Waitematā
District Health Board

Best Care for Everyone

Hospital Services
North Shore Hospital Campus
Shakespeare Road, Takapuna
Private Bag 93-503, Takapuna
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Telephone: 09 489 0527

13 July 2021

[redacted]

Dear [redacted]

Re: OIA request – Planned Care Three-Year Plan

Thank you for your Official Information Act request received 29 June 2021 seeking information from Waitematā District Health Board (DHB) about our Planned Care Three-Year Plan.

You requested the following information:

Can you please send me:

- ***A copy of your DHB's Planned Care Three-Year Plan (the one that needed to be signed-off by the Ministry of Health in 2020)***
- ***The latest update on the delivery of any existing or new community/general practice-based initiatives under your DHB's Three-Year Plan.***

On 6 July, we contacted you to clarify whether the second part of your request related to our Planned Care Three-Year Plan or the wider DHB Three-Year Plan.

You replied as follows:

I was seeking the latest delivery update on the community initiatives under the Planned Care Three-Year Plan. But if simpler to provide the total DHB three-year plan, happy to have that instead.

Before responding to your specific questions, it may be useful to provide some context about our services.

Waitematā is the largest and one of the most rapidly growing DHBs in the country, serving a population of around 650,000 across the North Shore, Waitakere and Rodney areas. We are the largest employer in the district, employing around 8,600 people across more than 80 locations.

In addition to providing care to our own resident population, we are the Northern Region provider of forensic mental health services and child rehabilitation services, plus the metro Auckland provider of child community dental services and community alcohol and drug services.

In response to your request, we are able to provide the following information:

1. **A copy of your DHB's Planned Care Three-Year Plan (the one that needed to be signed-off by Ministry of Health in 2020)**

Please find attached Waitematā DHB's Planned Care Services 2020 - 2023 Three-Year Plan - **Attachment 1**.

2. The latest update on delivery of any existing or new community/general practice-based initiatives under the Planned Care Three-Year Plan or the total DHB Three-Year Plan.

The Planned Care Three-Year Plan covers our intentions for elective/planned secondary care, with a focus on improving timely and equitable access to services for our population.

The strategies are consistent with already-agreed regional activities and programmes of work. We work collaboratively with our stakeholders, including regional and national DHB colleagues and non-government organisations (NGOs), to ensure the best use of all capacity across the system to deliver more timely and equitable access to high-quality planned care services.

While the plan includes overarching ambitions to see the DHB's healthcare services delivered closer-to-home for our local communities by 2023, there are currently no formal updates or reports available regarding new community/general practice-based initiatives.

As the plan is in relation to planned secondary care, its main focus is on outpatient management and consumer co-design of services in areas such as:

- the development of a new one-stop diagnostic breast service to improve diagnosis and treatment times
- the construction of a new Special Care Baby Unit (SCBU) at Waitakere Hospital
- the completion of a ward refurbishment at North Shore Hospital
- major upgrade of our Central Sterile Service Department (CSSD)
- upgrades and building works of our regional forensic psychiatry services (Mason Clinic).

If you have specific questions in relation to the attached plan, please contact us further.

I trust that this information is helpful.

Waitematā DHB supports the open disclosure of information to assist community understanding of how we are delivering publicly funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely

[redacted]

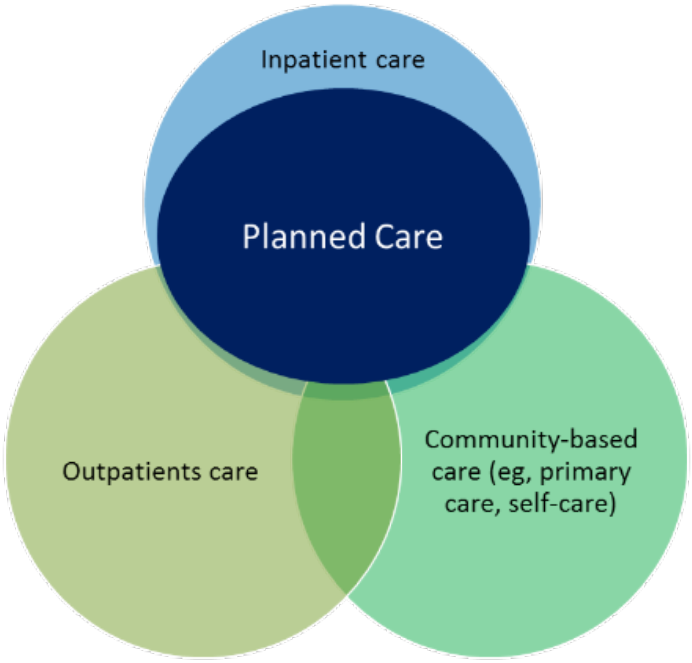
[redacted]
Executive Director Hospital Services
Waitematā District Health Board

Attachment 1

Planned Care Services 2020 -2023 Three-Year Plan

WAITEMATĀ DISTRICT HEALTH BOARD

Vision: New Zealanders experience timely, appropriate access to quality Planned Care which achieves equitable outcomes



Planned Care Principles

Equity, Access, Quality, Timeliness, Experience

Contents

Introduction

Waitematā DHB is committed to the promotion of wellness and the relief of suffering among all who use our services. Our planning and delivery of healthcare to our community supports our organisational promise to deliver "best care for everyone", with a focus on reducing health inequalities. We aim to identify and meet the needs of our diverse community through patient engagement, co-design, and partnership.

Key to the principle of partnership is our recognition of Te Tiriti or Waitangi as the foundational document of New Zealand, establishing Māori as equal partners with the Crown. We are committed to demonstrating the principles of Te Tiriti of participation, partnership and protection in all we do. The planning process has included Māori leadership and co-design.

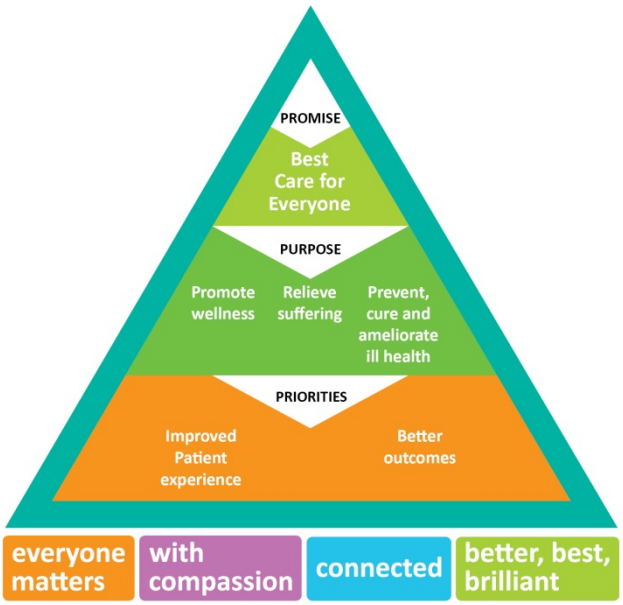
Our three-year plan is based on the principles of equity, access, quality, timeliness and patient experience. The plan delivers on timely and equitable access to Planned Care informed by our population's health and wellbeing needs following engagement with patients, their whānau and our wider community,.

Executive Summary

1. Improvement plans provided to the Ministry of Health (MoH) in July 2020 have been revised by the Provider team in collaboration with Planning and Funding to ensure alignment with local and regional priorities.
2. The three-year plan was informed by feedback from patients and whānau, including our Consumer Council. Community engagement included hui on local marae and attendance by our Pacific and Asian Health teams at community gatherings.
3. An updated Health Needs Assessment, analysis of intervention rates, and a review of models of care across services both locally and regionally form the foundation of this plan. A planning workshop bringing together 50 clinical and managerial leaders took place in July 2020.
4. Mitigation of the effects of the COVID-19 pandemic, particularly on patients living with cancer and on equity of health outcomes, is a focus of our work over the next three years. Our response to COVID-19 has included expanding innovations such as telehealth, which are expected to bring sustained benefits for patient experience and the effective use of health resources.
5. Five strategic priority areas have been identified, with detailed actions over the next three years to establish a strong foundation for improvement, build on these successes, and embed changes to transform the delivery of Planned Care to our community.
6. The strategic priority areas are:
    Priority 1: Improved understanding of local health needs, preferences, and inequities.
    Priority 2: Align local policy with national health and wellbeing priorities.
    Priority 3: Support consumers to navigate their health journeys.
    Priority 4: Optimise sector capacity and capability.
    Priority 5: Design Planned Care services to be sustainable to serve future generations.
7. Each strategic priority has identified actions, risk mitigations and governance processes. All actions are based on a framework of co-design with staff, consumers and the community.
8. A newly developed Improvement Committee will have oversight of the plan, with progress being reported monthly to the Executive Leadership Team (ELT).

Our vision and values

Our promise, purpose, priorities and values are the foundation for all we do as an organisation.



- Our **promise** is that we will deliver the **'best care for everyone'**. This means we strive to provide the best care possible to every single person and their family engaged with our services. We put patients first and are relentless in the pursuit of fundamental standards of care and ongoing improvements enhanced by clinical leadership.
- Our **purpose** defines what we strive to achieve, which is to:
  - Promote wellness
  - Prevent, cure and ameliorate ill health
  - Relieve suffering of those entrusted to our care.
- We have two priorities:
  - Better outcomes
  - Patient experience.

The way we plan and make decisions and deliver services on a daily basis is based on our **values** – **everyone matters; with compassion; better, best, brilliant** and **connected**. Our values shape our behaviour, how we measure and continue to improve.

Delivering on our strategic direction

Our strategic objectives are to achieve better and more equitable health outcomes for everyone in our community and enhance patient, family and whānau experience. We will do this by working with our communities and partners to deliver high quality, effective services that are patient focused and compassionate.

We are taking a population health perspective to improve the health of the entire population and achieve health equity for all groups, in particular for Māori. We will work with our iwi partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust, in the planning and provision of healthcare services to further Māori health gain. The establishment of the Waitematā DHB Consumer Council provides a strong voice for consumers on quality improvement and delivery of services that meet the needs of our population.

We will continue to work with our Alliance Leadership Team (ALT) to improve the integration and optimal configuration of services, to ensure patients receive more effective and co-ordinated care.

Our Institute for Innovation and Improvement (i3) supports the design and implementation of new models of care and best practice processes. An example is the increased use of teleclinics by our services.

Our ambitions for Planned Care

Overview

Waitematā DHB is committed to a programme of work to improve timely and equitable access to Planned Care services for the population of Waitematā with the outcome of best care for everyone. The purpose of best care for everyone defines how this will be achieved with the promotion of wellness through the priorities of better outcomes and patient experience.

The DHBs Planned Care Plan has been developed to:

- Develop models of care pathways that include case coordination for the complex patient, new ways of working and incorporating clinical innovation and improvement
- Improved partnerships with primary care and our iwi partners that enables care closer to home where this is clinically appropriate including increased use of telehealth, primary care pathways and community providers and facilities
- The establishment of the Waitematā DHB Consumer Council provides a strong voice for consumers on quality improvement and delivery of services that meet our population's needs.
- Enable the best use of resources and capacity across the system, ensuring that patients get the right care, in the right place, from the right people
- Address inequalities through an increased equity focus on all elements of service delivery across the planned care system
- Improve system reliability, response within the on-going COVID-19 environment
- Improve and increase communication and support to patients and whanau, placing increased value on patient's time and experiences
- Improve timely access to effective care with an increased focus on patient outcomes and patient experience
- Reduce waiting times through changing models of care that enable more patients to be assessed and treated
- Enable care closer to home where this is clinically appropriate and ensuring patients have choice including increased use of telehealth, primary care pathways and community providers and facilities
- Improve access to timely diagnostic services to enable patients to be managed within the community by primary care providers, avoiding the need for unnecessary attendances to hospital services
- Develop care pathways and services that enable patients to be managed in the community by primary care providers

Reduced access to timely care following the COVID-19 response

The year 2020 has had serious disruption to planned care and other service provision due to the COVID-19 pandemic. The DHB clinical, operational and planning resources have been redeployed to support the pandemic response. Prior to the advent of the COVID-19 pandemic and required response, Waitematā DHB had a number of on-going challenges within planned care services throughout the provider arm services which have been significantly exacerbated through the substantial reduction in assessment, diagnostic and treatment services able to be provided in the period between March and May 2020. Waiting times have substantially worsened across a range of planned care services, however following the 8 June move back to level 1 in the National Alert level, Waitematā DHB staff have been united in their

approach to ramping up our service delivery to deliver care previously deferred. This has seen Waitematā DHB deliver improved production since 1 July 2020 over the same time last year.

- **Planned Care Interventions:** In February 2020, Waitematā DHB was delivering 95% of planned care interventions and in the last week of May 2020 this had fallen to 54% of planned care intervention. While P1 and many P2 cases were completed, the Elective Surgical Centre was stood down until 8 June for regional COVID-19 capacity.
- **First Specialist Assessments (ESPI 2):** By June 15.57% of patients (1,557 people) were waiting more than four months for first specialist assessments compared with 607 patients waiting in excess of this waiting time in February 2020. In the month of June, Medical subspecialties had 5 non-compliant services out of 14 with a total number of noncompliant patients, 11. All 5 Surgical specialties across Waitematā DHB services (1,546 patients) were ESPI non-compliant.
- **Inpatient treatment discharges (ESPI 5):** By June 42.1% of patients (2,112 people) were waiting more than four months for inpatient treatment services compared with 857 patients (16.23%) waiting in excess of this waiting time in February 2020. In the month of June five out of the six Surgical specialties across WDHB services were ESPI non-compliant.
- Prior to the March impact of COVID-19 12 of 19 Waitematā DHB services were non-compliant for ESPI 2 and we were making progress towards regaining compliance across all services with 8 specialties with volumes of less than 15. The rapid introduction of Telehealth assisted the Medical specialities to maintain, and in several services regain, compliance throughout lockdown while surgical services had a clinical necessity to maintain a greater volume of face to face consultations. All non-compliant services have seen significant improvement in non-compliant volumes over the July / August period.
- ESPI 5 non-compliance across five of the six services increased by 40% over the March to June lockdown period due to Waitematā DHB having reduced theatre capacity with our Elective Surgical Centre stood up as our COVID-19 ready facility. With capacity back at normal levels production and theatre utilisation is being maximised and positively impacting our non-compliant volumes across July and August.
- **Radiology services:** The DHB has struggled for some time to provide timely access to outpatient radiology diagnostics as a result of limited capacity, on-going workforce challenges and industrial action, however the waiting times have deteriorated further during the March – June period. In June 56% of patients received access to CT within six weeks and 80% of patients received access to MRI within six weeks. Our plan to improve access to CT and MRI has been a combination of implementing additional internal sessions plus outsourcing. This has resulted in a reduction in waiting lists and over the next couple of months will result in a significant improvement in the measure of access within six weeks.
- **Endoscopy services:** Waitematā DHB has been unable to sustainably achieve the waiting time indicators for symptomatic and surveillance colonoscopy for some time. The reduction in services over the March to June period due to COVID-19 means that at the end of June 2020, only 52.7% of patients waiting for symptomatic colonoscopy and 57.9% patients waiting for surveillance colonoscopy have received their procedure within the aggregated waiting time. We remain 100% compliant within the aggregated waiting time of 30 days for urgent diagnostic colonoscopies. Our improvement plan includes adopting the newly revised colonoscopy surveillance guidelines to reduce patient demand, strategies to increase internal production, including collaboration with BSP to maximise theatre session capacity and continued outsourcing with contracted private providers to reduce our waiting lists.

How our Three-Year plan was developed

Informed by consumers

Waitematā DHB collects feedback from our patients and whānau in a variety of ways which informs the organisational strategic direction and highlights local service improvements to enhance the patient experience and achieve better health outcomes for our community. Our Patient Experience team leads the organisation in understanding and analysing patient/whānau feedback, determining strategic priorities and building staff capability to ensure we have the right capability throughout the organisation to enhance the patient experience.

Our newly appointed Māori Patient and Whānau Experience Lead also ensures an equity focus in our patient experience programme delivery. Understanding patient experience is a key step in moving toward patient-centred care. By looking at various aspects of patient experience, one can assess the extent to which patients are receiving care that is respectful of and responsive to individual patient preferences, needs and values. Several studies have shown that patient perception of 'quality of care' is primarily driven by human factors. By offering clear explanations, listening compassionately, and acknowledging patients' predicaments with empathy and caring statements, we can restore a degree of humanity to our care that will allow patients to trust that we have their best interests in mind at all times. In 2020/21 a Patient Experience Champion programme will be developed to enable expertise within all services, wards, divisions across the organisation to facilitate local improvement with co-design methodology.

Our Consumer Council was established in July 2019. In February 2020, the Council held their first strategy session in which they openly discussed how they will link with the communities they represent to bring the voices of the community to the organisation and input into key activities and service planning. In addition, they identified unmet community needs, consumer's health preferences, and inequities to be prioritised by the organisation.

The Consumer Council is made up of various ethnicities, cultures and backgrounds that reflect our community. With the Council established a year - formalised processes to participate and inform strategic planning activities of the DHB have been created to inform the three year plan for planned care, the annual plan and the Consumer Engagement Quality Safety Marker.

Other community organisations are consulted and contribute to specific service development and planning. Waitakere Healthlink organise focus groups and facilitate discussions for specific topics service development and planning. Huis are held on local marae, including the marae at Waitakere Hospital, to facilitate discussions with Māori community members with the support of our He Kamaka Waiora, (Māori Health Service). In addition, our Pacific and Asian Health teams support facilitated community events. The Consumer Council and other community organisations have highlighted the feedback loop of how their information/feedback is used to inform decision making, requires improvement in order to demonstrate positive engagement with the community in a transparent way.

We are working closely with the Northern Iwi-DHB Partnership Board to develop a Māori health equity plan that will identify and deliver health and wellbeing priorities for Māori throughout the greater region. Our DHB continues to have one of the highest life expectancies for Māori at 82.4 years. We also saw a significant boost in the number of Māori staff, rising by 14% over the last two years. Chief Advisor of Tikanga, Dame Rangimarie Naida Glavish, this year celebrated her third decade of work in the health sector and continues to be a driving force in our efforts to achieve equity. We will continue to look to her

for guidance during the implementation of exciting Māori pipeline projects that aim to further reduce inequity.

Informed by data

In order to progress the three year plan an initial review of the Health Needs Assessment was undertaken between Provider Arm Senior Management and Planning and Funding, with a number of outcomes:

- Update the Health Needs Assessment to assist with a better understanding of what is required now and over the next three years.
- Refer to the Health Needs Assessment information to assist with setting the priorities for the next three years and inform what services and resources will be required to address inequity.
- Development of the three-year plan for Planned Care will be based on a future view of population demand based on current and historical utilisation, assessment of unmet need and inequities across Waitematā DHB.

There are also a number of other areas that have been reviewed and considered to inform the three-year plan:

- Analysis of standard intervention rates to ensure where Waitematā DHB is not achieving targets, the DHB understands why and if there are identified reasons within our control to mitigate
- A review of Models of Care across services to look closely at our workforces and ways in which we may structure workforce differently to optimise capacity and capability
- Older people and their needs due to an ageing population within the catchment
- Paediatrics and the requirement for developmental and behaviour support
- Further expansion of Patient-Focused Booking across services within Waitematā DHB.

Informed regionally

The Northern region DHBs identified there was an increased risk of worsening inequalities as a result of the reduced access to primary care and specialist planned care services during the national lockdown and the COVID response between March and May 2020. As a result of these concerns a Regional Service Improvement Steering Group (RSISG) was established to oversee our equity focussed response to the planned care recovery in the Northern region. The group reports to the Northern Region Chief Executives and is supported by the newly established Māori Clinical Governance Group (Te Kāhui Arataki) and the Pacific Clinical Technical Advisory Group.

The RSISG will continue to support a range of activities that ensures the planned care response is regionally aligned and locally relevant, and this work will include a regionally prioritised and consistent approach to the use of third party provider capacity.

With the development of the RSISG, Waitematā DHB is actively participating in, the review of key clinical services that have been identified as being vulnerable with the intention that new service arrangements will enable more equitable access regionally, improved clinical consistency and will be more resilient and sustainable for all populations.

Due to widespread concerns regarding reduced Cancer registrations during the COVID-19 response, increasing waiting lists and the lack of a regionally consistent prioritisation framework within the Endoscopy and Radiology diagnostic services, the Northern Region has identified the need to prioritise regional network plans to support the post COVID-19 recovery and advance regional capacity and workforce plans to support sustainable delivery of these services in the longer term.

Informed by our capital development

It is essential to note that, while capacity can be developed through efficiency and optimising services which enable improvements in the delivery of planned care, this has natural boundaries which often relates to space. Work is beginning to build a new hospital, known as Totara Haumaru on the North Shore Hospital campus with the new facility scheduled to open in 2023, creating significant additional hospital capacity to meet the future health needs of our catchment and the broader region. This facility consists of 150 beds, 8 operating theatres and 4 Endoscopy Suites. In addition, we are also enhancing services physically across the district, including

- Design work on the E Tū Wairua Hinengaro inpatient building at Mason Clinic starts in 2020. The facility, containing two 15-bed units, will be built on part of a newly acquired 2.8ha neighbouring block that will allow further expansion of the site to meet the future needs of our fast growing population. Construction of E Tū Wairua Hinengaro is due for completion in late 2022
- A major upgrade of the North Shore Hospital-based Central Sterile Services Department (CSSD) will help us achieve maximum efficiency while providing a safe and timely service delivery for our patients. We look forward to opening the new CSSD in 2022
- Development of our Diagnostic Breast Service, into a one stop diagnosis and treatment service in one location at North Shore Hospital, thereby improving breast cancer diagnosis and treatment times while removing barriers to care for Māori and Pacific women. The newly refurbished area is due to open in January 2021
- The construction of the expanded Waitakere Hospital Special Care Baby Unit was delayed because of COVID-19 and is now due to begin in October 2020, boosting bed capacity from 12 to 18 to help meet projected regional growth by the time it opens in late 2021
- The completion of a ward refurbishment programme to improve patient and visitor experience at North Shore Hospital.

Informed by our staff

The three year plan was informed by a range of documents (see below), however it is essential that key organisational leaders have a collaborative forum to engage, discuss and coalesce information in the formulation of the plan. In July 2020 the Senior Leadership Team held a Three Year Plan Workshop.

This facilitated workshop brought together the top 50 clinical and management staff in a half day workshop to strategically develop the Three year plan. The design of the plan sets out clear one to three year horizons across the five key strategy areas in the plan. Staffs input and ownership of the plan is essential and as such the collaboration though the workshop supported the aspirations of change.

Finally, a review of local and regional strategic and operational plans, policies and other documents developed in the last couple of years that have identified a range of issues, priorities and initiatives to improve planned care services was undertaken. This included but was not limited to a review of the following:

WDHB	Regional	National
Waitematā DHB 2019/20 Annual Plan	Northern Region Service Plan, Annual Plan 2019/20 (date)	Planned Care 2020.21 Funding and Performance Policy FINAL
Draft Waitematā DHB 2020/21 Annual Plan	Northern Region Service Plan, Annual Plan 2020/21 *Draft 24 July 2020*	2020.21 CE Planned Care Letter FINAL
Iwi Partnership Board presentation, High Level Commentary, *February 2020*	Northern Region Service Design Principles, Vision and Strategies*, February 2020*	Planned Care 2020.21 Measurement Suite Technical Specifications
WDHB Pacific Navigator Reports *July 2020*	Progress towards Implementing the Auckland DHB and Waitematā DHB DNA Strategy *June 2019*	Planned Care 2020.21 Funding Information FINAL
Waitematā DHB initial review of the Health Needs Assessment	Waitematā and Auckland DHB Māori Life Expectancy Gap Report*, June 2016 (revised April 2017)*	
Demand forecasting assessment to developing a view of future capacity requirements	Waitematā and Auckland District Health Board Joint DNA Strategy, *July 2016*	
July Senior Leadership Team Three Year Plan workshop.	Cancer Diagnostics - Equity Prioritisation – Northern Region Integrated Cancer Service (NRICS) *May 2020*	
	Explicit clinical prioritisation criteria and equity - Literature Review *May 2020*	

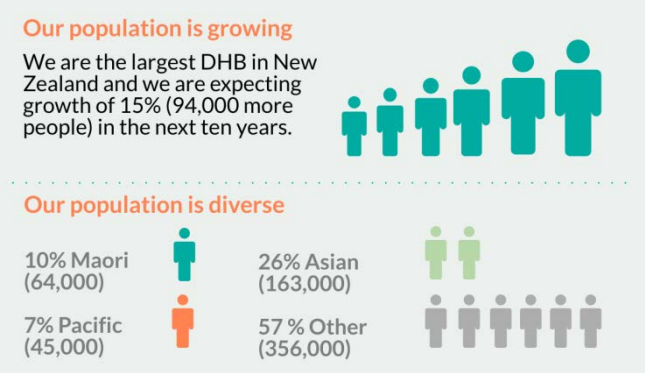
The strategies and actions identified in this plan are supported by the Waitematā DHB Senior Leadership team and the strategies dependent on regional collaboration are consistent with already agreed regional activities and programmes of work. This plan represents a range of commitments already made and being made by the DHB to improve the delivery of Planned Care services.

Our population

About Waitematā DHB

Who we are

- Waitematā DHB provides health services to the estimated 629,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest DHB in the country, and are experiencing rapid population growth.



- The age composition of Waitematā residents is similar to the national picture, with 19% aged less than 15 years, and 15% aged over 65.
- Our population is diverse. 10% of Waitematā residents are Māori, 7% Pacific, and 26% are Asian. Our Asian population is proportionally our fastest growing population, and projected to increase to 30% of the total in the next ten years.
- Waitematā's population is generally healthier than that of New Zealand as a whole. We have the highest life expectancy in New Zealand at 84.2 years (2016-18), with an increase of 3.7 years since 2001. Our obesity rates are lower than national rates, but more than half of our adults are overweight (61%) and over a quarter of our adults are classified as obese (26%) (New Zealand Health Survey 2016/17). Ten per cent are current smokers (2018 Census Usually Resident Population).

- Cancer is the most common cause of death (33%), and there are over 2,600 new cancer registrations in Waitematā every year (excludes in-situ). Cardiovascular disease (28%) and respiratory disease (8%) also account for a large proportion of deaths. Our 5-year survival rate for cancer is among the highest in New Zealand (68%) and our CVD and cancer mortality rates are also very low. There is room for improvement however, as a significant proportion of all deaths in those aged under 75 years are amenable through healthcare interventions (43% or 486 deaths in 2016).
- The boundaries of Waitematā DHB extend to Wellsford in the north and incorporates Whangaparaoa in the east, West Auckland and the west coast beaches of Muriwai, Piha and Karekare. The North Shore and Henderson-Massey are densely populated suburban areas, while the large rural areas to the north and west have a much sparser population.

- We are a relatively affluent population, with a large proportion living in areas of low deprivation. One in twelve (8%) of our total population and 22% of Māori and Pacific people live in areas ranked as highly deprived, concentrated in the Waitakere and Henderson areas. These individuals experience poorer health outcomes than those in more affluent areas.

What we do

- Waitematā DHB provides hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 sites throughout the district. Around 8,600 people are employed by Waitematā DHB.
- We have a budget of $2.03 billion in 2020/21.
- We provide child disability, forensic psychiatric services, school dental services, and alcohol and drug services to the residents of the overall Auckland region on behalf of the other DHBs. Since 2013, the DHB has been the national provider of hyperbaric oxygen therapy services.
- We contract other DHBs, particularly Auckland DHB, to provide some tertiary services, and have contracts with approximately 600 other community providers.

Assessment of priorities for improvements in Planned Care

We recognise the need for our DHB services to work collaboratively with all stakeholders including regional and national DHB colleagues and Non-Government Organisation (NGO) providers, to ensure the best use of all capacity across the system to deliver more timely and equitable access to high quality planned care services. We understand that we need to maximise the use of all physical and workforce capacity through designing and implementing new approaches to the commissioning and development of services.

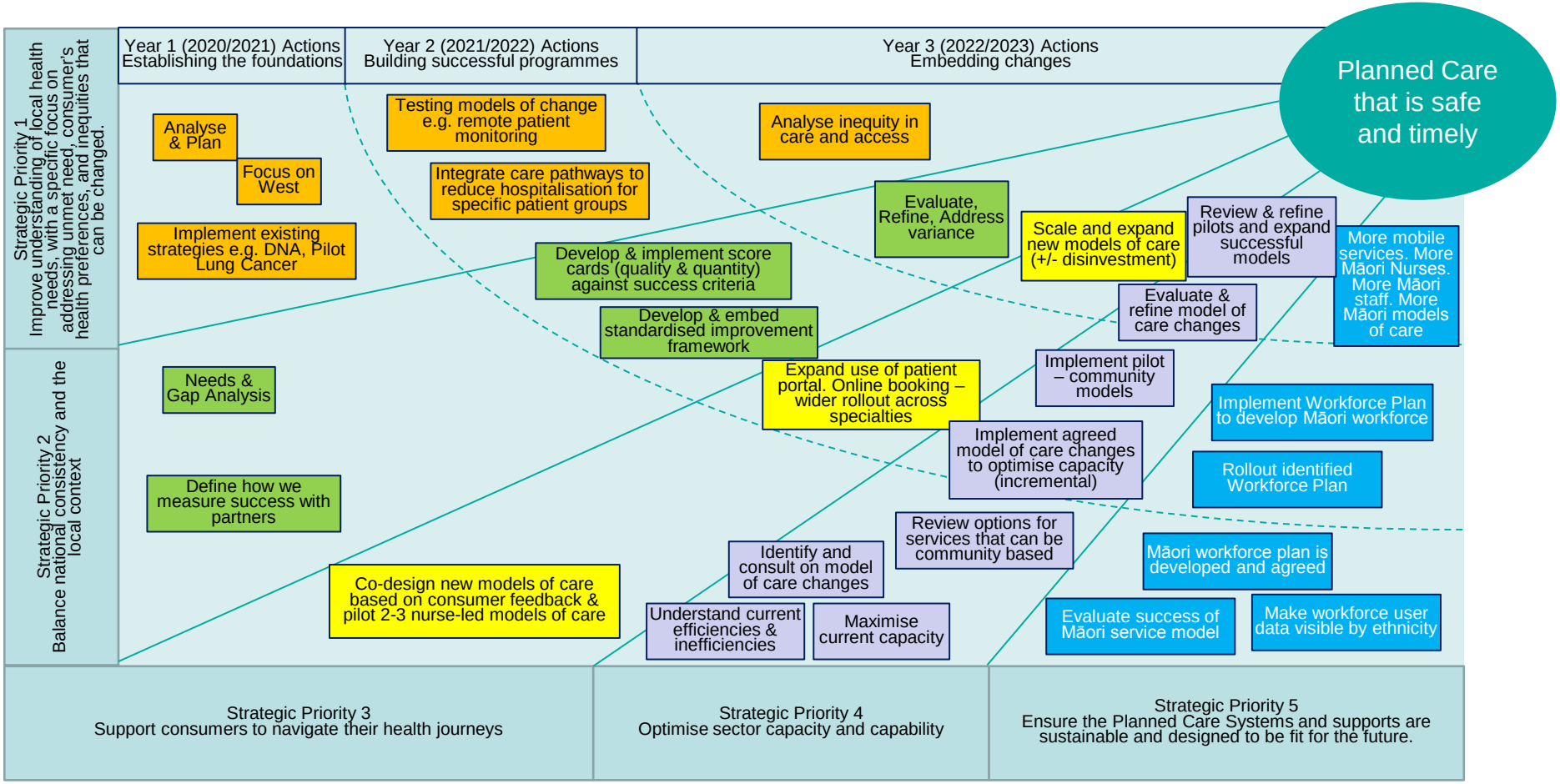
A number of activities we have described in this plan reflect the scope of work we have already commenced and are committed to develop, to address gaps and strengthen the current planned care services we provide.

As described in the 2020/21 Annual Plan, Waitematā DHB recognises Te Tiriti o Waitangi as the founding document of New Zealand. We commit to the intent of Te Tiriti that established Māori as equal partners with the Crown. The four Articles of Te Tiriti provide a framework for developing a world-class health system that honours the beliefs and values of Māori patients, that is responsive to the needs of Māori communities, and achieves equitable health outcomes for Māori.

We will routinely report progress against this plan through the Executive Leadership Team to the Waitematā DHB Board. We will formalise linkages and reporting with the newly established Māori Clinical Governance Group to ensure that the further development and implementation of strategies within this plan are appropriately informed by, and continue to respond to, the needs of Māori patients and whanau.

This plan is also aligned to the 2020/21 Northern Region Service Plan's updated Service Design Principles for the Northern Region Long Term Health Plan, which describes our vision for the future that flows from the Te Tiriti O Waitangi.

Summary of Proposed rollout for Planned Care



Strategic Priority area	*Year 1 (2020/2021) Actions* *Establishing the foundations*	*Year 2 (2021/2022) Actions* *Building successful programmes*	*Year 3 (2022/2023) Actions* *Embedding changes*
Strategic Priority 1 *Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed.*	• Analyse & Plan • Analyse inequity in care and access • Focus on West • Implement existing strategies e.g. DNA, Pilot Lung Cancer	• Testing models of change e.g. remote patient monitoring • Integrate care pathways to reduce hospitalisation for specific patient groups	• Evaluate data and assess whether sufficient gains made to be prioritised • Scale successful models of change
Strategic Priority 2 *Balance national consistency and the local context*	• Needs and Gaps assessment analysis • Define how we measure success in partnership with services • Actions to review local, regional and national consistency in access to services • Regional actions to understand demand and capacity requirements • Consistent regional approach to support equitable use of third party capacity relevant to local DHB needs • Waitematā DHB actions to ensure local policy and practice aligns with national guidance and expectations	• Standardised improvement framework to lift performance • Develop and implement scorecards against success criteria • Regional plans move towards greater consistency for priority services and priority populations • Regional plan to support development of sustainable capacity • Regional supply agreements to support planned care improvement • Revised policy and practice implemented	• Develop and refine to move ahead and address variance • Embedding increased consistency • DHB investment in physical and workforce capacity aligned to regional plan • Longer term supply agreements enable cost effective use of available capacity • Continuous monitoring to confirm alignment to policy • Service gaps visible and regional planning provides response
Strategic Priority *3* *Support consumers to navigate their health journeys*	• Co-design new nursing models of care based on key themes from patient feedback • Co-design a Patient Call and Telehealth • Pilot new model of care e.g. Anaesthetic 1 stop clinic • Establish online booking and patient kiosks • Design and test patient portal solutions including integration of	• Evaluate, iterate and scale • Expand online booking • Expand use of patient portal • Expand scope of Patient Call and Telehealth Centre • Implement and scale successful MOCs • Implement Patient pathways designed by Māori for Māori • Co-design of improvements identified and prioritised by patients and whānau • Expand electronic options to replace paper-	• Refine, evaluate and monitor outcomes • Realise benefits of new models • Look for disinvestment opportunities → financial savings

Strategic Priority area	*Year 1 (2020/2021) Actions* *Establishing the foundations*	*Year 2 (2021/2022) Actions* *Building successful programmes*	*Year 3 (2022/2023) Actions* *Embedding changes*
	patients' portals with the hospitals' Clinical Portal • Pilot 2-3 nurse-led model of care using existing resource → evaluate • Build business cases – engage stakeholders in our kaupapa • Patient pathways designed by Māori for Māori	based patient information • Test integration of GPs' PMS with Clinical Portal	
Strategic Priority 4 *Optimise sector capacity and capability*	• Understand current efficiencies and inefficiencies • Identify and consult on model of care changes • Maximise current capacity • Review options for services that can be community based • Develop and test telehealth hubs in the community	• Implement agreed model of care changes to optimise capacity (incremental) • Implement pilot – community models • Implement a structured, ongoing leadership programme • Embed teaching and education programmes in surgical services • Scale community telehealth hubs	• Evaluate and refine model of care changes • Review and refine pilots and expand successful models including OT team model • Implement skills based assessment and portfolio based management • Align education across all surgical disciplines • Implement a structured
Strategic Priority 5 *Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future.*	• Make workforce and service user data visible (i.e. by ethnicity) • Develop and agree Māori workforce development plan • Change HR structures to be inclusive and aligned • Educate non-Māori to understand the obligations to the Treaty • Test Māori designed models of care across services • Evaluate the success of Māori service models • Make commitment to Māori visible in the community • Develop and implement integrated production planning	• Target and track trajectory • Build Māori workforce capacity in every service • Continue to scale and change services to Māori MOC • Adapt existing measures to evaluate Māori models rather than continuing with current measures • No variation in length of time to treatment for Māori and Pacific patients • Reduced gaps in NPF data and data available informs on-going service improvement results	• Continue to grow Māori Workforce • Progress to more mobile / local service models

Strategic Priority area	*Year 1 (2020/2021) Actions* *Establishing the foundations*	*Year 2 (2021/2022) Actions* *Building successful programmes*	*Year 3 (2022/2023) Actions* *Embedding changes*
	systems • Standardise systems and processes including booking and scheduling; threshold criteria for access to specialist services • Confirm governance structures and leadership roles in outpatients and surgical services		

Note: Actions requiring a Regional approach highlighted with teal cells, progress and timelines dependent on regional engagement and prioritisation of activities

Strategic Priority #1 Understanding health need: both in terms of access to services and health preferences, with a focus on understanding inequities that we can change

Priorities	Actions	Risks	Year 1	Year 2	Year 3
1. ***Closing the ethnicity life expectancy gap***	• Māori – Lung cancer screening pilot • Pacifica – Endometrial cancer improved detection and prevention • Improved diabetes care • Reduced smoking in Māori esp women • Reduce stroke risk and improve outcomes in Pacifica	• Funding for pilot – some reliance on research grants • Suboptimal engagement with community and primary care	• Readiness to undertake lung cancer screening pilot – trial design, ethics, funding etc • Co-design approaches to endometrial cancer in Pacifica women	• Undertake pilots • Analyse opportunities for improved stroke/cardiovascular preventive models	Complete pilots, evaluate data and assess whether sufficient gains made to be prioritised as BAU (pre-specified gains will be agreed as part of the research design)
2. ***Improved access to services for key populations – West Auckland and remote rural***	• Develop/enhance community hubs • Telehealth solutions – build on current implementation • Mobile solutions – "bus" • Novel models in marae and other community centres	• Funding models do not align with novel care delivery pathways • Underpinning IT booking systems do not support telehealth choice	• Evaluate success of existing initiatives (Māori nursing mobile 'bus'). • Extend coverage and scope of existing mobile/telehealth strategies through co-design	• Continuation of year 1	
3. ***Equity of access to diagnostics and OP care***	• Implement the agreed DNA strategy • Focus on Radiology and Endoscopy for Māori-Pacific access and waiting times	• Inadequate resources to implement the strategy • Clinical resistance to ethnicity-based prioritisation processes	• Define highest need target populations to commence DNA strategy roll out and commence • Further analyse inequity in diagnostics – cumulative waiting, potential impact of prioritization of Māori--Pacific patients	• Assess success of DNA strategy implementation (% drop in DNAs) • Iterate and refine strategy as required	
4. ***Integrated models***	• Focus on CHF – link	• Suboptimal	• Design and pilot	Implement integrated	

Priorities	Actions	Risks	Year 1	Year 2	Year 3
of care for long-term conditions	between primary – secondary and subspec, and diabetes (see 1.) • Develop and test remote patient monitoring (RPM) model of care for CHF and Renal patients • Community options for planned rehabilitation • Musculoskeletal Orthopaedic Pathway	engagement with community and primary care • Inadequate resources to implement	community-based integrated care strategy for CHF care in West Auckland (link to 2.) • Pilot RPM model of care for CHF and Renal patients	MOC for CHF patients	
5. Frail elderly	• Enhance existing KARE model, RACIP and implement ARCHIP (ARC support) • Expand ortho-geriatric model of care to improve safety efficiency and person centred care. • Support for Advanced Care Planning including shared electronic solution		• Expand the ortho-geriatric model of care to improve safety efficiency and person centred care. • Ensure length of stay reductions in acute orthopaedics, create capacity for elective planned care	• Ensure patients are managed on an appropriate pathway to maximise their care. • Develop plan for implementation of perioperative geriatric model of care	• Monitor and manage • Implement perioperative geriatric model of care

Strategic Priority #2: Balancing national consistency and local context: Ensuring consistently excellent care, regardless of where you are or where you are treated

Priorities	Actions	Risks	Year 1	Year 2	Year 3
1. Equitable access to care (geographical, ethnicity, age)	• Understand the gaps through needs assessment analysis • Telehealth service to provide technology for patients	• Risk – who determines the need? • Mitigation – • Risk – create new equity gap (technology) • Mitigation – Telehealth hubs	• Monitor and manage % of appointments via Telehealth • Telehealth available for all services (not just med / surg) • Review of available sub specialty thresholds		Ensure focus on reducing delays, improved timeliness and increased access to planned care services and evident in key metrics including PROMS,PREMs, and waiting times across pathways
2. Deliver 24/7 care	• Integrated model of care	• Risk – workforce • Risk – Unclear parameters • Mitigation – co-design	• Sustainable plan to change or increase workforce • Co-design and develop measurement approach	Weekend Operating Theatre sessions and evaluate ability to deploy three operating sessions per theatre per day.	Prioritise services to be enhanced to ensure seamless service delivery 7 days per week.
3. Identify and strengthen areas of excellence	• Understand the enablers	• Risk – not all enablers are transferrable • Risk – quiet services (not aware of strengths) • Mitigation – systematically look for the areas of excellence • Mitigation – use health intelligence to benchmark best practice	• Develop KPI scorecards • Identify models of excellence which can be replicated to enhance other services	Utilise innovation and research to inform and strengthen areas of excellence	Reduce variation and ensure consistent delivery of care and outcomes

Priorities	Actions	Risks	Year 1	Year 2	Year 3
4. ***Increased consistency and reduced variation in services provided to the Waitematā DHB population***	Review and align access criteria and clinical thresholds regionally	**Risk:** DHBs unable to afford additional funding to align clinical thresholds **Mitigation:** Inequities identified through regional stakeholder forums to enable timely prioritisation of additional funding within annual planning cycle	Regional visibility of clinical thresholds and able to identify services where inequitable access for priority populations and all DHB population requires changes to thresholds	Regional agreement to align thresholds in priority services leading to reduced variation in access	Equitable thresholds achieved for Northern region population
	Regional reporting framework established to enable monitoring of waiting times to support equitable access to capacity	**Risk:** Data systems limit ability to obtain key data from all DHBs consistently and concerns re data privacy **Mitigation:** Chief Information Officers support development of regional reporting	Regular reporting of waiting lists by DHB including ethnicity data informs decision making re prioritisation of local and regional capacity	Data informs flexible use of regional capacity to support equitable access to planned care services	Patients receiving access to planned care services equitably regardless of domicile
	Review Standardised Intervention rate data at ethnicity level to identify services requiring increased priority to achieve equitable access for ADHB population and specifically for Māori and Pacific patients	**Risk:** Lack of clinical and service support to implement revised prioritisation criteria **Mitigation:** Executive and Directorate leadership of equity focussed clinical prioritisation	Clinical services identified that require a change to prioritisation processes to address unequal access Changes implemented to booking and scheduling practice	Reduced variation in rates of intervention by ethnicity able to be measured	More equitable access to interventions evident in reporting
5. Regional governance and planning arrangements in place to support equitable access to Planned Care	Establish Northern Region Planned Care network to monitor access and work collectively to address inequitable rates of access regionally	**Risk:** Local DHB priorities limit ability to align rates of access regionally **Mitigation:** Regional Executive Forum endorse regional actions that increase equitable delivery of services for Māori and Pacific populations	Northern region Planned Care network in place and work plan priorities established Key service gaps identified and work initiated to review regional options to reduce inequities	New service pathways established to support flexible use of regional capacity where inequalities identified are unable to be addressed by usual DHB of service	Regional processes in place to respond to changing capacity and provide alternative options to maintain equitable access to care for Northern region population

6. ***Regional planning to maximise the use of all provider capacity across the system***	Develop regional demand and capacity plan for Radiology services	**Risk:** Lack of coordinated and aligned regional approach to capacity planning leads to delays in increasing capacity and competing investment priorities regionally **Mitigation**: Regional Radiology network is supported by Regional Executive Forum to deliver single regional plan	A regional demand and capacity plan is established that identifies timing of additional capacity and investment needed that is endorsed by the Regional Executives Forum	Replacement and investment plan included in regional and local capital plans	Capacity changes are implemented as per the approved plan
	Establish regional approach to contracting use of third party providers for diagnostic and treatment services	**Risk:** Local autonomy and existing supply agreements limit ability to align regional procurement of clinical services **Mitigation**: Regional procurement strategy endorsed by Regional Executives	Regional Procurement plan for diagnostic and, treatment services and other capacity established Progress implementation of regional procurement processes as local DHB capacity plans approved and regionally consolidated	More supply agreements are procured regionally and longer term agreements provide increased and commitment to enable better pricing	Implementation of longer term agreements of regional scale leads to increased affordability of use of private capacity

Strategic Priority #3: Simplifying pathways for service users: Providing a seamless health journey, with a focus on providing person-centred care in the most appropriate setting

Priorities	Actions	Risks	Year 1	Year 2	Year 3
1. Act on data from engagement with consumers	• Analyse data and develop objectives via co-design • Embed Consumer Council as part of the governance structure for organisation • Enhance current feedback mechanisms for Māori and Pacific • Development and implementation of organisational wide Patient Experience Champion Programme – ensuring right capability at the right level to deliver positive patient experiences • Improve quality of recommendations from patient/consumer feedback and embed feedback loop with staff and patients/consumers of improvement outcomes • Monitor actions and outcomes	• Clinician/service driven rather than patient driven decision making • Resource available to progress and invest in action • Lack of staff engagement	• Outline process for Consumer Council to be embed within organisation governance • Promote Consumer Council throughout the organisation • Māori and Pacific engagement activity to explore current feedback mechanisms and current gaps in understanding Māori & Pacific Experiences • Develop Patient Experience Champion Programme • Develop and implement staff feedback management training module	• Accountability process for actions from Consumer Council discussions/direction • Recommendations for new mechanisms to provide a voice for Māori and Pacific patients. • Pilot patient experience champion programme on up to six wards or services. • Enhance feedback tracker to include: increased accountability for recommendation implementation, engaging consumers in solution generation and feedback loop	• Increased awareness of Consumer Council activity within organisation. • Consumer Council embedded into decision making/governance • Consumer Council has oversight of all consumer engagement activity throughout organisation. • Mechanisms for Māori and Pacific patient voices in place with regular meaningful engagement activities and an increase in feedback • Evaluation of feedback system, feedback management training and feedback resolution process
2. Develop and improve service pathways that work for consumers	• Identify alternative pathways: liaise with primary care, other DHBs and NGOs including:	• Funding / competing priorities • Lack of clinical buy-in/engagement	• DNAs are reduced • Advanced practice nursing in place across all sector / pathways	• Pilot co-design programme within six wards or services with specific programmes of	• Completion of six co-design programmes • Train the trainer

Priorities	Actions	Risks	Year 1	Year 2	Year 3
	• MSK orthopaedic pathway • ORL endoscopic largyngoscopy in the community • Increase nurse specialists working to the top of their scope • Development and implementation of organisational wide Co-design Programme to actively promote engagement with service users and other relevant stakeholders to co-design improvements in Planned Care. • Patient pathways designed by Māori for Māori • Complete an organisation-wide health literacy assessment process to gain a baseline for health literacy performance and gap identification; develop Action Plan based on identified gaps • Patient centred waitlist management communication protocols developed for all clinics • A revised outpatient letter and text message template will be developed and implemented to ensure they can be understood, are accessible, and support equity objectives. • Increase level of consumer		• Develop an endorsed Co-Design Programme for Waitematā DHB • Health Literacy steering group re-established • Completion of organisation-wide health literacy assessment, base line identified. • Identify current consumer challenges with specific clinic waitlist management process • Complete journey mapping of the outpatient communication process to identify current challenges and service communication gaps • Development of action plan with Regional Medication Safety and Patient Experience working group • Implement bladder cancer testing to establish urothelial cancers, to reduce the need for secondary care assessments and referral to cystoscopy	improvement/service redesign • Gap analysis and health literacy improvement plan developed and priorities identified • Co-design solutions and communication protocols to enhance patient experiences with services • Co-design solutions with consumers to enhance outpatient communication • Identify services with limited consumer engagement and/or committees/groups that require consumer representation • Create training programme for staff in working with consumers effectively • Create a network of consumers that are supported with training to enhance their consumer engagement experience • Create pathways to enhance communication between inpatient and community pharmacists. • Co-design information about specific	programme of co-design methodology introduced • Key priorities show improvement from baseline with specific intervention • Evaluation of co-designed solutions and expand to other services. • Evaluate solutions and create specific protocols for all outpatient communication • Increase level of consumer engagement through membership on committees and an evaluation of their effectiveness with influence and participation.

Priorities	Actions	Risks	Year 1	Year 2	Year 3
	engagement across the organisation. • Enhance patient/consumer understanding of new medications and their side effects. • Progress DNA improvement programme recommendations			medications in partnership with Health Navigator	
3. Use technologies that support patient-centred care	• Expand telehealth • Develop a Patient Call and Telehealth Centre • Online buddy • Develop patient portal solution • Expand electronic options to replace paper-based patient information • In partnership with the Consumer Council and other stakeholders - co-design a new website design to enhance communication with our community	• Resource available to progress and invest in action	• Patient portal solution designed and tested • Scope and investigate current challenges with Waitematā DHB with the Consumer Council and other stakeholders – to provide accessible information to the community • Expand electronic options to replace paper-based patient information	• Expansion of patient portal solution • Patients are booking online (measure: % appointments booked online) • Co-design and publish new website for Waitematā DHB within resource allocated	• Evaluate the website with the community and other stakeholders.

Strategic priority 4: Optimising sector capacity and capability: Optimising capacity, reducing demand on hospital services and intervening at the most appropriate time

Priorities	Actions	Risks	Year 1	Year 2	Year 3
1. ***Understanding our efficiencies and inefficiencies within the system***	• Improvement processes to ensure services are optimised • Eliminate inefficiencies and move to expanding working hours to increase capacity • Ensure good governance in service delivery and measurement of efficiency • Monitor actions and outcomes • Refurbishment and workflow redesign in clinical spaces	• Risk – workforce agreements / lack of FTE • Risk – Facilities within 3 year plan • Current physical capacity • Budget availability	• Using our metrics to inform change and to maximise efficiency of services (use what we have 100%) • Review production planning capability for CT and MRI, with the objective of better informing the need for internal capacity change and the need for outsourcing • Surgical pathway optimisation including –theatre schedules- OT flows and utilisation- anaesthetic pre op assessment to be a 1 stop clinic • ORL endoscopic largyngoscopy assessment in the community • Outpatient clinic optimisation including- patient centred bookings- OPD production planning- clinic flow/paperless clinics-patient & GP	• Clear definition of what is “in” and “out” of scope for catch up activity year 2 • Embedding optimisation practices achieved in year 1 • Continue to develop Waitakere Hospital infrastructure for defined casemix	Commissioning of funded capacity Totara Haumaru, the new clinical services building on the Nth Shore campus.

Priorities	Actions	Risks	Year 1	Year 2	Year 3
			access to clinical portal • Development of a medical pathway for chronic osteoarthritis cases (MSK orthopaedic pathway) • Review capacity at Waitakere Hospital and identify most appropriate casemix for increasing utilisation and activity Look to optimise Endoscopy service delivery with implementation of revised surveillance guidelines • Refurbishment of clinical spaces (Orthoapedic clinics; Women's Health)		
2. Model of care - internal and external	• Develop private practice principles • Public vs private sector work • Redefine medical models of care for new multi- year program of work • Ensure resources are aligned to priorities • Ensure good governance in service delivery and measurement of	• Lead time to unpack models of care and redesign these ensuring "fit for purpose" • Ability to liberalise resources	• MOC review for rehabilitation to ensure flow and capacity for planned activity • Establish effective outpatient management pathways and clinics for patients with heart failure and monitor the impact of this on their readmission rate • Utilise both General	Identify secondary services that can be provided locally and engage with tertiary providers to localise models of care	Further development of local delivery model to include care in non-hospital settings

Priorities	Actions	Risks	Year 1	Year 2	Year 3
	efficiency		Medicine and cardiology resources to support and further develop the chronic heart failure management system/clinics • Complete the Elective Surgical Centre Review to better understand the drivers of efficiency to deploy as "learnings" to other surgical units within the DHB		
3. Take the services to the people	• Hospital in the home • Tech and mobile services • Improve community systems that are already proven e.g. OPIVA • Remote patient monitoring (RPM) • Ensure good governance in service delivery and measurement of efficiency • Monitor actions and outcomes	• Workforce challenges • Variation of National Alert levels affecting service delivery • Budget availability	• Review of Transfor-MED models of care to better integrate district nursing, community Allied health and medical staff in a redesigned Hospital in the Home program. (this is a 3 year plan) • Embed Telehealth practices and principals and "test change models" to ensure sustainability, including- scheduling tools - acoustic pods in clinics and community centres • Develop strategy to improve management of chronic conditions in the community	Implement new Transfor-MED models of care and ensuring outcomes are maximised Co-design community services to ensure " Fit for purpose"	Continue to implement and develop of Transfor-MED models of care and ensuring outcomes are maximised

Priorities	Actions	Risks	Year 1	Year 2	Year 3
			• Test RPM model of care in the community (CHF and Renal patients)		
4. Service redesign to increase access and provide more timely care	Review pathway for children requiring access to specialist Oral Health services and implement plan that makes better use of local and regional community and DHB capability and capacity	**Risk:** Demand exceeds funded capacity and requires additional funding, affordability of funding limits rate of progress **Mitigation:** Prioritise use of existing funding to develop new capacity and prioritise new funding to support additional capacity, including from all regional funders	New pathway developed to enable faster path to treatment Alternative capacity is available to support increased delivery of assessment and treatments for children Services provided in new locations and by other providers closer to home for local populations	Expanded local delivery and reduced waiting time to treatment All children receive assessment and treatment services within four months of referral	All children receive assessment and treatment services within two months of referral
	Implement increased	**Risk:** Physical capacity at	Implement increased	Increased delivery of	Further development of

Priorities	Actions	Risks	Year 1	Year 2	Year 3
	delivery of non-surgical cancer treatment services at local DHBs	other DHBs limits the extent to which care can be provided locally **Mitigation:** Planning for local delivery is endorsed by Regional Cancer Board and capacity prioritised by local DHB Executives	delivery of non-surgical cancer treatment services at local DHBs Increased delivery of chemotherapy and other treatment services at local DHBs for women with breast cancer Development of 2-5 year capacity plan for increased capacity to support medical oncology delivered more locally	chemotherapy and other treatment services at local DHBs for other tumour groups Increased proportion of patients receiving non-surgical treatment cancer services locally	local delivery model to include care in non-hospital settings
	Increase local provision of care for priority Paediatric Medical services to increase local access consistent with shared care models available outside the Northern region	**Risk:** Physical capacity at other DHBs limits the extent to which care can be provided locally **Mitigation:** Planning for local delivery is endorsed by Regional Cancer Board and capacity prioritised by local DHB Executives	Proposal developed to progress regional review of opportunities and priorities to deliver Child Health specialist services within local DHBs	Regional implementation plan developed and agreed	Changes to delivery arrangements underway
	Implement new model of care for regional Sleep services delivered to Auckland and Waitemata DHB populations that enables increased assessment in local and community settings and enables more patients to be seen within existing resources.	**Risk:** Change in model is not supported by clinicians resulting in delays to increase access **Mitigation:** Development of revised model let by Clinical leadership and supported by evidence of success in other DHBs	A new service model is developed that reduces reliance on inpatient assessment and increases capacity to assess and treat patients with sleep disorders	Increased provision of sleep services more locally to the population Reduced waiting time for sleep assessment and treatment services Increased number of patients receive more timely access to assessment and treatment services	Increased provision of assessment and treatment services on an outpatient basis and access to the service is more timely and responsive to meet demand for priority populations
5. Alternative models of care reduce demand for surgical	Implement non-surgical pathway for patients with musculoskeletal	**Risk:** Delay in establishing pathway that is aligned to regional approach	Pathway agreed and resources identified to support implementation	Increased numbers of patient receive supportive musculo-	Reduced demand referrals for surgical management of

Priorities	Actions	Risks	Year 1	Year 2	Year 3
treatment	conditions (MSK orthopaedic pathway)	**Mitigation**: Leadership to engage in regional process to advance development of regional model	of alternative pathway to meet commitment to volume already agreed	skeletal care in a community setting care	musculoskeletal conditions amenable to non-surgical interventions

Strategic Priority #5: Fit for the future: Planning and Implementing system support for long-term funding, performance and improvement

Priorities	Actions	Risks	Year 1	Year 2	Year 3
1. Workforce reflects population	• Make workforce and service user data visible • Target workforce development for Māori health workforce • Make changes to HR structures to embed Māori engagement • Put agreements in place to drive change • Monitor actions and outcomes	• Limited ability to affect change due to industrial relations • Workforce availability	• Review and implement new service arrangements locally, regionally and nationally to improve sustainability of planned care delivery • Focus on enhancing the Māori/Pacifica scholarship program to ensure employment opportunities	• Continued development of business case proposals to support facility expansion aligned with WDHB Fit for the Future Programme and the Northern region Long Term Health Plan • Workforce planning to ensure Totara Haumaru can be commissioned on time and budget.	• Continuous engagement with local, regional and national stakeholders identifies additional service vulnerabilities for review
2. Māori Leadership Partnership	• Transfer (spread) Māori models of care to other services • Evaluate existing successful Māori models of care • Make commitment to Māori visible to the community • Monitor actions and outcomes	• The gap in life expectancy is not reduced • Limited impact service delivery	• Continue to work closely with the Northern Iwi-DHB Partnership Board to develop a Māori health equity plan that will identify and deliver health and wellbeing priorities for iwi throughout the greater region. • Provide tikanga-based strategic leadership across Waitematā DHB • Tikanga Māori ethics will be at the forefront of the Māori review process across Waitematā DHB	• Refresh the current Pacific Health action plan (2016-2020) for 2021-2025 in consultation with our Pacific communities, PHOs and representatives of Pacific providers, which includes jointly identified key priority areas to improve Pacific health outcomes.	• Commission prioritised work from the revised Plan to ensure change in impactful and at scale

Priorities	Actions	Risks	Year 1	Year 2	Year 3
			• Refresh our Asian, new migrant, former refugee and current asylum seeker health plan (2017-2019) for 2021-2023,		
3. Care closer to home	• Waitakere Hospital Master Site Planning to better define role of hospital and west Auckland community • Monitor actions and outcomes	• Physical resource limitations of the current hospital configuration • Lack of available capital to develop required infrastructure	• Review of Operation Theatre Capacity at WTH to define what casemix and services could be provided in the west. • Utilise equity data to influence site of service provision in WTH • Utilise the range of community centres in the DHB better for new Models of Care , including Site based care program eg pop up clinics	• Revise opportunities for implementation year 2 • Develop service plan for WTH to reduce load on NSH and improved access to care for those in West Auckland • Resubmit Business cases for expansion of WTH • Continue training and supporting GP's in specific needs eg, excision of skin lesions, naso-pharyngeal scoping	Continued monitoring and service development according to needs