OUR VISION FOR CHANGE

how we will transform our health system

2017–2027

HUTT VALLEY DHB

MIHI

Tihei mauri ora!
E te Atua, nāu te korōria
Te papa i waho nei, tēnā koe
Te mana whenua o tēnei rohe, tēnā koutou
Te hunga mate ki te hunga mate,
haere haere haere
Te hunga ora ki a tātou te hunga ora
Tēnā koutou, tēnā koutou, tēnā tatou katoa

Let there be life!
Glory be to the Lord
I greet the land outside
I greet the local people
I pay tribute to our ancestors/to the dead
I give thanks for those of us living
Greetings to you all

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MESSAGE FROM THE BOARD

We have developed this Strategy to support and shape the direction and approach the Hutt Valley District Health Board (HVDHB) will take over the next five to ten years in order to achieve our vision of: Health People, Healthy Families, Healthy Communities.

Our Strategy has been developed through engagement hui with whānau, patients, health professionals and service providers from our community. These groups told us we need to be more needs focused, more people and whānau focused, more responsive and more community-based.

We also need to invest early to enable lifelong wellbeing and prevent ill health, with a particular focus on maternal health and the first three years of life. In addition, technology provides a huge opportunity to support people to be well and access help when they are sick.

If we can respond effectively to this feedback, we will enable our communities to achieve their aspirations and the best possible life outcomes.

Māori as the indigenous peoples of Aotearoa have unique rights under Te Tiriti o Waitangi (The Treaty of Waitangi). Hutt Valley DHB values the Treaty and the principles of;

PARTNERSHIP: working together with iwi, hapu, whānau and Māori communities to develop strategies for Māori health gain

PARTICIPATION: involving Māori at all levels of the sector, in decision making, planning, development and delivery of health services

PROTECTION: working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

Thus, we need to pay particular attention to the health needs and aspirations of our Māori population. There are well-documented inequalities in the determinants of health between Māori and non-Māori, and these flow through to inequalities in health outcomes. Our intention is that the health care we provide, and the partnerships we develop with the wider social sector, supports equitable opportunities for Māori to attain good health and wellbeing. This will ultimately support them to achieve Tino Rangatiratanga (self-determination) and to shape their own kaupapa Māori driven development. This is core to reducing health inequalities between Māori and non-Māori.

We also need to focus on improving the health outcomes for other populations with higher health needs – Pacific peoples, people with disabilities, and people who are living in poverty. How we deliver our services is just as important as what we deliver so that everyone has the same opportunity for a healthy life.

Our intention is to be courageous, and to work alongside our communities to develop a responsive health system that is based on partnership, with an unflinching focus on the transformation we want to achieve.

Naku te rourou, nau te rourou, ka ora ai te iwi

With your basket and my basket the people will live

THE PEOPLE OF THE HUTT VALLEY

The Hutt Valley, *Te Awakairangi geographical area*, incorporates both Hutt City and Upper Hutt City. In 2016 there was an estimated 146,000 people who called the Hutt Valley home. People under 25 make up 32% of the population, while middle aged people represent 56% and therefore the bulk of the population. Population projections to 2030 show a small growth in the total population of 3,400 people, or a 2.3% increase.

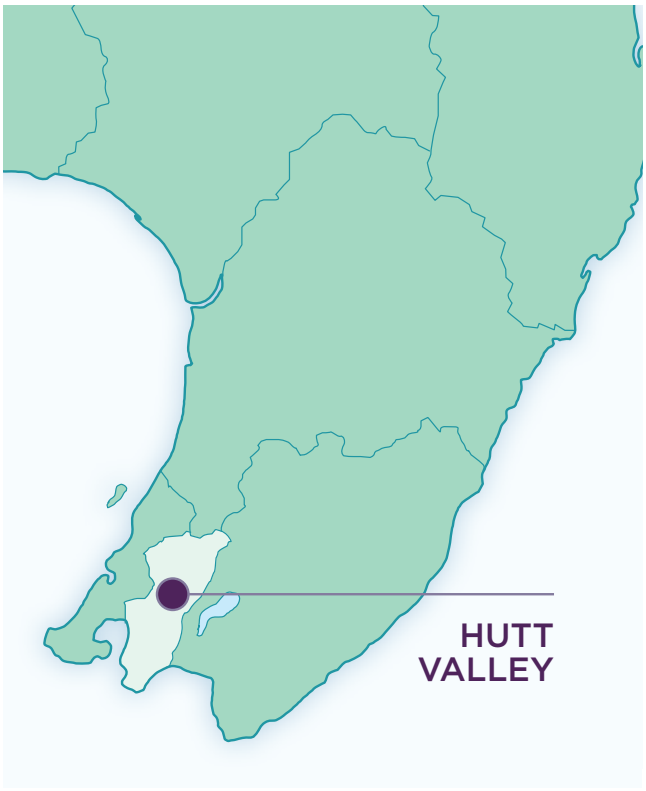
The two most notable changes that will impact on Hutt Valley DHB between now and 2030 are a significant increase in the number of people aged over 70 years, together with a decline in the number of people aged under 70 years. Forecasts suggest that by 2030 at least one in six people will be aged 70 years or over, and the population aged over 85 will increase by 70%. The number of children and young people will decrease by 10%.

Just over 17% of the population (24,060) identify as Māori. Our Māori population is younger and has higher fertility rates than non-Māori and current projections indicate significant growth in the Māori population by 2030.

Te Atiawa is the Iwi with mana whenua of Lower and Upper Hutt. We have nine marae across the community and two Whānau Ora collectives; both work across our geographical area and deliver a wide range of programmes and services with and for individuals and whānau. Our Māori population is from across the many Iwi of Aotearoa and we work to understand their whānau, hapu and iwi aspirations and needs.

The Hutt Valley is ethnically diverse; 7% of the population identify as Pacific and, like Māori, our Pacific peoples are also younger and have higher fertility rates. By 2030, almost 50% of the Hutt Valley DHB population will be Māori, Pacific and Asian, and a greater proportion of the community is likely to be living in socioeconomic deprivation if current trends continue.

There are significant variations in socioeconomic status within the Hutt Valley. The Hutt Valley DHB has an almost equal proportion of people who live in the highest deprivation areas and lowest deprivation areas. That is, 20% of people in the Hutt Valley live in the most deprived areas (Quintile 5) with 23% of Hutt Valley residents living in the least deprived areas (Quintile 1). A high proportion of individuals and whānau face a range of complex social issues that impact on their health outcomes.



FUTURE PROOFING OUR HEALTH SYSTEM

Although the Hutt Valley health system performs well, we know we are not meeting the needs of some individuals and groups, or supporting everyone to achieve the same standard of good health. Our future health system needs to be co-designed in partnership with our communities and address inequalities at every level.

When we think about the individuals and whānau who use our health system, we need to understand their needs and what matters to them, much like business seeks to better understand its customers' needs. We exist because of them and for them. Technology and the internet have changed how we think about health. Health and social services need to radically transform the way they are delivered to meet the needs and aspirations of individuals and whānau.

Our drivers for change are:

- Health inequalities across different population groups
- Our ageing population
- Long-term health issues, many of which are preventable
- Preventable illness and disease at all ages
- Increasing and complex mental health needs
- The opportunity afforded by new technology, in particular mobile technology
- Increasing pressure on our workforce, which will need to continue to adapt to changing health needs
- The need to be well prepared for emergencies and emerging challenges such as global climate change
- The reality of funding constraints.

THE HEALTH SYSTEM WE WANT

In our engagement hui, we heard common views about how our communities would like our future health system to work for them.

Our vision is that the future Hutt Valley health system will be one where:

- Care and services are organised and delivered equitably to ensure everyone has the opportunity to achieve the same level of good health
- Individuals and whānau are owners of their care and we involve them fully in decision-making about their care and how it is provided
- The majority of health services focus on prevention, and health care is provided earlier and closer to people's homes
- Urgent and complex care is readily available for episodes of ill health but the majority of health care will be planned
- Individuals and whānau experiences of health care is optimal, throughout their life span
- Services are planned and delivered in partnership with local government, the wider health, social and education sectors
- There is a clinically and financially sustainable future for our health system.

OUR PRINCIPLES FOR DECISION MAKING

We know we have the opportunity to transform our health care system and this will require investment based on need. We will be courageous in our decision-making and will work in partnership with our communities. We will work with other groups in the social sector and our neighbouring DHBs to strengthen the delivery of services that meet the needs for individuals and whānau.

We will consider the following to ensure we are making good investment decisions:

- **EQUITY**
  our decisions will support the elimination of health inequalities
- **PEOPLE-CENTRED**
  our decisions will improve individuals and whānau experiences of care and address what matters most to them
- **OUTCOMES FOCUSED**
  our decisions will improve health outcomes and wellbeing for individuals and whānau
- **NEEDS-FOCUSED**
  our decisions will be based on where the greatest need lies
- **PARTNERSHIPS**
  our decisions will increase connections between individuals, whānau, health and social services
- **SYSTEMS-THINKING**
  our decisions will benefit the health system as a whole
- **CO-DESIGN**
  our decisions will draw on the knowledge and expertise of our partners and be co-designed with them
- **STEWARDSHIP OF RESOURCES**
  our decisions will ensure we get the best value from our funding and carefully balance the benefits and costs of our investments.

OUR PRIORITY POPULATIONS

From the health needs analysis of our population, we know the extent of inequalities between groups in our population. Through our engagement hui, we identified seven priority population groups and we will work with individuals and whānau in these groups to design and deliver services that respond to their needs:

- Māori as the indigenous peoples of Aotearoa
- Pacific People
- Young children (under 3 years old)
- People living with disabilities
- Older People
- People experiencing Mental Health and Addiction illnesses
- Refugees.

OUR VISION FOR CHANGE:

how we will transform our health system


"establishing good
health as early in life
as possible and continuing
to keep people well
through the years."

STRATEGIC DIRECTION

SUPPORT LIVING WELL

WHAT DO WE MEAN?

Living well means consideration of both mental and physical wellbeing; preventing ill-health or further onset of disease by establishing good health, in its broadest sense, as early in life as possible and continuing to keep individuals and whānau well through the years. A wellbeing approach focuses on broader outcomes than just health, and considers patient and whānau outcomes in relation to safety, security, stability, wellness and development of people and communities.

A strong focus on the early years means working with individuals and whānau in pregnancy, actively encouraging and supporting healthy choices (such as immunisation, encouraging breastfeeding and physical activity), and targeting high-risk groups to advise on smoking, alcohol, unsafe sexual practices, and health screening. It means understanding the risk factors that impact life course outcomes and working with health, social and education services for a broader collective impact with vulnerable populations.

Living well will require change on the part of individuals, whānau, and health professionals; moving from a model in which individuals and whānau are passive recipients of care to a model based around engagement and active participation. Professionals will need new skills to support better self management. Technology will be required to better enable self care and people will need to be actively engaged in their care. Some will become 'expert patients' as they partner with their health care team.

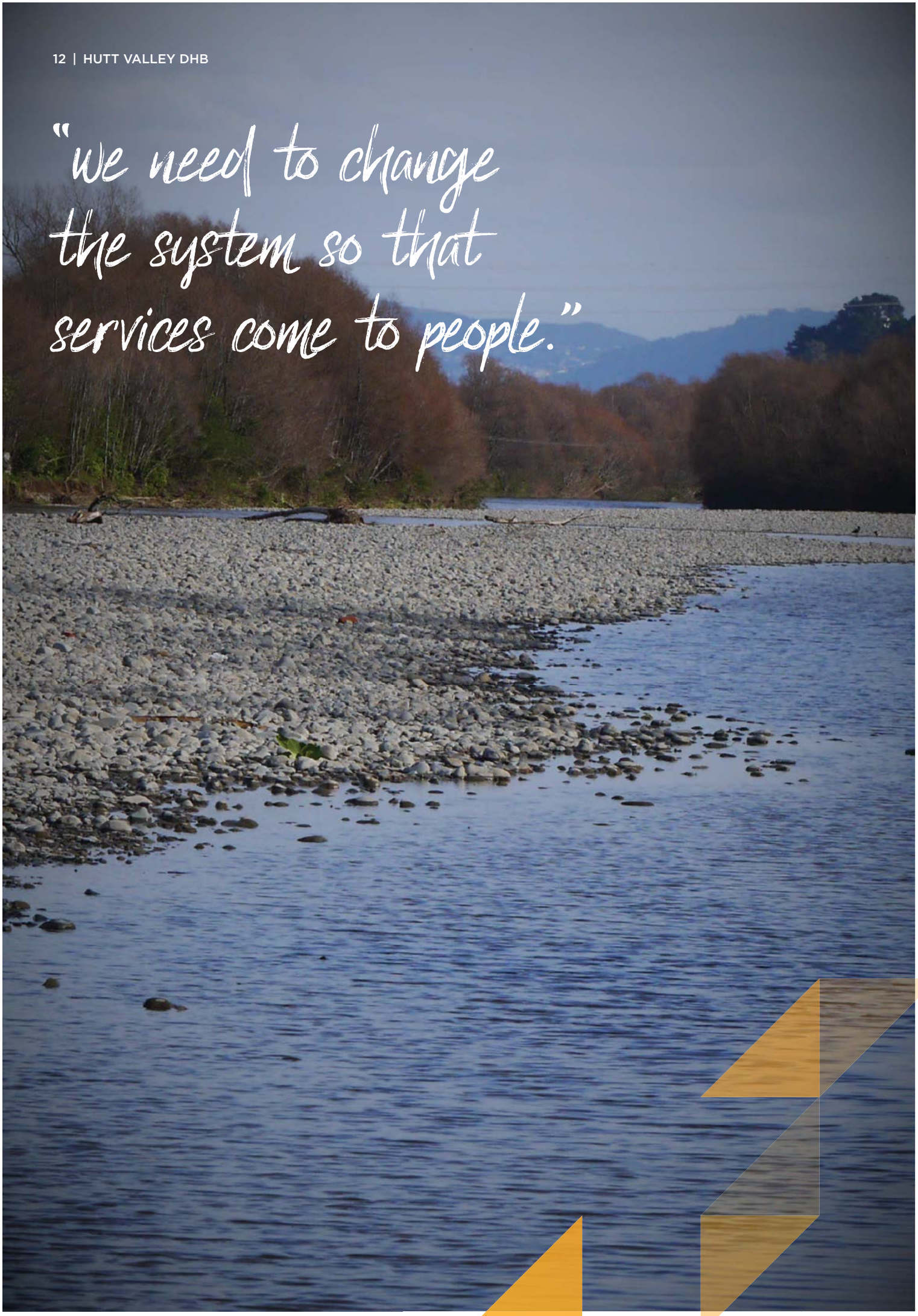
Making a shift to living well requires collaboration across a range of sectors and wider communities working in partnership as a population health system. It's not only about ensuring our people have the 'basics' – for instance a warm home to live in, a violence free home, access to healthy food to support good learning for children. It's also about focusing on the environments we create and a collective focus on system outcomes.

WHY IS THIS IMPORTANT?

We know that over a third of health loss in New Zealand is potentially preventable. The development of single and multiple morbidities is linked to lifestyle factors. We also know the first three years of life determine a large proportion of poor outcomes for individuals through the next life stages. Investment in a 'good start to life' is critical to improving health overall for generations to come. By investing in wellness; supporting, and creating the right environments for everyone to adopt healthy life-styles, we can prevent avoidable health problems. By detecting disease early, such as some cancers and heart disease, we can take actions to prevent people from dying early.

WHAT DO WE WANT IN FIVE YEARS?

- We invest in helping people and whānau to help themselves and each other keep well
- We invest in the first three years of life
- We intensify our services and approach for individuals and whānau most at risk of poor life outcomes
- We have shared goals for improving physical and mental health and wellbeing, and eliminating health inequalities across the health and social sector
- We work collaboratively with strategic partners and other sectors to create healthy environments for all


"we need to change
the system so that
services come to people."

STRATEGIC DIRECTION

SHIFT CARE CLOSER TO HOME

WHAT DO WE MEAN?

A large proportion of health care is still provided in the hospital setting. We have developed a system of care that is sometimes more convenient for the people who provide services than the recipients of that care. We need to change the system so that services come to people, community teams are truly community-based, and where possible people can receive most of their (non-complex) care within their neighborhoods or homes.

Shifting care closer to home means people could receive services either in their general practice, in community health hubs, or in the home. It means organising services around the people using them. Individuals and whānau will choose their appointment times, how and when they wish to receive services, and in what format. Enhanced primary care services should facilitate this approach alongside broader health and social sector partners.

The workforce across the system will need to work differently. Specialist services will play a much stronger consult liaison function, with community-based providers providing specialist advice where required, and supporting more complex care in the community via inter-disciplinary ways of working. Different workforces will emerge and as regulatory functions change these new teams will take on tasks that were traditionally undertaken by medical professionals. The role of nurses, paramedics, and support workers will adapt and change, providing a much broader range of services in the community. Cooperation amongst clinicians will be a priority.

WHY IS THIS IMPORTANT?

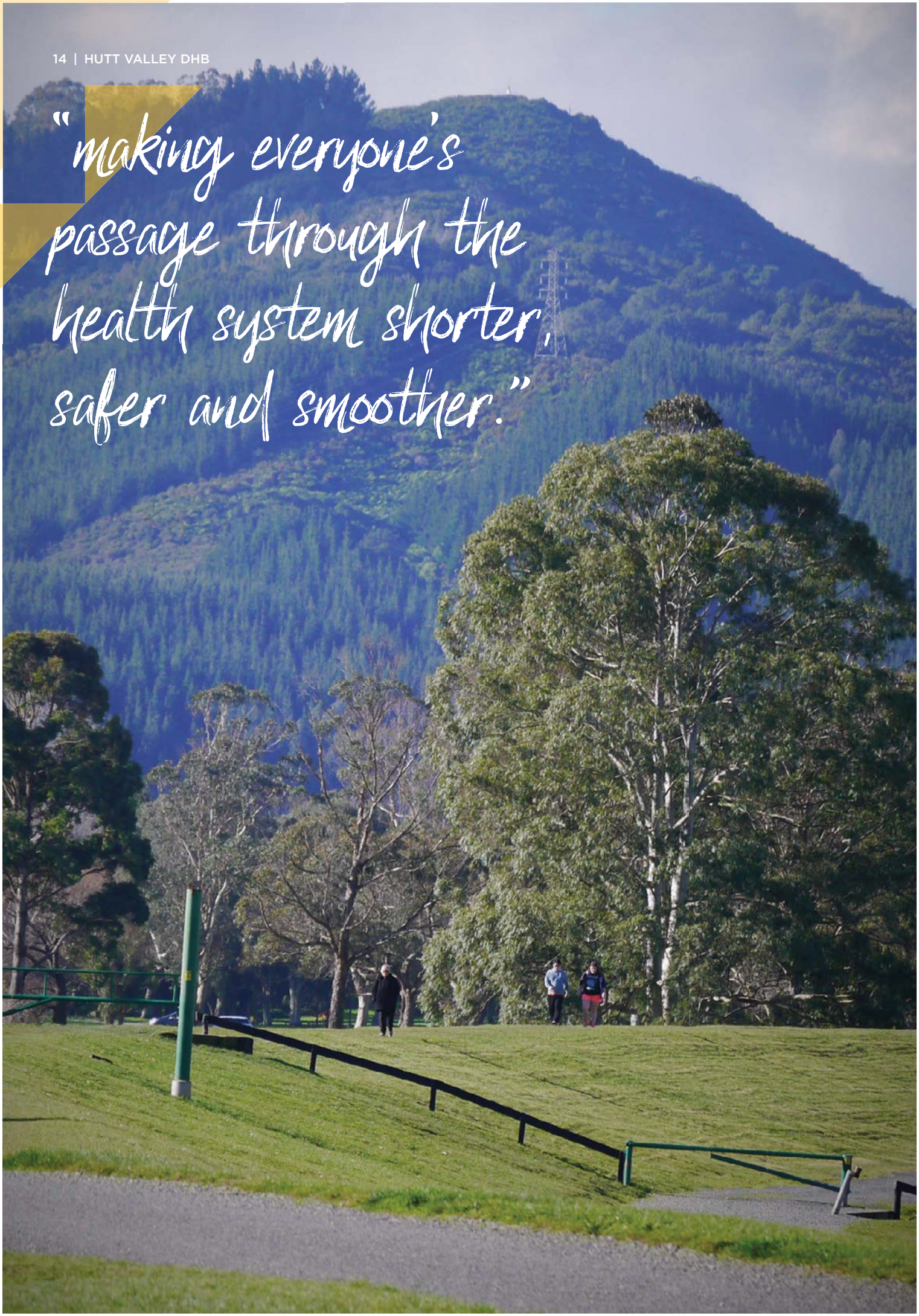
The cost of hospital infrastructure is a significant barrier to moving investment to prevention, wellness and community services closer to patients. By focusing the hospital on quality, complex episodic care, we can focus our infrastructure on a fit for purpose modern facility, and ensure our health services are sustainable long term.

Well-designed schemes that shift care closer to the home are likely to have equal or better clinical outcomes than hospital care. Patient access also increases when services are closer to home, and impact positively on the patient experience.

Where specialist services have shifted their models of care, they have been most successful when the changes have been designed to target particular populations (such as those in nursing homes or with complex health conditions); to improve access to specialist expertise in the community; to support and train staff; and address a gap in services rather than duplicating existing work.

WHAT DO WE WANT IN FIVE YEARS?

- Care is community-based ‘by default’ - services are delivered closer to people and their whānau
- Enhanced primary care functions as the ‘health care home’ of people and their whānau
- Health professionals and community providers collaborate, and work as one team to support people in their communities
- A hospital facility footprint focused on complex care and designed for contemporary models of care


"making everyone's
passage through the
health system shorter,
safer and smoother."

STRATEGIC DIRECTION

DELIVER SHORTER, SAFER AND SMOOTHER CARE

WHAT DO WE MEAN?

Making everyone's passage through the health system shorter, safer and smoother requires responsive, accessible, high quality and timely services. Services will streamline patient care, so that individuals and whānau will spend less time waiting and being shifted from service to service. People will experience consistently high standards of care and health professionals will work off one shared care plan. Individuals and whānau won't have to repeat their story every time at each step.

Individuals and whānau will be encouraged to 'choose wisely'. They will consent to treatment options that they fully understand the risks and benefits of. Services and health professionals will support this opportunity by avoiding unnecessary tests and treatments that do not add value to care.

It also means a key role for the broader social sector. Primary health services (as the 'health care home' for individuals and whānau), will work closely with other health professionals and services to help navigate people to the appropriate health and social services seamlessly and without delay.

Those working in the health system embrace continuous quality improvement and share their learning and quality infrastructure across the system. It also means that the wellbeing of those who work within the health system is paramount. We are creating a work environment for staff that values what they do, and provides the culture for them to do their best in every way, every day to improve the quality of care and improve patient's experience of care which in turn drives improved health outcomes.

WHY IS THIS IMPORTANT?

Valuing and respecting people's time by making access to health services easy and responsive ensures a more positive experience with the health system. The available evidence suggests that measures of people's experience are clear, distinctive indicators of health care quality.

Higher staff engagement and satisfaction drives quality customer care. Clinical leadership of integrated quality improvement programs across the system minimizes unwarranted variations and complications in care and improves patient outcomes.

WHAT DO WE WANT IN FIVE YEARS?

- People and whānau can communicate with a wider range of health providers electronically
- Patients, their whānau and health professionals engage in informed conversations about treatments and interventions that add value to care
- Individualised shared care plans are built around what's important to people and whānau
- Primary and community services coordinate care across a wide range of health and social services based on a shared care plan
- All health professionals within the system engage and collaborate in training, leadership and quality improvement activities and opportunities

"people will become the 'Chief Operating Officer' of their care delivery."

STRATEGIC ENABLER

SMART INFRASTRUCTURE

WHAT DO WE MEAN?

New targeted drugs and personalised treatments, smart diagnostics, and digital technologies promise to redefine healthcare as a proactive system that everybody can tap into. The internet has the potential to make better, more individualised care available for everyone, and allow people and whānau to be more informed and more involved in their care.

People will become the 'Chief Operating Officer' of their care. They will use technology to drive their own care; making their own appointments when it suits them, self managing via telemedicine options, accessing their own data and diagnostics. Shared care plans will be the norm, with a person's full set of transactions and interactions with the health and social system in one place.

By accessing large data we can find patterns in data to pinpoint which populations we need to focus on, when, and allow us to move faster on prevention and treatment than ever before. We will have the ability to better understand and reduce variation in care, reduce errors, target interventions, and provide more advanced, personalised treatments.

Optimal configuration of services in fit-for-purpose facilities like hospitals, community clinics or mobile units means that people and whānau will have a better experience of care, with minimal delays due to bottlenecks in the workflow and better communication when services are more joined up. Hospital stays will be safer, more comfortable and result in better outcomes for complex treatments. Hospitals will be networked, with patients and their whānau receiving care in the most appropriate complex care facility.

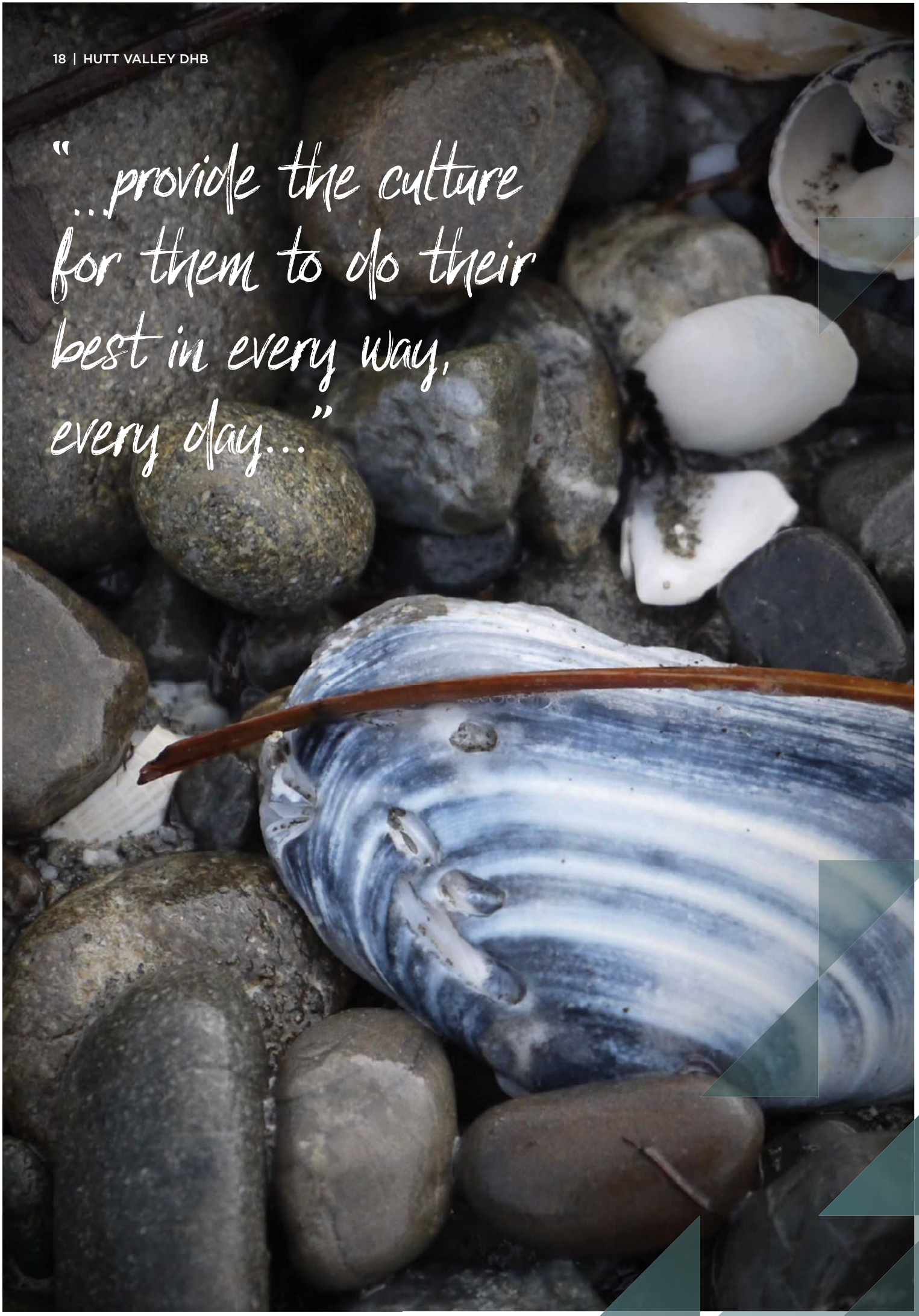
WHY IS THIS IMPORTANT?

A technology enabled health system will improve patient experience, quality of care, free up the workforce and support integration across health professionals. It will speed up care, make high quality care more consistent, and will contribute to services being taken out of the confines of the hospital walls. Technology will improve self-management capability and ultimately allow people and whānau to drive their own care. It will allow far better individualised and tailored care.

A fit for purpose contemporary facility designed for smooth workflow unimpeded by bottlenecks, enables hospital services to deliver quality, complex episodic care, and ensure our health services are sustainable long term.

WHAT DO WE WANT IN FIVE YEARS?

- A digitally-enabled health system that finds technological solutions to:
  - improved care and experience for people and whānau
  - support people and whānau to stay well with more individualised care
  - allows the patient, and those involved in the care of that patient, to share information and care plans
  - improved quality of care through better tracking of care, prompting of care, reduced variation in care, reduced errors
- Use of data to understand people's needs and drive people focused services
- A local hospital facility footprint designed for complex care, and networked with other hospital services


"...provide the culture
for them to do their
best in every way,
every day..."

STRATEGIC ENABLER

ADAPTABLE WORKFORCE

WHAT DO WE MEAN?

Professionals will need new skills to drive our strategic transformation: to support better self management, to work in multi-disciplinary teams co-ordinating care across community and hospital settings, to participate in and lead quality improvement changes, to use technology and data, and to take a system-wide view of health services and outcomes. In short, they will need to be flexible and adaptable.

All those providing services in the health system need to be technology savvy and connected, sharing information and working as one team. All health professionals will understand their roles, and work cohesively across the system to share learning, innovation and expertise.

It also means that the workforce will need to work differently to the way they do today. Different workforces will emerge and as regulatory functions change, new healthcare teams will take on tasks that were traditionally undertaken by medical professionals, allowing them to provide a much broader range of tasks and services in the community. Community support workers will take a more prominent role in supporting people and whānau, paramedics will support more planned care, and the voluntary sector will have a greater role in community support.

The wellbeing of those who work within the health system is paramount. We will create a work environment for staff that values what they do, nurtures skill development and provides the culture for them to do their best in every way, every day, with the aim of improving the quality of care. This in turn improves people's experience of care and drives improved health outcomes.

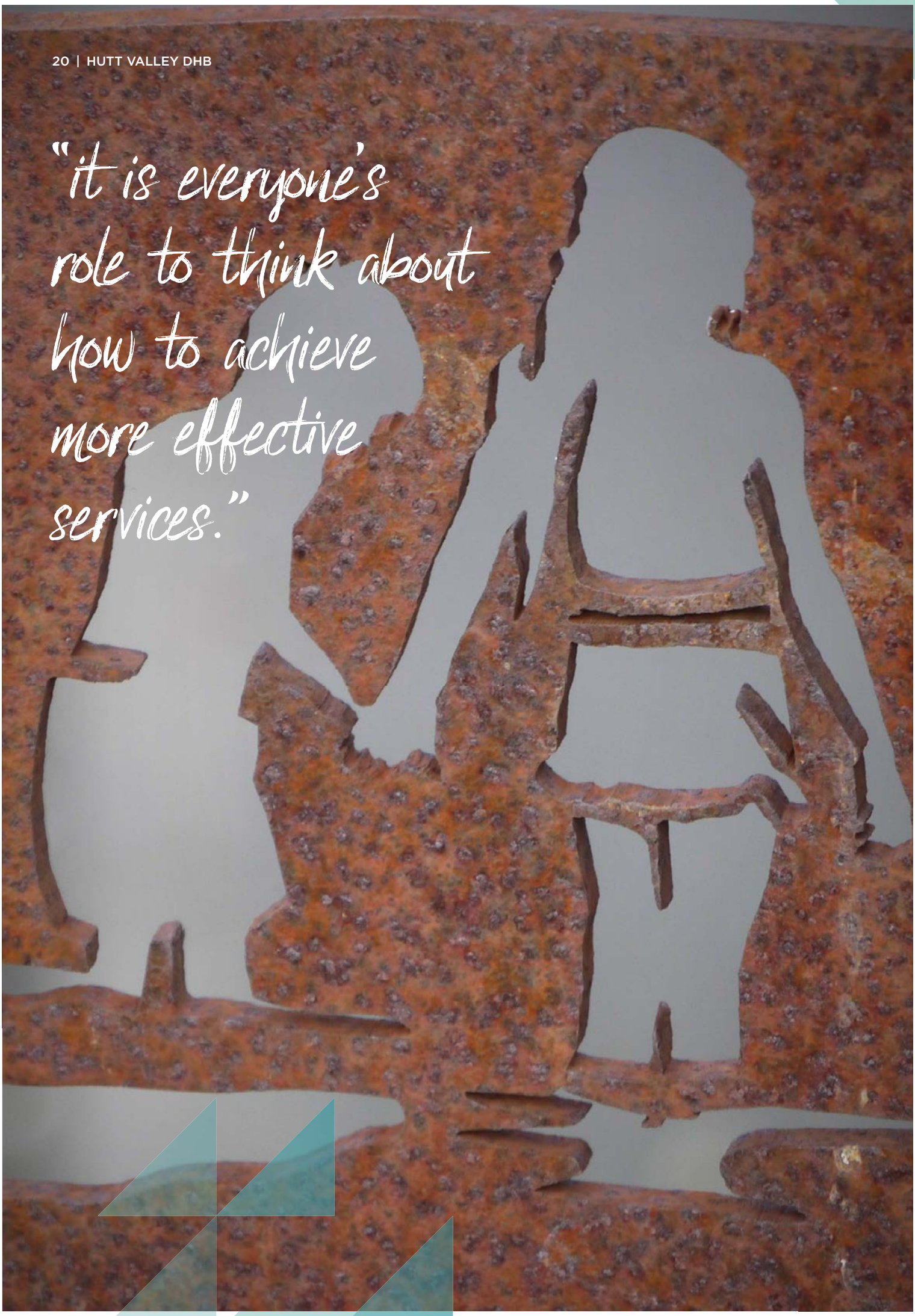
WHY IS THIS IMPORTANT?

Staff and volunteers from across the system are vital to the achievement of better health outcomes for our whole population. Higher staff engagement and satisfaction drives quality customer care. There is a clear relationship between the wellbeing of staff, and patients' wellbeing. The available evidence suggests that measures of people's experience are clear, distinctive indicators of healthcare quality.

Excellence in leadership underpins engagement and growth in the capability and capacity of teams to support innovation and drive sustainable change.

WHAT DO WE WANT IN FIVE YEARS?

- A health system culture that nurtures professional competence and staff wellbeing
- A well-trained workforce able to motivate and support people to stay well
- A flexible and adaptable workforce with greater diversity in skill mix
- A workforce that is technologically capable
- Different workforces take on new roles and responsibilities
- Health professionals, leaders and managers engage and collaborate in training, leadership and quality improvement activities and opportunities



"it is everyone's role to think about how to achieve more effective services."

STRATEGIC ENABLER

EFFECTIVE COMMISSIONING

WHAT DO WE MEAN?

Commissioning is the process through which health needs are identified, services are developed to meet those needs and responsible resource decisions are made. Commissioning is an ongoing process. Good commissioning focuses on managing value, rather than cost. Our commissioning approach will ensure we continuously improve services and intentionally commit resources to achieve the best health outcomes for individuals and the population, support the elimination of health inequities, and improve people's experience of care.

Commissioning also needs to move towards measuring outcomes. Measuring what matters to patients is critical in improving our responsiveness as a health system.

Commissioners sit across the system, including those who manage services as well as those who directly provide services. It is everyone's role to think about how to improve patient experience, achieve more responsive services and demonstrate responsible stewardship for entrusted resources. The workforce can directly influence appropriate allocation of resources by the decisions it makes every day in the treatment options it offers patients and their whānau.

Effective commissioning is evidenced when we:

- use data to understand who needs what, where the gaps or overlaps are, and use evidence to understand what works
- work with patients and whānau to understand their experiences of care and tailor services better
- co-design service delivery with all the appropriate stakeholders
- measure and evaluate individual's and whānau experience of care and outcomes
- measure and evaluate outcomes for the system
- monitor ongoing performance to ensure effectiveness and continuous improvement
- use built in feedback loops to inform future service investment

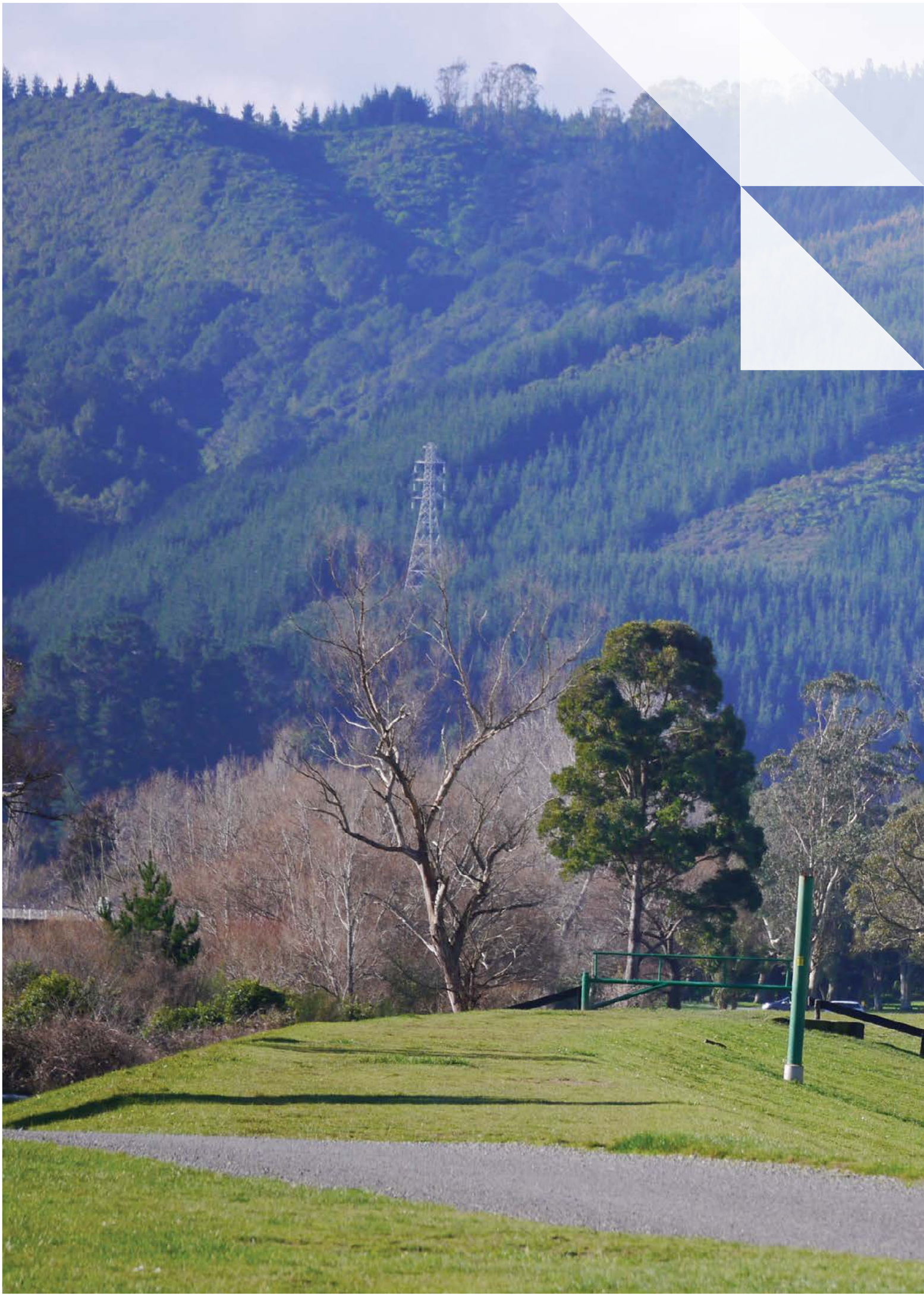
Our funding and business models will encourage and support collaboration and partnership; effective service delivery integration; and responsible stewardship of our limited resources. Important foundations for this are the principles of co-design of services, systems-thinking and planning for the long term.

WHY IS THIS IMPORTANT?

Demands for services under current models are unsustainable. We cannot fund more of what we do now. The traditional way of planning and funding services does not encourage the system to act with a communal mindset to use our financial resources to get the best value for the whole system.

WHAT DO WE WANT IN FIVE YEARS?

- Decisions by all those working in the system demonstrate responsible stewardship of limited resources
- Commissioning for outcomes – measuring against what matters to patients and whānau
- Whānau, communities and health professionals are central to allocation decisions
- Available resources achieve equitable and sustainable outcomes
- Resources are considered across the whole of system, including across the broader social sector
- 'Smart investments' are based on sharing of data and pooling of resources




HUTT VALLEY DHB