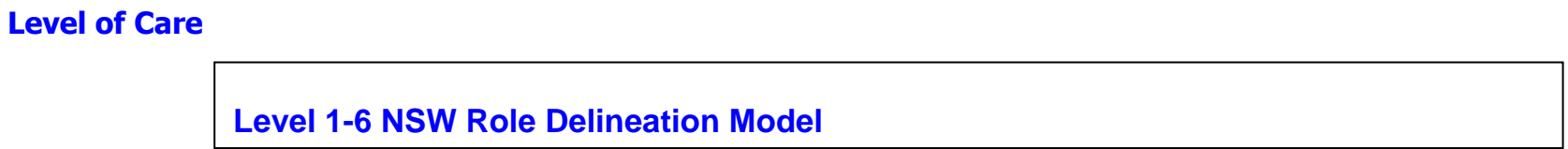
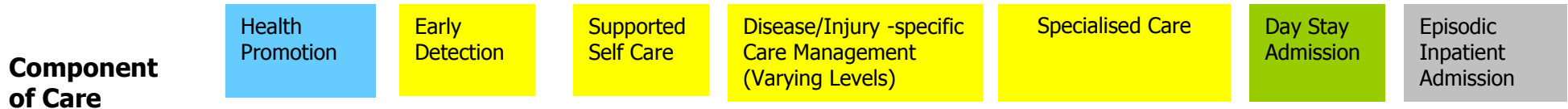
NSW Role Delineation Model Level 1 services have lower complexity of need, a lower reliance on hospitals, and a higher association with services that are delivered in the community. Level 6 services, at the other end of the continuum, have attributes of highly complex tertiary specialist services that are generally delivered in large tertiary hospitals.

Service continua within a district will generally operate across a number of the service levels using different providers, or within different services offered by a particular provider. For example, higher end (Level 6) patient requirements can be met by other tertiary providers; a local District Health Board provider arm can provide services at different levels at different sites and different settings; and in most continua of care there will be multiple other providers providing components – again perhaps at different levels, different settings and different sites.

Explicit within the NSW Role Delineation Model are approaches to ‘Core Services - Integrated Community and Hospital Services’ and ‘Community Based Health Services’. The former provides role delineation clarity around a number of service areas including Mental Health, AT&R, Palliative Care, health promotion etc that operate integrated models across both hospitals and communities. ‘Community Based Health Services’ within the NSW Role Delineation Model considers those services (e.g. Community Nursing, Sexual Health) that are predominantly community-based. One advantage of this NSW Role Delineation Model approach to integrated and community facilities is that it provides a framework by which to consider the development of better integrated services – particularly in relation to clinical support levels and service interdependencies.

**CMDHB MODEL OF CARE**

**Complexity of Condition/Need**



### Models of Care Planning Template

<b>Condition/Need Complexity</b>						
		General population	Population at risk of a condition	Population with an early condition and minimal co-occurrences	Population with an advanced condition and multiple co-occurrences	Population with an end-stage condition
	<b>Prevention</b>					
<b>C O M P O N E N T  O F  C A R E</b>	<b>Early Detection</b>					
	<b>Supported self-care</b>					
	<b>Disease/Injury specific care</b>					
	<b>Specialised Care</b>					
	<b>Day Admission</b>					
	<b>Inpatient Admission</b>					
	<b>Palliative Care</b>					



Not applicable



Community Care Settings



Specialised Care Settings



Episodic Inpatient Admission

### **4.3 Application of the Planning Tools**

A process was determined for the development of specific models of care for individual service streams from the generic CMDHB Model of Care. This development of service stream models of care was an iterative process with several stages, and incorporated looking outside the individual service stream to ensure integration across service streams, and 'whole of society' healthcare planning across the full Continuum of Care including areas outside the traditional Health sector. HSP principles, assumptions and enablers were considered at all stages in the process for developing Models of Care.

Full continuum of care planning templates were developed for major service continua, i.e.:

- Surgery (refer Elective Services workstream)
- Mental Health
- Rehabilitation
- Health of Older People
- Child and Adolescent Health

Subspecialty services worked within these continua, and considered service direction and Models of Care changes within them. All workstreams took into account the same planning assumptions and enablers, and are consistent in the CMDHB strategic direction.

#### **4.3.1 Completion of Continuum of Care Template**

The first stage in the development of a service specific Model of Care involved workgroup mapping the current model of care using the Continuum of Care template with a particular focus on:

- Identification of current components of care
- The ability of patients to move seamlessly through appropriate components of care across this continuum
- Identification of current gaps in the continuum of care and how these manifest themselves
- Identification of key intersectoral activities that could change demand for services or improve service provision.
- Identification how alternate components of care could be developed, or service gaps
- Consideration of demographic, service delivery and workforce trends appropriate to the service stream both currently and in the future
- Broad identification of current service providers (e.g. general practice, district nursing, hospital services) for each of the components of care within the current model of care
- Confirmation that related identified strategies have been or are being developed by relevant service streams (e.g. the impact of obesity and diabetes programmes on future demand for dialysis services)
- Definition of problems and challenges with the current model of care and in reference to the CMDHB Model of Care.

#### **4.3.2 Identification of Future Model Options**

- Identification of future models of care options or directions that would better meet the strategic intent of CMDHB and the planning assumptions for CMDHB for the next 20 years, and that are consistent with the principles and assumptions for models of care, and the generic Model of Care for CMDHB.
- Completion of the planning template for the future model of care options acknowledging enablers to implement proposed models.

#### **4.3.3 Analysis of Implications of Model Changes**

- This stage is undertaken as part of the workgroup project plan using robust information to affirm or reject proposed future models of care options. Consideration of key service integration issues across other continua of care need to be taken into account, e.g. demography, service volumes, clinical trends, funding model issues, workforce development,

clinical support structures, and DHB and non-DHB facility and service capacity where applicable.

#### **4.3.4 Revising Proposed Future Models**

- Critical to further development of a changed model of care is ensuring that a large number of issues have been considered. Models of care will develop through an iterative process with consideration of multiple factors and opportunities.

#### **4.3.5 Validation and confirmation of models**

- Future models of care are validated and confirmed. Strategies and plans are considered for moving towards new models of care.

## 5.0 Future Direction for Counties Manukau Health Services

Over the next 20 years, there will be significant changes in the way that services are delivered within Counties Manukau. CMDHB is charged with providing leadership in health services delivery to optimise health outcomes for the local population within the available resources. It is particularly important to ensure that any capital investment is robust, and that healthcare facilities have a long lifecycle, and have flexibility of purpose to allow new models of care over the course of the building's lifespan.

The key models of care within the HSP are consistent with the direction of the CMDHB District Strategic Plan and the planning principles, assumptions and enablers that were established at the outset of HSP development.

### 5.1 Key Future Delivery Themes

A number of key future delivery themes run across all HSP workstreams to meet the particular needs of the local population and ensure that CMDHB meets its commitments to key stakeholders. In the future, increasingly:

- Health promotion and illness prevention programmes will target healthy lifestyles, early detection and early intervention.
- Services will be configured for patients to receive earlier intervention in primary and secondary care to reduce the impact and severity of disease.
- Self-management will be a focus of health care delivery as individuals play a stronger role in avoiding poor health and in self-management of chronic conditions.
- Specialist services will be provided in community-based settings with models of care including more ambulatory care delivery.
- Specialist services will be provided in ambulatory and community settings consistent with the growing incidence of chronic conditions, and to support “upstream” care that reduces subsequent demand for secondary care. Hospitals will be used by patients with higher acuity and complexity, and where care needs cannot be met in community based settings.
- There will be closer relationships between primary care and specialist care. More specialist services will be delivered in primary care, specialists will support primary care in the management of chronic patients, and there will be a greater range of easy to access options for primary care to avoid patient referral to hospital.
- Information systems will be better integrated through both local and national initiatives to allow ease of transferring information between providers, to reduce duplication of investigations, and to reduce the risk of adverse clinical outcomes.
- Collaboration between providers, services, professions and specialty teams will be required to manage growing patient complexity, and to ensure that all options to avoid hospitalisation are utilised.
- Services will be culturally appropriate to meeting the needs of Maaori and Pacific populations with poor health status, and to the growing number of Asian people living in Counties Manukau.
- CMDHB and other providers will work intersectorally in recognition that many of the determinants of health require participation of other sectors.
- Specialist services will deliver services locally that are high quality, clinically and financially sustainable. System and process redesign will support modern service delivery methods.
- CMDHB will develop appropriately configured local provider-arm services to meet the specialist needs of the growing Counties Manukau population.
- Evidence-based practice, protocols and pathways, decision support systems and information systems will enable more robust service provision.
- A philosophy of continuous quality improvement will become part of the normal way of providing care. This will make a focus on quality and safety one of the key determinants of service provision, and a cornerstone of future service planning.
- Evidence-based care will be supported by better access to information, and increasing sophistication of clinical quality systems.

- Advance care planning will improve the focus on clinical care, support informed decision making by patients/whanau, and avoid protracted and inappropriate treatment.

## 5.2 Key Directions and Models of Care Changes

The key strategic Models of Care arising from the HSP workstreams is contained in detail within each of the workstreams reports. A summary for the direction of both the facilities and each of the workstreams follows.

### 5.2.1 Middlemore Hospital

Middlemore Hospital will remain the acute hospital for CMDHB during the period of the HSP, providing upper secondary care for the people of Counties Manukau. Specialist services will be particularly notable for the:

- Increasing intensity and complexity of acute services provided in a hospital environment as ambulatory care options increase, and lengths of stay are progressively reduced.
- Greater range of diagnostic, treatment and clinical services that are available both for hospital inpatients but also on an outpatient basis through specialists or primary care.
- Creation of workforce strategies to cope with scarcity of health professionals and to support the changes in expectations or better work/life balance.
- Increased teamwork required to maintain clinical safety and efficient management of hospital beds and workforce.

### 5.2.2 Manukau Campus

Manukau Campus will continue its development as a centre for services where care can be efficiently and effectively provided at a large sub-acute facility. These include:

- **Elective Surgery:** for the majority of elective surgery undertaken by CMDHB where clinical risks can be effectively managed without inappropriately duplicating clinical and clinical support services at Middlemore Hospital.
- **Ambulatory Care:** for the ongoing development of outpatient consultation and review for all services, undertaking of office procedures and clinical diagnostics, and for the provision of a range of services that are most appropriately delivered by an ambulatory care model (e.g. dialysis, chemotherapy).
- **Rehabilitation:** Manukau will become the hub for the provision of Rehabilitation services with an increasing focus on community-based rehabilitation. The tertiary Spinal Rehabilitation services relocated to the site will be part of the Rehabilitation Centre and there will be closer collaboration with non-DHB funders (e.g. ACC). Increasingly rehabilitation services will accept direct planned community admissions from primary care to avoid acute admissions to Middlemore Hospital.
- **Mental Health Services for Older People:** Manukau will become the hub for the provision of MHSOP inpatient services with an increasing tendency for provision of MHSOP by community teams in community-based settings (i.e. residential care and private homes).

### 5.2.3 Mental Health

#### Adult Mental Health and Addiction Services

- Increased availability of information to aid and support self care, and educational programmes to support self care and recovery
- Peer support specialists to assist people to assume self care and take a leadership in their own recovery
- Mental health and addictions workers who are well equipped to establish trusting relationships and support people to drive their own recovery
- Promoting employment of service user peers within the clinical and NGO sector
- Initiatives that recognise the contributions that peer support can make to help people manage their own mental health issues and their impact on lifestyle choices

- Improve the knowledge of the health consumers and the public of what is available to support people living in the community
- Increased co-ordination and integration between specialist mental health, addictions services and primary care providers ensuring continuity and quality of care
- Timely access to specialist mental health and addictions services that provide a range of evidence based approaches to care and therapies
- Most services provided in the community by teams that are multidisciplinary and include peer support specialists who assist people to live in communities and access services
- Geographically based community specialist teams providing support in primary healthcare settings and a range of specialist interventions including crisis intervention
- The workforce in mainstream services reflects the ethnic balance of their community (including Asian and migrant). Maaori and Pacific service users have access to specialised services that operate within their cultural frameworks
- Sub-specialist teams including Maaori and Pacific teams, maternal health, severe trauma complex psychosis, and severe addictions. Some provide their service within a specific geographical area, whilst others cover a wider geographical area
- People with severe and ongoing mental health and addiction problems are supported by their peers and a wide range of other workers who reflect the ethnic diversity of Counties Manukau
- People with severe and ongoing mental health and addiction problems are supported to participate fully in the roles and responsibilities of community life
- A wide range of initiatives that recognise, respond and support the specific needs of family and whanau of people with mental illness and addiction problems
- Chronic mental illness is generally managed by specialist DHB and NGO services and primary services working in partnership, with patients moving between specialist and primary based care in relation to their mental illness. Specialist mental health and addictions services promote the patient maintaining strong links with their general practitioner to ensure that other health needs outside Mental Health are being met and to ensure continuity and quality of care
- The role of NGO services within the Mental Health continuum of care increases and the emphasis shifts to enabling people to access community resources rather than direct provision of support
- Specialist services support people to co-ordinate their health and social needs, ensuring community tenure and minimising acute inpatient episodes of care
- Community workers include peer support specialists
- Timely access to a range of evidence based approaches to care and therapies that are delivered within a culturally appropriate context
- Responsive 24-hour crisis services with increasing range of community based options for people whose mental health is deteriorating - including home based treatment, respite options and community based crisis support centres
- Increasing availability of emergency housing and other social supports for people who present at Middlemore Emergency Care, or other primary and secondary services in social crises or when they are intoxicated
- Integrated model of care extends into acute inpatient facility and community clinicians take a leading role in inpatient care and treatment
- Two facilities (one at Middlemore and Manukau) aligned and integrated with community Mental Health teams
- Geographically aligned wards with their own low stimulus areas
- Peer support specialists to support a person through their inpatient experience
- Cultural supports and sensitive cultural practices, including for Asian and migrant people.

### **Mental Health Services for Older People**

- Support for population-based health initiatives and programmes that promote health and wellbeing in older age and the social inclusion of older people
- Support for and participation in programmes that enable older people, their families and whanau to make well-informed choices about options for healthy living, health care and/or disability support needs (including drug & alcohol abuse)
- Support for and participation in programmes that increase awareness of mental illness and

addictions in older people and reducing the discrimination against those who experience MH&A problems in later life

- Ongoing development and/or support of culturally relevant health programmes that are shown to improve the mental health status of older Maaori
- Ongoing development and/or support of culturally relevant health promotion programmes that improve the mental health status of the diverse ethnic populations of Counties Manukau, including Pacific and Asian communities
- Ongoing participation/support of national and local programmes to prevent and minimise addictions that are likely to impact on older population groups
- Continue current initiatives in adult mental health services (e.g. Intensive Community Team, Community Living Services) to reduce the severity of illness and disability in current adults with serious mental health problems
- Promotion of early intervention at the onset of MH&A problems in older people to limit the severity of the disease, and improve patient wellbeing
- Promotion of early identification and intervention programmes within health and wellness programmes for Maaori, Pacific, Asian and refugee communities to encourage earlier presentation for older people with symptoms of MH&A conditions
- Building the capacity and expertise of primary care practitioners for early identification, and intervention in MH&A problems affecting older people
- Building the capacity and expertise of culture specific practitioners and services for early identification, and intervention in MH&A problems affecting older people
- Diagnosis and treatment for mental health conditions of older people will continue to commence in primary care with referral for specialist consult if required
- Specialist MHSOP and HOP specialist teams integrated with primary health care providers to support timely and appropriate advice and intervention for older people with MH&A problems
- Specialist community based MHSOP teams acting as a conduit for primary care or secondary specialists (e.g. Surgery, Medicine) to access specialist MH&A assessment, treatment planning and support services
- Effective alignment with NGO and other social agencies that can provide support to family/whanau early in the course of illness, in their normal living environment or cultural context
- Support for the development, funding and utilisation of new medications for dementia
- Primary healthcare teams becoming increasingly skilled at coordinating and treating MH&A problems in older people
- Improving range of specialist supports to primary care providers including integration of specialist MH&A workers within primary care settings
- Increased provision of support services for family/whanau in the community with an expanding range of community-based providers
- Integrated health care and disability support services for older Maaori and their whanau
- Ensuring timely and responsive access to specialist MHSOP, primary care, crisis and community care services to support key caregivers, maximise patient wellbeing in community care settings and avoid hospitalisation
- Improving the knowledge of the public, health consumers and health providers of the services available to support people living in community settings, and to avoid residential care or hospital admission where appropriate
- Community and non-government organisations will continue to play a major role in supporting people to remain in the community – in the direct provision of care, and in integrating care services
- Expanding 'ageing in place' strategies will continue to play an important role in supporting elderly and disabled people to live in the community. e.g. Meals on Wheels; Respite Care access via NASC funding
- Increasing community development with recognition of existing structures and organisations that can play a vital community support role (e.g. Pacific churches, marae)
- Promoting high quality residential and home-based care for older people coping with Mental Health conditions through workforce development for community based providers, responsive specialist service support within the community sector, and managing compliance and capacity of the residential care sector

- The key physician in the management of older people with Mental Health conditions is the General Practitioner with support from their primary health care team
- Increasing range of interventions available to GPs, e.g. screening tools, psychiatric medications
- Shared care initiatives that enable people with MH&A issues to have both physical and mental health care from primary providers
- Home health care services provided by District Nurses will increasingly act as a linkage between primary care teams, caregivers and specialist MHSOP teams, and will assist primary care and residential care to maintain complex patients appropriately within community settings
- Specialist MSHOP will continue the transfer of service delivery to a community rather than hospital inpatient care model
- Expanded geographically aligned specialist MHSOP Teams will provide early and prompt access to consultation and treatment in community based settings to avoid hospital admission
- Closer relationships developing between specialist MHSOP and Rehabilitation services with more patients having shared care or cross-consultation
- Services will be coordinated at primary care level for people with mild to moderate mental health conditions and configured around the needs of the patient to provide a safe and effective therapeutic environment
- Wherever practicable and appropriate, primary care or specialist assessment and treatment will be provided in the patient's normal living environment to avoid hospitalisation
- Development within specialist teams of skills and expertise in delivering community-based programmes and care to people from diverse ethnic groups as the number of older Maaori, Pacific and Asian people with Mental Health conditions increases
- The Specialist MHSOP team will work with primary care and specialist medical and surgical services to implement an Advance Care planning programme supporting quality decision-making around end-stage conditions.

#### **5.2.4 Primary and Community Health Services**

- An increased focus on prevention, early intervention, support for self-care, chronic disease management and integration
- The new Model of Care for PCHS is based on two principles. First, the decentralisation of specialist services that are not facility dependent and which can be efficiently delivered outside hospital settings; and secondly the aggregation, integration and co-location of primary and community health services – including general practice, CMDHB community services and NGO services
- Primary care services moving from reactive, unplanned and episodic care to a systematic patient-centred approach; delivered sooner (early intervention) and closer to the patient and based in community settings ('the most intensive care in the least intensive settings'); and delivered by multi-professional teams with the delegation of traditional clinical tasks to achieve more appropriate use of skills
- Service co-location with other community based services to improve integration and coordination
- Visiting specialist services being 'part of the team' and supporting primary care to manage and support their patients
- More integrated multi-disciplinary programmes for Chronic Care Management across primary and specialist services and incorporating expanded nursing and allied health specialist roles
- An increased focus on self-care knowledge and support (the 'expert patient') and empowering people to make healthier choices - diet, physical activity, and lifestyle
- A less fragmented service delivery model by removing unnecessary funding and contracting 'silos'
- Active case management for people with complex and multiple needs including out-reach and home based services where appropriate
- Better use of clinical information and technology to identify patients with complex needs, to provide structured personalised care, and to incorporate best practice clinical decision-support
- Access to patient information that is available to providers in primary, specialist, emergency and acute care settings

- Use of population information to analyse utilisation across primary and specialist settings, for planning services to a defined locality and for targeting services to people at risk
- More co-ordinated discharge planning, rehabilitation and community-based care to reduce hospital length-of-stay, avoid unnecessary hospital re-admission, and manage a higher rate of chronic illness and disability in community settings
- Inclusive, culturally appropriate care to target groups with poorer health status and to promote lifestyle changes appropriate to the individual's cultural and health needs
- Ongoing development of evidence-based practice, clinical guidelines, audit and quality improvement programmes
- Primary and Community Health Centres (PCHC) will be the key health delivery 'hubs' for delivering primary health care in defined localities
- PCHCs will provide local delivery of a wide range of services across the continuum from prevention, diagnosis and treatment, through to rehabilitation and continuing care for people with long term conditions. Some care previously provided through a day admission or overnight stay in hospital will to be provided as a day attendance at PCHCs or in the home through outreach services
- PCHCs will allow general practice services to move into settings that are 'scaleable', i.e. able to provide services for a larger population without a corresponding increase in practitioner numbers. A high proportion of routine care will be delivered through a 'nurse-led team-based' model allowing general practitioners to assess and treat more complex cases and develop skills in areas of GP specialisation. In the long term, it is envisaged that the majority of general practitioners in Counties Manukau will practise from a PCHC and/or its satellite clinics
- PCHCs will provide a base for outreach workers, including community health workers, clinical and support services delivered in people's homes, public health nursing, community rehabilitation, and needs assessment and service co-ordination (NASC). In high-need localities, other government agencies will have customer service offices located within the centres
- Priority will be given to PCHC development in localities with the highest health needs in order to reduce avoidable hospitalisations and inequalities. These will be funded through public/private partnerships with private sector investment capital
- Integrating services in the PCHCs will also be fostered by integrating funding through a Locality Health Improvement Plan which will form part of the CMDHB District Annual Plan. The community and patient user groups will be actively involved in local health services delivered by the PCHC which will ensure that services are responsive to local needs
- The PCHC will provide imaging and point-of-care diagnostic services as these become available with advances in technology
- Home diagnostic technology will enable patients to take greater responsibility for monitoring and managing their health care (patients as partners)
- PCHC staff will provide acute, accident and urgent care that is better integrated with specialist DHB services
- The PCHC core teams will provide a structured approach for those who require active ongoing planned care and support
- Internal referrals will be made to GPs with a special interest (GPwSI) and other primary care subspecialty practitioners.

### **5.2.5 After Hours Primary Care**

- CMDHB will work with Primary Health Organisations (PHOs) to align Counties Manukau after hours services with the national framework through a range of initiatives
- PHOs and their providers will be responsible for making formal arrangements for contracting any services outside the hours they themselves are open for business
- These formal arrangements will include provision for information transfer to support continuity of care for patients, will give greater financial certainty to afterhours providers like Accident and Medical clinics, and will ensure better access to clinical information to assist in managing acute presentations. In turn after hours service providers will be accountable through their contractual arrangements for the quality of the services they offer
- A disposition pathway will be developed and well promoted throughout the community so that patients are able to access the most appropriate service for their needs.

- Telephone triage and disposition services will play a key role in the disposition process. The community will be encouraged and supported to contact these services for advice
- CMDHB will work with primary care providers and the community to gradually reduce the unnecessary use of Middlemore Hospital Emergency Care by walk-in patients through promotion of the disposition pathway, education and encouraging patients to enrol with and use their primary care provider
- As primary care services are aggregated into Primary & Community Health Centres (PCHCs) serving their respective communities, after hours primary health care services will increasingly be delivered from these centres. Over time existing Accident and Medical facilities will gradually be incorporated into Primary & Community Health Care Centres
- To attract and retain a skilled workforce in the face of an increasing shortage of both doctors and nurses in Counties Manukau requires recognition, status and appropriate compensation for the extended hours of availability of Accident and Medical clinics
- Formal agreements which specify the quality of after-hours services to be provided will ensure that after-hours providers have effective clinical governance processes together with the appropriately skilled personnel to deliver a quality service. The after-hours agreement will include provision for clinical governance, regular peer review and a credentialing process such as the three yearly AMPA audit of premises. Skill transfer and enhancement will be facilitated by greater collaboration between Middlemore Emergency Care and primary care providers offering emergency medical services and opportunities for up-skilling
- The development of an integrated acute care network and recognition of the specialised role of accident and acute medical care will offer career pathways for nurses interested in nurse practitioner roles and in time will see nurses playing a greater role in after-hours acute care
- Ambulance services are an important part of an integrated acute care network and will be increasingly aligned with primary care. With up-skilling, ambulances will increasingly be able to reduce the number of ambulance transports for non life-threatening conditions and provide a service in the patient's own environment, thereby increasing patient satisfaction
- After hours services of the future will incorporate a mobile paramedic practitioner who will be able to assess patients without mobility or transport in their homes and either treat and discharge, or arrange transport to the most appropriate service for their needs. In some cases this may be a social agency rather than a health service
- A&M services will provide almost all of the after hours care throughout Counties Manukau as part of an integrated network of services for management of acute and urgent medical conditions and accidents with first entry point in the community and subsequent referral of more complex cases requiring secondary level care to Emergency Care at Middlemore Hospital. Closer integration with Emergency Care within the continuum for management of acute illness will support the maintenance of quality and a seamless service for acutely ill patients. Accident and Medical work will be recognised as a subspecialty in its own right for both doctors and nurses.

### **5.2.6 Maternity Services**

- Promote the current use and future development of primary maternity services
- Maintain Middlemore Hospital (MMH) as the single specialist maternity facility
- Provide a service that is clinically safe for women and babies
- Support the maintenance of low rates of Caesarean section and interventional deliveries whilst recognising the choices women make in their maternity care
- Support the integration of maternity services across the care continuum. Women should be able to move easily between community, primary, secondary and tertiary services depending on their needs for the different components of care
- Provide a service that is culturally safe for Maaori, Pacific and the ethnically diverse communities served by CMDHB
- Promote efficient and effective use of workforce and facilities
- Future-proofing to respond to unplanned changes in birth forecasts or changes in clinical birthing trends will be achieved through creating flexibility of workforce models, facilities, Models of Care and operating systems
- Promote the separation of primary and secondary maternity service provision to encourage primary birthing whenever appropriate

- Develop maternity services that are culturally appropriate and meet the needs of women/whanau, and the professional needs of clinicians for provision of safe clinical services
- Support integration of services for women and babies across the care continuum including the development of services for women complex needs (e.g. maternal medicine, maternal mental health), and recognising the particular issues for women/whanau in communities with socioeconomic deprivation.

### **5.2.7 Rehabilitation Services (including Spinal Rehabilitation)**

- Care will be individual and family centred, and based in community settings wherever this is appropriate. The aim is to improve accessibility, increase efficiency, improve quality of care, and decrease potentially avoidable hospital admissions
- Health promotion and illness prevention within the rehabilitation continuum includes national and local strategies aimed at increasing the individual's commitment to self-responsibility for their own health care, and for community development
- Closer collaboration between Rehabilitation services and Mental Health Services for Older People (MHSOP) in the management of patients with dementia. This will be facilitated by the co-location of MHSOP inpatient beds with the Manukau Rehabilitation Centre, and by sharing of core allied health staff and associated support services across both Rehabilitation and MHSOP
- Improved integration of services between the CMDHB home health care teams, specialist rehabilitation services and primary care teams
- While aged residential care residents will continue to be under the medical care of a general practitioner, the specialist rehabilitation service will provide an increased range of consultation services (physician, specialist nurse and allied health). This will increase the capacity of primary care and residential care to maintain higher complexity patients within community settings and avoid hospital admission
- Care across the continuum will be based on a client participation model (WHO: International Classification of Functioning, Disability and Health) and will include increased vocational and recreational components of rehabilitation. Vocational and recreational rehabilitation will be provided outside specialist rehabilitation services with close linkages to all other components of care, and supported through closer relationships between the Health sector, ACC and Ministry of Social Development
- Rehabilitation services will be provided to patients who are less physiologically stable in both hospital and community settings. This will require increasing the skills and knowledge for both health professionals and caregivers. Rehabilitation service input will be provided during an acute phase of an illness with earlier transfer of appropriate patients to rehabilitation services (inpatient, or community based), and improved functional maintenance within an acute inpatient hospital episode
- Increasing delivery of Rehabilitation services in appropriate cultural and/or environmental contexts to support patient participation and enlist the support of family and community in ongoing care
- As a major provider and funder of rehabilitation services in Counties Manukau, CMDHB has a role to assume leadership to the Rehabilitation sector through working with other Health sector agencies, non-government organisations and intersectoral agencies.

### **5.2.8 Health of Older People**

- Develop multi-disciplinary inter-agency teams providing capacity for 7 days per week response
- Provide some services in the patients' homes
- Provide joint assessment for patients identified as at risk within 48 hours
- Facilitate access to a comprehensive geriatric assessment
- Multi-disciplinary interagency teams working in conjunction with GPs
- Multi-disciplinary interagency teams facilitating access to fast-track diagnostic services (pathology and imaging) and to specialist aged care clinical advice.
- Multi-disciplinary interagency teams facilitating access and linkage to community services for to short and long-term care

- Transitioning of Franklin Memorial Hospital into rehabilitation, respite and palliative care services over time.
- Long term sustainable care based on patients' individual choices, references and plan
- Information and resource sharing with older people, families and workforce.

### **5.2.9 Child and Youth Services**

#### **For All Children and Young People**

- CMDHB will contribute to building cohesive, self-reliant communities that have capacity to manage the wellness status of their residents, by working collaboratively with other government and non-government agencies and organisations to support healthy families which, in turn, are more likely to nurture children who will grow into resilient, confident young people
- Develop multiple access points and facilities within communities offering easily accessible, culturally appropriate services that appeal to parents/families as well as a technology literate young population
- The ongoing movement from hospital to community based services supports a community 'hub and spokes' model of delivery which offers access to a range of child, young people and family/whaanau friendly services as close as possible to where people live
- Participation in intersectoral initiatives that support healthier housing, improved educational outcomes, high employment rates, reduction in family violence, and improved access to public transport. We will increase involvement with local authorities when urban plans might affect the well-being of children and young people, eg risks of pedestrian injury
- Extend the Healthy Housing programme as an intersectoral model for families requiring cross-sectoral services
- Ongoing universal health surveillance and screening of children will support a change from an illness model to one of wellness. The success of universal surveillance will depend on more effective sharing of information across all providers
- Focus on wellness, health promotion and education, and early identification of potential health risks. This includes increased local delivery of integrated community health, education and social services
- There will be closer integration of public health nursing with primary care; delivery of some outpatient services from Primary & Community Health Centres; and an increasing role for paediatricians and specialist nurses in supporting and upskilling primary care
- Comprehensive packages of care will be available for all children with high support needs irrespective of whether the underlying cause of the problem is accident, illness or disability
- Improved access rates to specialist mental health services, in particular for Maaori and Pacific children, young people and their families/whanau
- Primary and Community Health Centres will offer families a range of health and social services and incorporate a 'whole child' approach including child protection services and mental health support services for children
- Children, young people and their families/whanau will be involved in the design of new services
- Child and adolescent oral health services and facilities will be reconfigured to deliver a modern and family-friendly service which will be more visible and accessible to groups who have had historically low rates of utilisation. Child and adolescent oral health services will integrate with other primary and community health services
- Improved data collection to inform local population statistics and ongoing review of services
- Apart from the tertiary Plastics & Burns and Neonatal services, specialist tertiary services will continue to be provided at ADHB's Starship with an anticipated increase in tertiary outpatient services being provided at Manukau campus.

#### **For Babies and Pre-schoolers**

- Focus on the early years of life by increasing services that start pre-birth, such as initiatives to reduce smoking during pregnancy, support breastfeeding and prevent teenage pregnancies

- Improved integration of Well Child services with primary care through the Primary & Community Health Centres
- Services will be more flexible with hours to suit working families and for priority populations, eg vaccinations will be offered opportunistically at community clinics and for a very few 'at risk' families, consideration will be given to offering vaccinations at home
- All services for this age group will take account of the emotional and social needs of infants and in addition to this, specific services will be targeted at those at risk of developing difficulties including access to specialist therapeutic programmes.

### **For School Children**

- Every child will have access to universal well child/well-being/developmental services that include regular integrated multi-agency assessments
- CMDHB will encourage and support 'whole of school' initiatives such as AIMHI, and Health Promoting Schools which involve the entire school community in health and well-being programmes
- Health promotion and health education services will be co-ordinated between Health, Education and other agencies offering a 'whole child' approach
- There will be an increase in preventative health promotion, particularly for Maaori, Pacific and Asian children, covering lifestyle behaviour messages around obesity, diabetes, cardiovascular disease and oral health
- There will be increased multi-agency support for families who are caring for children with high medical and/or psychological needs
- We will improve access to specialist mental health services providing assessment and treatment of children and their families, with teams dedicated to services for Maaori and Pacific people.

### **For Young People**

- We will develop a 'whole of youth' approach, offering regular assessments that are youth oriented
- Young people will be involved in design of service delivery, facilities and evaluation so that they access services in settings with which they are comfortable and that are specific to their cultural needs
- Youth focused health clinics with 'wrap around' social support and specialist services will be developed
- Services in the future will be more technology enabled and capable of interfacing directly with schoolchildren and young people using technology in creative ways (e.g. texting appointment reminders)
- We will expand existing secondary school based services with a target of providing a health clinic in every school within Counties Manukau that is staffed by registered nurses and supported by GPs
- There will be improved access to flexible, mobile mental health services for youth, including alcohol and drug prevention/intervention services
- We will increase prevention/self-help and education services for young people to deal with all health problems, including emotional and mental health (e.g. using web based and peer education programmes)
- Services will have a focus on growing strong, positive and loving whaanau/families to support young people
- All health professionals working with young people will have a core skill set and competency for working with young people
- We will improve services for young people with disabilities so that every young person is supported to adulthood with appropriate services specifically designed for them
- We will support development of one-stop-shops for young people. Integrated services will include recreational facilities, an internet café, exercise facilities, as well as a range of health and social services.

### 5.2.10 Elective Services

- Continuing the shift to ambulatory focussed care at the same time as reducing the boundaries between primary and secondary care
- Ongoing incremental change arising from technological developments; changes in delivery systems driven by workforce availability, ongoing quality improvement, and a focus on patient safety; and better integration between primary and secondary care services
- Development of health promotion, illness prevention, early detection and screening programmes nationally, supported by Counties Manukau health providers. Specialist services will provide input into the development of national strategies and provide local/national leadership
- Increasing primary care access to diagnostics, GP training in appropriate office procedures, and improving the referral management for elective surgical conditions
- Adoption of non-invasive surgical treatment options for GPs and the development of GPs with Special Interest (GPwSI) for the assessment and management of key surgical conditions
- Continuing the split locations of Middlemore and Manukau campuses, where services can be efficiently and effectively configured across both locations. This separation allows the greatest opportunity for surgical scheduling to meet contracted volumes. There will be continuing development of clinical support services on the Manukau site to support the delivery of robust elective services at the Manukau Surgery Centre
- Technology will continue to be one of the drivers encouraging the shift of care to a more ambulatory-focused approach. Changes in technology, whilst making some surgical operations more theatre intense, have and will continue to decrease the length of post-operative hospital stay, and allow quicker recovery times in returning-to-life activities
- Development of nurse specialist roles within specialist services for the management of some key conditions to support better integration of secondary and primary care
- The development of Primary & Community Health Centres will allow development of closer working relationships between primary and secondary clinicians with the benefit of patients being able to access more care closer to home
- Increasingly moving care from hospital to daypatient or outpatient models with devolution of components of care from specialists to GPs, specialist nurses, physiotherapists, optometrists etc.

### 5.2.11 Acute Surgery

- Acute Surgery for Counties Manukau residents will continue to be provided at Middlemore Hospital only for Plastic and Reconstructive Surgery, Orthopaedics, General Surgery, Gynaecology and ORL Surgery. There are a number of changes to Models of Care involving acute surgical services and these are contained within various surgical sub-specialty workstreams within the HSP
- Acute GP-referred patients presenting to Middlemore EC triaged as category 3, 4 and 5 will be assessed in the Assessment & Planning Unit and managed by the Surgical Specialty Team (refer Emergency Care services workstream and key directions)
- Service development, forecast trends and changes, and future directions for each specialty are contained within the Elective Services workstream (refer Elective Surgery workstream and key directions)
- A number of significant changes in Ophthalmology are proposed including acute clinics being developed at Manukau SuperClinic in five years. Hence a separate workstream for ophthalmology has been developed as part of the HSP (refer Ophthalmology Services)
- The current complexity of Trauma services will continue for the foreseeable future and this will require maintenance of robust on-call and emergency response teams of surgical specialties at Middlemore Hospital (refer Trauma Services)
- Perioperative Services are proposed to develop with continued expansion of Manukau Surgery as the Elective Surgery centre for patients with 'predictable outcomes'. The current level of patient complexity is proposed to continue for the foreseeable future. Middlemore Hospital will continue to provide a range of high complexity surgical procedures and surgical procedures on high risk patients (due to co-morbidities). With phased developments of additional theatres on both sites, there will be ongoing reconfiguration of allocated elective

and acute arranged lists undertaken at each site to manage increased acute demand and staging of theatre expansion across two sites ( refer Perioperative workstream)

- Current issues related to delayed access to acute operating theatres are being addressed to reduce the reliance on acute surgical inpatient beds. 'Time to Operating Theatre' data will inform system and process changes and monitor performance.

## **5.2.12 Surgical Sub-Specialities**

### **Ophthalmology**

- Repatriation of remaining elective secondary care surgical volumes from ADHB (2008-2009)
- Development of acute ophthalmology consultation and treatment service (2013)
- Development of multidisciplinary workforce
- Enhanced diabetes retinal screening and management of patients with diabetic retinopathy
- ADHB as the provider of tertiary ophthalmology services.

### **Neurosurgery**

- Neurosurgical services for people of Counties Manukau will continue to be provided at ADHB for the period of the HSP.

### **Cardiothoracic**

- Cardiothoracic surgery for people of Counties Manukau will continue to be provided by ADHB at ADHB facilities
- Participation of cardiothoracic surgeons in multidisciplinary clinics at Manukau SuperClinic.

### **Urology**

- Through a RSP process in 2008, explore development of local delivery of core elective urology surgery services at Manukau by ADHB through a 'hub and spokes' model, or through development of a full local secondary care service.

### **Trauma**

- CMDHB will continue to provide the current scope and complexity of trauma services for the foreseeable future. Service levels will be adjusted for demographic growth
- Strengthen internal management and clinical leadership processes associated with the CMDHB Trauma services
- Strengthen internal systems and processes for managing the patient pathway through CMDHB facilities (emergency, acute and rehabilitation). Ensure that patient pathways accommodate patients returned from Auckland City Hospital requiring further care or rehabilitation
- Work collaboratively with ADHB on development of regional trauma networks
- Strengthen local patient transfer/retrieval services to Auckland City Hospital
- Strengthen data collection systems to support ongoing service development and quality review.

### **Vascular Surgery**

- Repatriation of remaining elective and acute secondary care vascular surgery for Counties Manukau residents currently being provided by ADHB in 2008
- Service expansion to accommodate growth in volumes related to rates of vascular disease and demographic growth
- Continuation of acute and elective vascular surgery (excluding minor procedures on low risk patients) remaining on the Middlemore campus
- Continued development of service synergies in close collaboration with other CMDHB clinical teams – particularly interventional radiology, diabetes, renal, ICU and orthopaedics

- Continue to pursue development of clinical network with ADHB and explore the opportunity of shared on-call systems
- Development of an abdominal aortic aneurism (AAA) screening programme
- Expansion of the nurse specialist role in the management of chronic vascular disease.

### **Plastic & Reconstruction Surgery**

- WDHB will be providing a secondary care hand surgery service for WDHB residents from March 2008
- CMDHB to explore with ADHB the development of capacity to manage ADHB residents requiring secondary care hand surgery
- CMDHB is promoting enhanced outreach services to WDHB and ADHB in the short term with phased development of secondary care Plastic Surgery Units in ADHB and WDHB at some time in the future
- CMDHB will continue as the provider of regional tertiary PRS for the foreseeable future
- Developing of resource capacity within the National Burns Unit to ensure capacity to accept all nationally referred and Tahitian major burns
- Development of specialist nursing roles to integrate patient care and enhance service provision.

### **Oral Health**

- Foster improvements in oral health through primary care initiatives and oral health promotion
- Increase the provision of medically compromised care by non-DHB dentists with funding, support and advice from the Specialist Dental Service
- Improve the input of therapists in triage and the monitoring of adult and adolescent patients
- Improve access for older people in residential care through community based strategies applicable to residential care
- Develop the Oral Health module at Manukau SuperClinic, and transfer services from the current Middlemore Hospital Oral Health department. This will provide greater synergy with the Plastic and Reconstructive services provided at Manukau
- Retain acute Maxillo-Facial Services at Middlemore, particularly the provision of acute theatre access where surgery is frequently associated with other injuries
- Develop Oral Health community hubs within Primary & Community Health centres for improved access to targeted services and population groups
- Investigate and develop expanded services for preventative oral health for target groups such as pregnant women, older people and people with long term conditions
- Investigate improved access for low income access to some oral surgery such as wisdom teeth extraction.

### **Perioperative**

- Most elective surgery will continue to be undertaken at Manukau with the same types and conditions currently being managed at each site. A possible change is the movement of elective spinal surgery to MSC (but these volumes would not be material for facility planning purposes)
- Manukau ICU will operate at Level II at least for the foreseeable future. Emergency ventilation will continue to be available pending transfer of the patient to Middlemore ICU. Due to the needs for higher levels of intensive care medical support for ventilated patients, and the very low volume of elective patients who require post-operative ventilation, there are no plans to develop further capacity to ventilate patients at MCS
- Ongoing refinement of systems and processes to improve the quality of patient care and patient throughput
- Development of increased acute theatre availability at Middlemore Hospital to improve the timeliness of treatment for acute patients, reduce ALOS for acute surgery and improve quality of acute patient throughput
- Possible development of elective Urology inpatient surgery by 2013
- Phased repatriation of 95% of secondary care Ophthalmology day patients by 2008
- Repatriation of secondary care Vascular surgery (principally acute surgery) in 2008

- Management of acute arranged admissions will continue to evolve. Wherever possible and where clinically appropriate, patients will be managed as an acute presentation and receive prompt and timely theatre treatment on that presentation. For some services/conditions/patients, admission within seven days for surgery is appropriate. These patients will be managed through a robust process either at Middlemore Hospital or Manukau Surgery Centre.

### **5.2.13 Medicine and Acute Care**

- Increasing introduction of evidence-based health promotion, illness prevention and early detection programmes involving both primary care and secondary care
- Improving supported self-care to assist the growing number of people with chronic conditions to cope with living in the community
- Responsibility for the ongoing management of most chronic conditions sitting with primary care with improved access to specialist services as required. A small group of conditions (e.g. management of end stage renal failure) will remain highly dependent on specialist service management due to high complexity, high clinical risk and the level of subspecialty knowledge required
- Improved access to earlier specialist assessment, diagnosis and treatment
- Earlier discharge from specialist care to primary care for ongoing condition management
- Maintenance of Middlemore Hospital as the acute care unit for Counties Manukau. Within specialist services, the development of an Assessment & Planning Unit at Middlemore Hospital will improve the efficiency and effectiveness of clinical management of GP referred patients. The development of a High Dependency Unit (HDU) will improve the standard of patient care. Close observation units on medical wards for subspecialty patients not requiring HDU will support improved continuity of care for subspecialty patients while also developing the nurse specialists of the future
- The implementation of Advance Care Planning across all services will assist secondary and primary care to work with patients and their families to make more informed decisions and provide a framework for avoiding futile healthcare interventions.

### **5.2.14 Medical Sub-Specialties**

#### **Cardiology**

- Continued development of primary care management of cardiology conditions and the provision of community based services
- Ongoing development of additional cardiology investigation and treatment services, and the introduction of new technologies
- Movement of specialist consultation clinics to community and primary care settings
- Better access for primary care to cardiology investigations to support timely diagnosis and treatment
- Workforce development for all groups of staff to meet needs for additional services and the introduction of new services
- Development of Nurse Specialist and Nurse Practitioner roles across the care continuum.

#### **Neurology**

- Development of outpatient services at Manukau to ensure that most outpatient services for Counties Manukau residents are delivered locally
- Enhanced visiting specialist neurologist services for inpatients at Middlemore Hospital
- Further development of the integrated Stroke service at Middlemore Hospital
- Further development of Nurse Specialists to support case management and support integration of care between primary and secondary care providers.

#### **Clinical Haematology**

- Continued development of services at Middlemore Hospital to address demographic growth
- Potential development of autologous bone marrow service at CMDHB within the HSP timeframe

- Continued development of Clinical Haematology services on the Middlemore Hospital due to the small size of the service, and specialist commitment in both clinical haematology and laboratory haematology.

### **Diabetes**

- Continued implementation of the “Let’s Beat Diabetes” programme with specialist Diabetes services supporting primary care providers with training and long term management of people with diabetes
- Continuing the development of community-based secondary care clinics in high need areas
- Continued support of secondary care specialist services in the provision of care for patients with diabetes experiencing other health episodic or chronic care.

### **Respiratory**

- Extension of outpatient operational hours to improve patient access
- Development of sleep apnoea screening services in primary care with development of full polysomnography services within 10 years
- Development of coordinated multidisciplinary clinics and services for patients with lung cancer
- Continuing to promote the management of chronic respiratory disease by primary care with rapid response by specialist services on referral
- Continued development of specialist nursing and allied health roles within Respiratory Medicine
- Integrated care models across secondary, primary and community settings
- Early discharge planning for community acquired pneumonia and COPD in the acute care setting
- Increases in pulmonary rehabilitation
- Increased utilisation of investigative tools.

### **Gastroenterology**

- Development of a Gastroenterology suite at Manukau campus for outpatient consultation, elective endoscopy and other investigations
- Development of Nurse Endoscopists to improve the ability of the service to respond to growth in demand
- Implementation of Colorectal screening programme for early detection and treatment of colorectal cancer
- Introduction of new gastroenterology investigations and treatment modalities across both Middlemore Hospital and Manukau sites.

### **Renal**

- Respond to growth in dialysis numbers across all treatment modalities through the development of further services and serviced facilities
- Implementation of early prevention strategies including medications that avoid or delay demand for dialysis
- Incorporation of new technologies and practices to more effectively manage dialysis therapies
- Reduce the work-up time for transplantation and increase live donor transplantation rates
- Develop in-house training program for haemodialysis technicians.

### **Dermatology**

- Continued development of local secondary care Dermatology services including the development of weekly paediatric dermatology clinic, daily UV therapy sessions, and significant improvements in patient access to services
- Development of secondary care inpatient service at Middlemore Hospital
- Support dermatology capacity and workforce development through a Dermatology Registrar role

- Development of a Clinical Nurse Specialist role in Dermatology for triage, education, nurse-led follow-up clinics and to support closer links with Kidz First Home Care nurses
- Development of stronger links between Plastic Surgery and Dermatology to support improved secondary care management of skin lesions. This includes the development of skin lesion clinics and a minor procedure service.

### **Endocrinology**

- Development of subspecialty areas of endocrinology practice
- Collaboration in development of local bone densitometry services
- Development of multidisciplinary clinics.

### **Rheumatology**

- Upskilling of primary care teams, associated with credentialing, so that patient visits to specialist can be spaced more widely, with a safety net of registers to ensure that suboptimal care is avoided. This will include telemedicine education and observational learning clinics in primary care
- Telemedicine for virtual clinics and direct links between patients and clinical staff
- Biologicals clinics, including infusion facilities, in Primary & Community Health Centres
- Combined clinics, where appropriate, with other specialist groups, e.g. Renal, Orthopaedic, Adolescent Health
- Develop a more efficient triage system, where patients with musculoskeletal and connective tissue disorders will be reviewed by a nurse and rheumatologist, and devolved to orthopaedic surgeons, pain specialists, nurse practitioners, specialist physiotherapists, rheumatologists, and GPs with special interest in musculoskeletal conditions, with much of the subsequent management being in multidisciplinary teams in the community
- Incorporation of clinical research and audit into everyday practice.

### **Cancer Services**

- Continuation of a 'hub and spokes' model for non-surgical cancer services with transition to most services being provided at Manukau campus by ADHB during the period of the HSP
- Development of chemotherapy services at Manukau in 2009/10
- Development of radiotherapy service provision at Manukau in 2014/15
- Continuation of inpatient oncology service provision at Auckland City Hospital for the foreseeable future
- Development of increased multidisciplinary clinics at Manukau (e.g. oncology/respiratory, breast cancer) to improve the coordination of patient care
- Implementation of the CMDHB Palliative Care Plan involving a multi-disciplinary network of health services centred on primary and community based care, but supported by access to specialist Palliative Care services for advice, complex symptom management and ease of access to assessment/review
- Additional service volumes in response to the rising incidence of cancer and demographic growth.

### **Infectious Disease**

- Input into facility and service design across CMDHB to facilitate robust infection control practice and support subsequent development of new infection control practices consistent with CMDHB facility developments
- Advice on infection control strategies to support the introduction of new clinical services within CMDHB
- Continued stewardship of antibiotics practice within Counties Manukau including the introduction of new antibiotics, guidelines, prophylaxis and restrictions
- Continued development and expansion of the IV home service to include additional service areas and conditions (e.g. bronchiectasis, pulmonary TB)
- Pilot innovative approaches in the management of community acquired pneumonia

- Continued development of local HIV-AIDs services alongside Sexual Health, Public Health, and tertiary Infectious Diseases services.

### **Emergency Services**

- Redevelop models of care to achieve timely response and shortened length of stay in EC
- Middlemore will continue to function as a Regional Trauma Unit for the foreseeable future with supra-regional services for patients with neurosurgical, cardiothoracic surgery and paediatric surgery provided at Auckland City Hospital
- Develop an Assessment & Planning Unit at Middlemore Hospital as part of the Clinical Services Building development. This will reduce the number of GP presentations to EC, offsetting increases associated with population growth
- Overnight provision of primary care will influence the staffing requirements in EC. If this responsibility rests in EC, this occurs over a period when there are lower numbers of presentations and adequate physical capacity but additional staffing will be required. (Overnight provision of primary care is considered within the After Hours workstream).

### **5.2.15 Clinical Support Services**

#### **Pharmacy**

- Increase focus on pharmaceutical safety
- Promote development of a funded high-needs minor ailment service for community pharmacists to avoid hospitalisation and poor health outcomes
- Introduction of Medication Usage Review and Medication Review involving pharmacist, patient and prescriber
- Medication reconciliation across community and hospital pharmacies
- Movement to automated Pyxis medication administration system
- Extending clinical pharmacy services within hospital settings
- Provision of pharmaceutical services at both Middlemore and Manukau with co-located clinical pharmacy and operational pharmacy services at each site
- Limited sterile compounding services available on both sites
- Develop a retail pharmacy at Manukau campus to increase patient compliance and discharge planning
- Develop an integrated electronic pharmaceutical system across the metro-Auckland region
- Increase focus on using the different components of the pharmacy workforce in the most effective and efficient manner. This includes administrative staff, pharmacy technicians, pharmacists and pharmacy practitioners.

#### **Laboratory**

- Continued growth in volume of laboratory investigations above demographic/service growth levels
- Focus on improved productivity through matching workforce to activity, improving systems and processes, and through realising the benefits of new technology
- Development of new facilities configured to optimise productivity and address current constraints
- Electronic service order management to avoid duplication of tests with resultant patient and cost benefits
- The Middlemore laboratory, supported by an end-to-end information system, will operate as an end-to-end clinical system and be a core contributor to the clinical aspects of the patient's journey
- The Laboratory service will provide supporting information and education to help users to ensure they are ordering the right tests and correctly interpret results, thereby addressing the increasing knowledge gap between requester and the pathologist as the result of laboratory medicine becoming more sophisticated

- Increase laboratory automation with potential total laboratory automation in some service areas. This will deliver major clinical quality benefits of reduction in errors and improved timeliness of results, and potential cost savings
- Adopt Middleware (i.e. expert decision-making software) to provide an efficient system that increases response and improves clinical quality
- Expand service at Manukau campus to support major growth in elective surgery and development of new services (e.g. Rehabilitation, Mental Health and Mental Health Services for Older People)
- Develop point-of-care testing where this is appropriate, supported by evidence, and when the process can be quality controlled
- Develop workforce strategies to manage high rates of attrition of an ageing technician workforce.

## **Radiology**

- Resite Middlemore Radiology department in 2013 to a newly created clinical services block
- Development of additional capacity at Manukau to meet the growing demands of ambulatory care, new services on that site (e.g. Rehabilitation) and the increases in elective surgery
- Mammography is likely to move into a purpose-built facility within the next 5 years that would combine surgical breast services, Breast Screening Counties Manukau, and the mammography service CMDHB Radiology provides. This will be at Manukau and may become a dedicated service physically separated from the Middlemore Radiology department. This new facility would provide the opportunity to convert the entire mammography and Breast Screening service to digital mammography equipment. In the interim, investment in digital interventional mammography attachments will be made to promote efficient work practice
- A third CT scanner will be acquired and placed at Manukau to provide separation of acute and elective CT scanning. This would enhance the service provided to Middlemore Hospital referrers
- Investigate the requirement for a 24hr Plain Film service at Manukau
- Ensure re-investment in new equipment continues to ensure the best imaging is provided to the patient and referrer
- Investigate a 3T MRI scanner as the next MRI acquisition
- Promote a regional PET CT service
- Promote access to CMDHB Radiology PACS by community providers
- Introduce electronic Radiology orders to CMDHB clinical staff and investigate its introduction to community referrers
- Continue existing Radiologist fellowships and introduce others to assist recruitment
- Promote sabbaticals with overseas hospitals amongst all staff groups
- Promote and maintain educational activities within Radiology
- Encourage and support role extension amongst MRT's and Sonographers ensuring buy-in from the Radiologist team
- Promote services integration and support multidisciplinary teams. This will improve patient care, enhance staff learning and assist in retention
- Investigate decentralisation of services and the impacts on the Radiology workforce
- Promote a longer working day in order to fully utilise the investment in equipment, e.g. 10-12 hour days are routinely worked in Europe on MRI scanners
- Investigate the impact of weekends in the 'routine' working week since the volume of work at weekends is growing and the requirements for lower acuity work to be performed is increasing to ensure the patient is discharged from hospital as soon as possible. The need for a routine seven-day week for Radiology is growing
- Investigate the feasibility of home based reporting for Radiologists to provide greater flexibility of work practice
- Investigate the feasibility of cross-DHB utilisation of Radiology staff to assist when staffing numbers are low
- Develop GP educational model for imaging in conjunction with the introduction to PHOs of a 'preferred referrer' status to allow access to CT and MRI services. This will reduce FSAs whilst ensuring that imaging is appropriately utilised

- Investigate further all options for the provision of Community Radiology
- Develop contract with Mercy Radiology to improve quality of service provided to CMDHB at Botany SuperClinic
- Encourage private providers to invest in digital imaging equipment through the contractual process
- Ensure Radiology involvement in organisational service planning
- Ensure robust claiming methods are used for optimising ACC revenue.

#### **Nuclear Medicine**

- CMDHB will continue to have ADHB provide nuclear medicine for the people of Counties Manukau for the foreseeable future.

### 5.3 Key facility configuration changes

The HSP proposes a number of key CMDHB facility configuration changes.

Current facilities	Key facility and associated service change
<b>Middlemore campus</b>	
<ul style="list-style-type: none"> <li>Acute Medicine wards</li> <li>Acute Surgery wards</li> <li>Elective surgery on high risk patients only</li> <li>Neonatal level I, II and III services</li> <li>Paediatric medical and surgical wards (Kidz First)</li> <li>Emergency Care (Adults and Kidz First)</li> <li>Assessment, Labour and Birthing Unit</li> <li>Maternity Ward (antenatal and postnatal inpatient care)</li> <li>Inpatient mental health services</li> <li>Clinical support services</li> <li>Rehabilitation wards</li> <li>Mental Health Service Older People ward</li> </ul>	<p>Two Rehabilitation wards will remain on the Middlemore Hospital site but will be within the main clinical Middlemore building in 2009. These two wards will be adjacent to an orthopaedic and a medical ward and will support a new rehabilitation model of care.</p> <p>Further incremental transfer of elective surgery cases to Manukau campus as clinical support and physician support at Manukau is enhanced.</p> <p>Closure of the MHSOP ward with development of the replacement inpatient MHSOP service at Manukau campus.</p>
<b>Manukau campus</b>	
<ul style="list-style-type: none"> <li>Elective adult surgery</li> <li>Elective daypatient surgery for children</li> <li>Clinical support services</li> <li>Ambulatory care modules</li> </ul>	<p>Increases in complexity and the ongoing transfer of elective surgery cases with predictable outcomes to Manukau as onsite clinical support and physician support is enhanced.</p> <p>Incremental growth in clinical support services to support the growing volume of services being delivered at Manukau and growing complexity of elective surgery.</p> <p>Increased utilisation of Manukau ICU to manage postoperative care.</p> <p>Development of more ambulatory care modules to accommodate additional reciprocal services increased numbers of consultations, office procedures and increased range of clinical support procedures.</p> <p>Allocation of appropriately located footprint for potential development of a Community Maternity Unit on the Manukau campus.</p> <p>Allocation of footprint for potential 60-bed Mental Health inpatient ward.</p> <p>Development of new MHSOP ward (39 beds) beds adjacent to the new Rehabilitation centre.</p> <p>Development of new Rehabilitation Centre.</p> <p>Development of new Spinal Unit with 20 beds, shared allied health and allied health gym facilities with the Rehabilitation Centre.</p> <p>Development of Spinal Alumni Gym.</p>
<b>Bairds Road</b>	
Otara Spinal Unit	Closure of the Spinal Services at Otara with all existing services transferred to the new Rehabilitation Centre at Manukau campus.
Tamaki Oranga (20 bed secure psychiatric unit)	
<b>Pukekohe Hospital</b>	
Community Maternity Unit Slow Stream Rehabilitation Outpatient facility	Additional slow stream rehabilitation beds
<b>Franklin Memorial Hospital (Waiuku)</b>	
Inpatient aged care services	Transition to short term provision of rehabilitation, respite and palliative care
<b>Papakura Community Maternity Unit</b>	
Community Maternity Unit	To be confirmed
<b>Botany Community Maternity Unit</b>	
Community Maternity Unit	To be confirmed
<b>Botany SuperClinic</b>	
Visiting outpatient service	Visiting outpatient service

## 6.0 Key Workforce Development Strategies

In mid-2007, CMDHB completed development of a comprehensive Workforce Development Plan (WDP) for 2007-2011 covering the spectrum of health services activity across the district. This plan represents the CMDHB's proactive approach towards growing and retaining a workforce that will deliver health services within Counties Manukau - both within the DHB provider arm and within services provided by the broader community.

The CMDHB WDP takes into account not only the health needs of the diverse local population, but also how CMDHB can support development of a local, national and international workforce that will be most appropriately trained to meet the needs of Counties Manukau. While the diversity observed in the local population translates into a culturally diverse workforce across the district, the composition of the workforce does not yet reflect the ethnic diversity of the local population. A major challenge for CMDHB is therefore to ensure that its workforce better reflects the community it serves.

The context in which the WDP operates is stated clearly within the Plan:

"The Workforce Development Plan has also been driven by increasing evidence that suggests that the current CMDHB health workforce will be unable to handle the demands placed on it by an ageing population with increasing demand for health services. Over the longer term (to 2021) demand for hospital services is expected to increase by 52%, while the workforce is predicted to only grow 29% over the same period (NZIER, 2006<sup>16</sup>)<sup>17</sup>.

"The reality is that CMDHB needs more people in all professions, doing things differently if it is to sustain health service provision in the future. It also needs to continue to work within the national workforce development framework already established, while continuing to push the boundaries at a local level with respect to workforce and other workforce-related innovations"<sup>18</sup>.

The WDP identifies the role of CMDHB in moderating the demand for labour, and in increasing the supply of labour. The demand for labour is very much being driven through the planning for health services where services will be transferred from one setting to another, and different roles will take on different activities to provide a skilled and flexible workforce. Increasing the supply of labour will be driven through the WDP which will take a proactive response across the district.

### 6.1 The Counties Manukau Workforce

Two major pieces of work were undertaken as part of developing the WDP:

- CMDHB Hospital Staff Census (NZIER, 2005)
- Community, NGO and Primary Care Workforce Census (NZIER, 2005)

The key themes to emerge from that research were:

- *The workforce is mainly female* - around 83% of employees in both the community workforce and the CMDHB hospital workforce are female compared to 46% for the wider local economy.
- *The workforce is ethnically diverse* - 47% of the hospital workforce classified themselves as non-European (Asians are the largest non-European group at 18%) and 53% of the community workforce.
- *The workforce is ageing* - nearly half of all hospital staff are over 40 years of age, with just under one-third aged 31-40. Compared to the hospital workforce, the community workforce comprises relatively large proportions of very young workers (<25) and older workers (aged 50+).

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<sup>16</sup> Community, NGO and Primary Care Workforce census (NZIER, 2005)

<sup>17</sup> CMDHB Workforce Development Plan 2007-2011

<sup>18</sup> CMDHB Workforce Development Plan 2007-2011

- *The hospital workforce is well qualified (70% holding degrees) - but compared to the hospital workforce, the community workforce is around twice as likely to have no qualifications or only high school qualifications.*

## 6.2 Workforce Development Trends

The more significant workforce trends affecting CMDHB are:

- Increasing competition to recruit and retain health professionals in a global market – New Zealand's unemployment rate is currently at a 30-year low
- Greater specialisation of medical professionals within a context of a shrinking supply of generalists
- Broadening of roles for nurses and general practitioners
- Increasing diversification of roles, e.g. development of Community Health Workers which can lead to longer careers in health and opportunities to upskill
- Increasing shift from full time to part time work (casualisation) and demand for increased flexibility for workers
- Increasing proportion of health professionals who are women and who are ageing
- Growing emphasis on team based functions
- The DHB operating in a highly regulated industrial relations environment within the context of national multi-employer bargaining.

## 6.3 The Workforce Development Plan

A radical shift needs to take place in order to match workforce demands with supply. It is not just about workforce numbers but "how we work". The current model is not sustainable and we need to design new models of care. Population based approaches and scalability of care are going to be crucial influences on how we balance workforce demands with providing appropriate levels of care. The role of self management and workforce competencies to support this is going to be significant.<sup>19</sup>

Work has been done to identify key workforce gaps – they tend to be large, to some degree quantifiable, and cut across most services and occupations. To make a difference to health status, we need to target key services and occupational groups. Health services need to look at how good people are recruited and retained. Better use of health professionals as promoters of health sector careers and workforce development is also important.

The six priority workforce outcomes for the term of the CMDHB Workforce Development Plan are:

1. Organisational infrastructure supportive of workforce development and innovation
2. Increased workforce supply at entry level
3. Stronger relationships with tertiary institutions to provide fit for purpose workforce
4. Recruitment and retention of skilled workforce
  - a) Attract, recruit and retain workforce across the provider arm
  - b) Increase sector workforce in DSP priority areas to support capacity of the community health sector
5. Career development that promotes multiple entry points/pathways for health professionals (provider arm and community health care sector)
6. Reduced demand for labour through demand-side activities

The Workforce Development Plan summary table (contained as an appendix in the WDP) identifies desired workforce outcomes and actions for implementation by CMDHB. This is a whole of society approach with goals of the WDP operating at several levels:

- Nationally, to address systemic issues (e.g. education), improve inter-agency coordination, drive sustainable workforce development, and ensure that national policy settings support local initiatives;

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<sup>19</sup> Workforce Development Plan, CMDHB 2007-2011

- Regional leadership to ensure that where appropriate DHBs and other Non-Government Organisations (NGOs) and community-based organisations work together to find solutions and implement national plans; and
- Local leadership within the DHB, from funders and planners to service managers, clinical leaders and HR, to support workforce initiatives that are best addressed at a local level.

To effect sustainable workforce change we need to be cognisant of market dynamics and the broader labour market in which CMDHB operates; therefore a systems approach is important. The DHB could rely solely on market dynamics and central government policy and initiatives, but this is not CMDHB's approach. Instead this DHB is taking a proactive approach and is actively involved in local workforce development.

Addressing workforce issues across the range of activities outlined above is a major contribution that CMDHB can make to reducing health inequalities in our community. By attracting and retaining a workforce that reflects the community we serve we will not only contribute to improving the health status of those with the greatest need, but will also help to raise the living standards of families within the Counties Manukau district.

## **7.0 The Way Forward**

### **7.1 Facility Planning**

Completion of facilities planning relies on work done concurrently or following the development of the HSP – particularly volume and facility modelling (e.g. bed, theatre modelling and ambulatory facility modelling), system and process redesign, masterplanning, financial planning, and workforce planning.

Facility masterplanning cannot be effectively accomplished without knowledge of service scope (volume and complexity level), appropriate co-locations and service synergies, and knowledge of existing lifespan of organisational infrastructure. It needs to be informed by out-year volume and service requirements to create suitable “redundancy” in construction through informed location of departments and the identification of “soft space”. Masterplanning needs to provide future options for construction in the event of significant variation from volume forecasts, or where there are unanticipated changes in service provision (e.g. additional services are developed or services are lost).

Effective masterplanning avoids:

- Creating units that have poor co-location for achieving effective patient flow and service delivery
- Unnecessary duplication of clinical or non-clinical support services or facilities
- Temporary departmental relocations, each with additional facility costs, before a permanent facility solution is reached
- Poor staging that drives avoidable capital expenditure (with its resultant IDCC)
- Creation of unnecessary capital expenditure with an IDCC that was avoidable with different staging
- The need for surplus capacity.

Completion of masterplanning follows identification of future Models of Care (from the HSP) and ensures that required facilities have been included.

### **7.2 A Culture of Continuous Quality Improvement**

The creation in 2007 of CMDHB's Quality Improvement Unit signalled the intention to focus on quality and safety as key ways of developing services in the future. The Unit has a mandate to build a quality and safety focus into the way CMDHB plans and provides all services and increasingly this focus will become an important precursor to physical planning for services. Planning for quality is a way of ensuring that services have redesigned the way they provide care before looking to increase the resources they require.

### **7.3 Further Service Planning**

While work on the HSP is now complete, there remain a number of areas where further detailed planning is required during 2008. These include:

- Primary maternity services
- Primary and community health services
- Community radiology
- Regional Services Planning (continued medical and surgical sub-specialty planning in association with the other northern region DHBs)
- Child & adolescent community oral health services (business case development as part of a national process)
- Smoking cessation services (part of a national process).

## **7.4 HSP Review**

A number of areas have not been expressly detailed as service workstreams but are identified as areas where additional service planning will be done at the time of the 3-yearly HSP review. Each of these services crosses several traditional service boundaries and requires multidisciplinary collaboration.

### **Obesity Services**

Obesity is a major health issue in Counties Manukau. Public Health issues related to reducing the prevalence of obesity are addressed through the "Lets Beat Diabetes" programme.

Many patients receive management of obesity-related conditions in primary or secondary care but further planning is required to coordinate this care better. Critical areas for management of morbid obesity include: access to dietetic input, assessment of suitability for surgery, pre-bariatric surgery care, bariatric surgery procedures, post bariatric surgery follow-up, and plastic surgery reconstruction following major weight loss. CMDHB will develop a service that better coordinates and integrates treatment for the morbidly obese person, and that is consistent with the national direction for the funding of bariatric surgery.

### **Transition from Youth to Adult Services**

The transition of chronic patients from Child Health services to Adult Health services creates some challenges. This is particularly the case for people with severe intellectual or physical disability where there are child and adolescent health services focused on people with these disabilities, but adult services are disparate and focused on specific clinical conditions (e.g. pressure areas, contractures, heart failure). Further work is required to develop coordinated services to assist people with complex needs to maintain their health status across all aspects of the health care continuum.

### **Incontinence**

Further planning is required to develop an integrated incontinence service involving urogynaecology, urology, physiotherapists, district nursing and incontinence specialists. Involving a number of specialties, integration is critical to maximise health outcomes within available funding, to optimise decisions around treatment versus symptomatic management, and to manage the high cost of consumables.

### **Sexual Health Services**

Currently CMDHB has a local Sexual Health plan and is engaged in an RSP process around the provision of Sexual Health Services. Services for Sexual Health are and will continue to be predominantly delivered in primary care. CMDHB will be proposing to have more Sexual Health services provided locally and will ensure closer collaboration with services provided within CMDHB in both primary and secondary care.

### **Rural Health**

Although CMDHB is a large and highly urban DHB, rural health remains an important issue for people living in the south of Counties Manukau. CMDHB is undertaking work to further work to identify specific health issues affecting people living rurally with intention of ensuring that health strategies and programmes reflect the needs of people living rurally.

### **Allied Health**

The HSP process addresses Allied Health professions in the same manner as other professional groups, i.e. as a critical component across the continuum of care within individual workstreams. In practice, Allied Health professionals with Counties Manukau may be attached to different services (e.g. orthopaedics); primary or secondary care delivery (or both); or may have a focus across the management of a specific condition that straddles several services. Like other health professions,

Allied Health has key workforce issues and opportunities and there are opportunities to work in many expanded roles in the future. These opportunities are discussed within individual workstreams in this HSP.

## **Pain Services**

Acute Pain services at CMDHB are provided as a component of Anaesthetic services. Acute Pain services are provided for inpatients/day patients with needs for acute pain management. While most of these patients are under the care of surgical speciality teams, patients may be under the care of medical specialities, or may be referred by consultation from Palliative Care.

CMDHB has recently enhanced services for Counties Manukau residents suffering from chronic pain. Outpatient services are provided to ACC or non-ACC patients at the Manukau SuperClinic with access to some selected procedures in either outpatient or day patient settings. This service is dependent on only three part-time anaesthetists and is not yet multidisciplinary. A proposed and agreed ACC Procedures Contract still awaits completion of the paperwork to commence.

An RSP process has been underway for over 2 years. It will further inform the direction of local services. In addition to evolutionary implementation of new technology and medications, this is likely to include development of a multidisciplinary chronic pain team and closer collaboration with Palliative Care services.

A start has been made (under the RSP process) to form a fully regional Complex (Chronic) Pain service by seconding CMDHB Anaesthetics staff to the Auckland Pain Clinic (TARPS) at the Greenlane Clinical Centre. Here they see mainly Counties Manukau patients who require complex multidisciplinary management not currently available at CMDHB. Also, all referrals for complex pain management of Counties Manukau patients are now triaged at TARPS for service at either Greenlane Clinical Centre or at the Manukau Pain Clinic according to the clinical need and available staff expertise.

## **7.5 HSP Implementation**

CMDHB health services planning has provided the long term strategic direction for core health services in Counties Manukau. Implementation will occur through use of the HSP to:

- Inform volume modelling, capacity modelling, facility planning and service co-locations
- Inform District Annual Plan development, and annual operational plans of service units
- Via the NSW Role Delineation Model, inform future service and facility developments by service and site, cognisant of required clinical support levels
- Inform workforce planning to ensure availability of workforce for delivering new Models of Care. This compares with the common practice of configuring services to reflect workforce availability
- Develop change management strategies, and guide service direction and funding within both the provider arm, and funder arms of CMDHB
- Review and update the CMDHB long term financial plan
- Review and update the CMDHB and Northern Region information systems strategic plans.