HUTT VALLEY DHB

Annual Plan
2016/17

Incorporating

Statement of Intent and

Statement of Performance Expectations

2016/17-2019/20

Version as at 2 September

Annual Plan 2016/17 & Statement of Intent 2016/17-2019/20

Persuant to Section 38 of the New Zealand Public Health and Disability Act 2000 and Sections 139 and 149C of the Crown Entities Act 2004 as amended by the Crown Entities Amendment Act 2013

Hutt Valley District Health Board, Private Bag 31907, Lower Hutt 5010

Note: This document should be read in conjunction with the Hutt Valley DHB Māori Health Plan 2016/17, Central Region Regional Services Plan 2016/17 and Regional Public Health Business Plan 2016/17. These plans are available on our website: http://www.huttvalleydhb.org.nz
This document incorporates content from the above plans and also content from the Ministry of Health's website: http://www.health.govt.nz/

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

31 OCT 2016

Dr Virginia Hope
Chairperson
Hutt Valley District Health Board
Private Bag 31907
Lower Hutt 5040

virginia.hope@ccdhb.org.nz

Dear Dr Hope

Hutt Valley District Health Board 2016/17 Annual Plan

This letter is to advise you that together with the Minister of Finance, I have approved and signed Hutt Valley District Health Board's (DHB's) 2016/17 Annual Plan for one year.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

The Government is committed to improving the health of New Zealanders and continues to make significant investments in health services, including for electives initiatives. In Budget 2016 Vote Health received an additional $2.2 billion over four years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, the refresh of the New Zealand Health Strategy is now complete and the Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to New Zealanders. I note that you have committed to the Health Strategy and its themes in your 2016/17 Annual Plan and I look forward to seeing your progress throughout the year. In order to ensure that the Strategy is informing DHB planning, and to ensure value and high performance throughout the health sector, I am considering changes to streamline annual plans in the future and you will be engaged in this process.

Living Within our Means

In order to assist the Government to remain in surplus in 2016/17, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

I note that your DHB is planning a deficit for 2016/17 and for some out years. I expect that you will work to improve this position in out years and will work closely with the Ministry to achieve this. For 2016/17, I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

National Health Targets

Your Annual Plan includes positive actions that will support health target performance for your population. However, as you know, I am concerned about the pace of improvement in relation to the *faster cancer treatment health target* and remind you that this needs to be a particular focus of your service delivery, as does the *improved access to elective surgery* health target given the additional investment made in this area.

I expect delivery of your Annual Plan will improve your performance in relation to the *better help for smokers to quit* health target, and also on your continued performance towards delivery of the *more heart and diabetes checks* target goal, where your most recently published results indicate further work is needed.

As you are aware, the *raising healthy kids* health target was launched at the beginning of July 2016 and will see 95 percent of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017. I am pleased to note that your Annual Plan shows a clear plan for achievement of the target and I look forward to hearing of the progress made in your district.

System Integration including Shifting Services

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2016/17, in line with one of the core Health Strategy themes of providing services and care closer to home. The ability of DHBs to shift services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Hutt Valley DHB has committed to increase the uptake of its primary options for acute care (POAC) services, expand the scope of its POAC services, and develop and consider a business case for health care home development.

Cross-government Initiatives and Collaboration

Delivery of Better Public Services continues to be a key focus for the Government. Of the ten whole-of-government key result areas, the health service is leading the following areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

In addition to these areas, the health service has a significant role in supporting and contributing to other cross-agency work that will have significant impacts on health outcomes, such as Reducing Unintended Teenage Pregnancy (as a sub-focus of the Better Public Service Result One), Whānau Ora, the Children's Action Plan, Healthy Families New Zealand and Youth Mental Health.

I note that you have included a clear focus and appropriate actions to demonstrate that you are working as one team to deliver on these priorities within your 2016/17 Annual Plan.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes, including any changes to models of care, that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval

of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2016/17 Annual Plan. I look forward to seeing your achievements, in particular in relation to IT programmes, mental health and the New Zealand Health Strategy.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

cc Dr Ashley Bloomfield
Chief Executive
Hutt Valley District Health Board
Private Bag 31907
Lower Hutt 5040

ashley.bloomfield@huttvalleydhb.org.nz

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‘MODULE 1’ INTRODUCTION and STRATEGIC INTENTIONS

1.1 FOREWORD FROM DHB CHAIR, DEPUTY CHAIR, AND CHIEF EXECUTIVE

We are pleased to present the Hutt Valley District Health Board’s (DHB) Annual Plan for the 2016/17 financial year. This plan outlines actions we will undertake over the next year to ensure delivery on our local, sub-regional, regional and nationally driven priorities. Our overarching goal is to continue to focus on the ‘triple aim plus one’: to improve our patients’ experience of care; to improve health outcomes and equity for our people; to get the best value out of our allocated resources; and to build a thriving organisation.

We share a strong desire to ensure our DHB can continue to deliver and fund the services our population needs, now and into the future. By proactively managing cost growth and implementing more effective and efficient ways of delivering services, we are putting ourselves on track to not only live within our means but also to invest in new and expanded services that meet the needs of our population. To help achieve this, our 2016/17 budget is a significant improvement on our financial results in the past two years. This will be a challenge and there are potential risks to achieving this result. We will remain focused on delivering safe and effective services that our population needs while managing potential financial risks.

Strengthened collective leadership is a key element in achieving our plans. This includes our newly-established Clinical Council and the clinical networks that are advancing our integration work programme. Partnership and collaboration across our health and disability system and across agencies and sectors are also key to ensure we make progress to address current and emerging health needs and issues, and to show continued improvements in our performance against health targets.

This plan reflects the co-operative approach we have undertaken to the planning and delivery of services across the sub-region for a number of years and we will continue to work closely with our sub-regional neighbours. By progressing regional and national initiatives we will contribute to implementation of the refreshed New Zealand Health Strategy and its roadmap towards a smart, joined-up system that delivers high value services close to where the people live.

Virginia Hope
Board Chair,
Hutt Valley District Health Board

Wayne Guppy
Board Deputy Chair
Hutt Valley District Health Board

Ashley Bloomfield
Chief Executive
Hutt Valley District Health Board

The Hutt Valley District Health Board Annual Plan, incorporating Statement of Intent and Statement of Performance Expectations, is approved for 2016/17.

Hon. Jonathan Coleman
Minister of Health
Date 20/10/16.

Hon. Bill English
Minister of Finance
Date 25/10/16

Virginia Hope
Board Chair
Hutt Valley District Health Board

Wayne Guppy
Board Deputy Chair
Hutt Valley District Health Board

Ashley Bloomfield
Chief Executive
Hutt Valley District Health Board

1.2 CONTEXT

Our District Health Board (DHB) is one of 20 DHBs established under the New Zealand Health and Disability Act 2000. DHBs are required to plan and deliver services regionally, as well as in their own individual areas. DHB objectives include:

- Improving, promoting and protecting the health of people and communities
- Promoting the integration of health services, especially primary and secondary care services
- Seeking the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs
- Promoting effective care or support of those in need of personal health services or disability support
- Promoting the inclusion and participation in society and the independence of people with disabilities
- Reducing – with a view toward elimination of – health and outcome disparities for Māori and between other populations groups.

DHBs are expected to show a sense of social responsibility, to foster community participation in health improvement, and to uphold the ethical and quality standards commonly expected of providers of services and public sector organisations. Public hospitals are owned and funded by DHBs.

Each DHB has a statutory responsibility to prepare:

- an ***Annual Plan*** for approval by the Minister of Health and providing accountability to the Ministry of Health (this document)
- a ***Statement of Performance Expectations*** providing annual financial accountability to Parliament and the public (Modules 3 and 4 of this document)
- a ***Statement of Intent*** providing accountability to Parliament and the public at least triennially (Modules 1 and 5 of this document).

Guidance on the Government's and Ministry of Health's expectations and priorities are provided as part of an annual planning package[1].

[1] http://nsfl.health.govt.nz/dhb-planning-package/201617-planning-package

1.2.1 Background information and operating environment

System Context

The New Zealand health and disability system's statutory framework is made up of over 20 pieces of legislation. The most significant are the New Zealand Public Health and Disability (NZPHD) Act 2000, the Health Act 1956, and the Crown Entities Act 2004.

The NZPHD Act establishes the structure underlying public sector funding and the organisation of health and disability services. It establishes DHBs and sets out the duties and roles of key participants. It also sets the strategic direction and goals for health and disability services in New Zealand. These include to improve health and disability outcomes for all New Zealanders, to reduce disparities by improving the health of Māori and other population groups, to provide a community voice in personal health, public health, and disability support services and to facilitate access to, and the dissemination of information for, the delivery of health and disability services in New Zealand.

The Health Act sets out the roles and responsibilities of individuals to safeguard public health, including the Minister of Health, the Director of Public Health, and designated officers for public health. It contains provisions for environmental health, infectious diseases, health emergencies, and the national cervical screening programme.

The Crown Entities Act provides the fundamental statutory framework for the establishment, governance, and operation of Crown entities. It clarifies accountability relationships and reporting requirements between Crown entities, their board members, responsible Ministers, and the House of Representatives.

The Minister of Health is responsible for strategies[2] that provide a framework for the system and for reporting on their implementation to Parliament. Key strategies currently in place are the:

- *New Zealand Health Strategy* (refreshed in 2015/16, see Module 2A)
- *New Zealand Disability Strategy* (see Module 2B – Disability)
- *Primary Health Care Strategy* (see Module 2B – Service Integration/Configuration)
- *He Korowai Oranga: Māori Health Strategy* (see Module 2B - Māori Health).

Te Tiriti o Waitangi (the Treaty of Waitangi), the founding document of Aotearoa/New Zealand, encapsulates the fundamental relationship between the Crown and Iwi and the responsibility of its Treaty partners. The NZPHD Act supports this by requiring DHBs to establish and maintain processes to enable Māori to participate in and contribute towards strategies to improve Māori health outcomes. DHBs are required to:

- Create a stand-alone Māori Health Plan, jointly with Primary Health Organisations, to achieve health equity and improve health outcomes for Māori
- Work with Māori at both governance and operational levels
- Ensure there are mechanisms to enable Māori to contribute to decision-making on and to participate in the delivery of health and disability services.

[2] For the New Zealand Disability Strategy, this responsibility is shared with the Minister for Disability Issues.

Māori ethnic reporting is included in a range of monitoring indicators that DHBs are required to report to the Ministry of Health (see Module 7). DHBs with a significant Pacific population are also required to include Pacific ethnic reporting in their DHB indicator reporting to the Ministry of Health. 'Pacific priority DHBs' are those in which over 90 percent of Pacific peoples reside; they are (in order of highest numbers of Pacific peoples): Counties Manukau, Auckland, Waitemata, Capital & Coast, Canterbury, Hutt Valley, Waikato and Hawke's Bay.

New Zealand's health and disability system is mainly funded from general taxation, with Vote Health funding currently around $15 billion per annum. Other funding sources include other government agencies (most notably Accident Compensation Corporation – ACC), local government, and private sources such as insurance and out-of-pocket payments. Government funding of health and disability services means that eligible people may receive free inpatient and outpatient public hospital services, subsidies on prescription items and primary care, and a range of support services for people with disabilities in the community.

The Ministry of Health allocates more than three-quarters of Vote Health funding to DHBs, who use this funding to plan, purchase and provide health services in their district, including public hospitals and the majority of public health services. Disability support services and some health services are funded and purchased nationally by the Ministry of Health. The Population-Based Funding Formula (PBFF) is a tool used to help equitably distribute the bulk of DHB funding according to the needs of each DHB's population. The formula takes into account the number of people who live in each DHB catchment, their age, socio-economic status, ethnicity, and sex.

Other Plans

In addition to key national strategies, a variety of tools and plans have been developed that guide DHBs at national, regional, sub-regional and local levels and which link into the DHB's Annual Plan for 2016/17. More information on specific plans is contained under section 1.3 *Strategic Directions and Outcomes* and in Module 2B.2 under the relevant *Priority Area Deliverables* sections, including:

- *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*
- *Central Region Regional Services Plan 2016/17*
- *Hutt Valley DHB Māori Health Plan 2016/17*
- *Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018*
- *Wairarapa & Hutt Valley DHBs Pacific Health Action Plan 2015-2018, Pāolo mo tagata ole Moana*
- *Regional Public Health Business Plan 2016/17*
- *3DHB Disabilities Implementation Plan 2013-2018*
- *3DHB Tobacco Control Plan 2015-2018*
- *Allied Health Scientific & Technical 3DHB Strategic Approach 2015-2025, Designing our Future Together*
- *3DHB Human Resources Plan 2014-2016*
- *3DHB Radiology Plan*
- *3DHB Rheumatic Fever Prevention Plan* (refreshed 2015)
- *Hutt Valley DHB Maternity Quality & Safety Programme: 2015-2017*.

Other sub-regional health system planning work undertaken in 2015/16 for the Wairarapa, Hutt Valley and Capital & Coast DHBs is designed to identify options for sustainable and high quality

health services over the next 15 years. This will allow our Boards to focus attention on the most important areas for service development and to guide decisions about investment in facilities, workforce and technology. The development of a sub-regional Health System Plan is being governed by the Sub-Regional Clinical Leadership Group (SRCLG) and provides scenarios and options for service delivery in key service settings, informed by engagement with key stakeholders.

Population and Health Profile

In 2016/17 Hutt Valley DHB will have a projected population of around 144,550 people, including 17% Māori, 8% Pacific and 11% Asian populations. The district spreads across 916 square kilometres, covering the Lower Hutt City and Upper Hutt City territorial local authorities.

We assess the health needs of our district at regular intervals to assist in determining the optimum mix of services we can provide within available funding and to inform the on-going development of responsive and effective services. The *2015 Health Needs Assessment for the Wairarapa, Hutt Valley and Capital & Coast District Health Boards* provides a key input into our annual and longer-term planning.

In addition, a series of reports on child and youth health for our sub-regional DHBs is being produced by the New Zealand Child and Youth Epidemiology Service. This includes the 2014 report *The Determinants of Health for Children and Young People in the Hutt Valley, Capital & Coast and Wairarapa,* the 2015 report *Health Status of Children and Young People in the Hutt Valley, Capital & Coast and Wairarapa DHBs* and to be followed by a report on *Children and Young People with Chronic Conditions and Disabilities*.

Key findings from our Health Needs Assessment are common across our sub-region:

- The populations is growing and aging
- Overall health status has improved
- Obesity is emerging as the leading risk factor for health loss
- The scope for health gain remains high
- Inequitable health outcomes persist between populations groups
- Getting on top of chronic disease is a significant challenge
- The aging population will increase pressure on our health services
- Access to services has improved but is still variable between populations groups
- Demand for urgent hospital services is increasing.

Key health issues for the DHB include:

- The incidence of long term conditions (such as cardiovascular disease, diabetes and respiratory conditions) and the impact on people's daily lives. Māori and Pacific tend to have earlier onset of long term conditions than other groups
- The burden of cancer and disparities in survival
- Experience of mental illness and its unequal impact on younger, disadvantaged population groups
- Child and youth issues, including oral health, respiratory illness, skin infections and injuries, mental health and youth suicide, as well as sexual health
- Health of older people, including management of long term conditions, cancer, musculoskeletal disease (for example, arthritis, osteoporosis), injury from falls, the impact of dementia, and home and community support needs

- Responding to the needs of the 23% of the district population estimated to have a disability.

Ethnicity is a strong indicator of need and demand for our health services. Reducing disparity based on ethnicity is essential for creating a fair health system in which individuals have equity of outcomes. Nationally, regionally, sub-regionally and locally Māori continue to have poorer access to health services and poorer health outcomes. Pacific communities also experience poor health outcomes in New Zealand and their health status remains unequal with non-Pacific across almost all chronic and infectious diseases.

Operating Environment

There are a range of issues common to all DHBs, these include:

- Population growth and aging
  This requires ever increasing service provision, particular to older people who are living longer
- Growing burden of long term conditions
  This includes the increasing prevalence of some risk factors, e.g. obesity
- New technology and drugs
  These are often expensive and drive increasing public expectations
- Workforce
  A highly mobile global workforce, also subject to population aging
- The emergence of new infections, antibiotic resistance and the consequences of climate change
- Financial sustainability
  Meeting increased demand within a constrained financial environment.

Issues, Opportunities and Risks

There is particular pressure in 2016/17 from wage increases and growth in demand for both acute and elective services. We will continue to have a strong focus on reducing costs and being innovative to live within our means.

Key strategic challenges for the DHB include how we can:

- 'Recalibrate' the Hutt Valley health and disability system to fit within our allocated funding to enable investment in new models of care and key infrastructure/facilities
- Develop greater capacity and capability in primary and community settings so that more services can be delivered there
- Implement sustainable solutions to deal with increasing acute demand.

Actions to address these include:

- Health system planning processes
- Master site planning
- Further development of clinical networks
- Strengthening primary care infrastructure to support a shift to a Health Care Home like model.

1.2.2 Nature and Scope of Functions

DHB roles and services

DHBs have four key roles to deliver on their objectives - as planners, funders and providers of health services, and as owners of Crown assets (our hospitals and facilities).

We plan the strategic direction of the local and sub-regional health system in partnership with our regional and sub-regional DHBs, Alliance Leadership Teams, clinical leaders, service providers and communities.

We provide a range of health and well-being, hospital and specialist services based out of our Hutt Hospital campus and other district locations, with over 1,800 full-time equivalent staff. Our specialist and community-based services include emergency department, general medicine, cardiology, dermatology, gastroenterology, haematology, neurology, renal medicine, sub-regional rheumatology, older persons rehabilitation, sub-regional plastics, general surgery, orthopaedics, ENT, gynaecology, dentals, oral-maxillofacial, ophthalmology, rehab services, paediatric medicine, neonatal , mental health and addictions, maternal and child health, respiratory services, diabetes and endocrinology, district nursing services (including oncology and wound care, stomal and continence services), dietetics, occupational therapy, physiotherapy, social work, speech therapy and podiatry.

In addition to our DHB provided services, we also fund a range of primary, community, population health, diagnostic and treatment services from Primary Healthcare Organisations (PHOs), pharmacies, age-related residential care providers, home-based support service providers, child and youth dental services, private hospital and community radiology/imaging services, mental health and addiction providers, Māori health providers and other service providers. Our sub-regional Service Integration and Development Unit (SIDU) manages around 700 contracts and service agreements across the sub-regional health system[3].

The costs of providing services to people living outside of our district are met by the DHB of the patients and are referred to as Inter-District Flows (IDFs). Where we do not provide a service locally, we have funding arrangements in place with other DHBs to enable our local residents to receive that service outside the district. We also provide services for other external funders such as the Accident Compensation Corporation (ACC).

The Ministry of Health and National Health Board also have a role in the planning and funding of some services which are contracted for nationally, e.g. public health services, national screening programmes, and disability support services for people aged less than 65 years.

[3] Towards the end of 2015/16 the sub-regional DHBs began consulting on proposals to strengthen the local executive management and support structures within each of the 3 DHBs. This included a proposal for a blended operating model for planning and funding (SIDU) functions, with some functions proposed to be returned to being locally-based while other functions to remain shared, based out of CCDHB, and provided to Wairarapa and Hutt Valley DHBs as part of service level agreements.

1.3 STRATEGIC INTENTIONS AND OUTCOMES

1.3.1 Our DHB's Vision, Mission, Values and Strategic Goals

Our Vision

Whānau Ora ki te Awakairangi
Healthy people, healthy families and healthy communities.

Hutt Valley DHB continues to strive for excellence in ourselves as individuals and collectively as an organisation. We expect it of the services we provide, the way we treat each other, the systems we put in place and the achievements we make.

For the purposes of joint planning, the Boards of the three sub-regional DHBs (Wairarapa, Hutt Valley and Capital & Coast) have agreed to consolidate their individual vision statements into the single operating vision of:
Improved health and independence for our people, our families and our communities.

Our Mission

Working together for health and wellbeing
We commit to work cooperatively, as an active part of the health sector and the Hutt Valley community.

Our Values

'Can do' – leading, innovating and acting courageously
Hutt Valley DHB leads the New Zealand health sector. We are committed to quality and innovating to improve the health of our people.

Working together with passion, energy and commitment
We are passionate about our work. We direct our energy to doing the best for our clients and the community.

Trust through openness, honesty, respect and integrity
We regard trust as essential to success. The people we serve must have confidence in us. We are open, honest, and respectful. We act with integrity.

Striving for excellence
We aim for excellence, individually and as an organisation. This commitment defines us, the services we provide, the way we work with each other and how we shape our systems.

Our Strategic Approach

Our overarching approach is to continue to focus on the 'triple aim plus one':

- For our Patients - Improved quality, safety and experience of care and a better patient journey
- For our Populations - Improved health and equity for all populations

- For the Public - Best value for health system resources and living within our means
- A thriving organisation, including our organisational culture, clinical leadership, engagement and workforce development.

Our Strategic Goals for the DHB

- Fully integrated patient journey through the Hutt Valley health and disability system (including aspects of care provided by other DHBs, especially Capital and Coast DHB)
- Strong, system-minded clinical leadership
- A thriving culture of improvement and innovation
- Tangible reductions in health inequalities and in key risk factors
- A 'fit for purpose' hospital campus and well-developed community hubs delivering a wide range of ambulatory services.

1.3.2 Strategic outcomes in national, regional, sub-regional and local context

National Context

The Ministry of Health's Statement of Intent 2015–2019 identifies outcomes for the New Zealand health system and the Ministry:

- New Zealanders live longer, healthier and more independent lives
- The health system is cost-effective and supports a productive economy.

The Ministry of Health has three high-level outcomes that support the achievement of the above health system outcomes:

1. New Zealanders are healthier and more independent
2. High-quality health and disability services are delivered in a timely and accessible manner
3. The future sustainability of the health and disability system is assured.

The Ministry of Health and DHBs are charged with giving effect to the overarching goal for the health sector of Better, Sooner, More Convenient (BSMC) health services for all New Zealanders, including *Better Public Services*. Key principles that are foundational to planning in order to achieve BSMC services are:

- Using an alliancing approach to service planning in which Alliance Leadership Teams (ALTs) involving the appropriate primary/secondary clinicians and primary/secondary managers jointly agree service priorities along with appropriate funding levels.
- Using a whole-of-system view to determine the most efficient model of service delivery. Ensuring service planning is not done in silos, including using alliancing principles to jointly plan and agree service models with appropriate stakeholders for other services (e.g. community clinicians and Non-Governmental Organisations)
- Providing a model of care that incorporates a range of 'hospital' services to be delivered within community/primary care settings
- Active engagement of 'front-line' clinical leaders/champions in health services delivery planning across the sector at both local and regional levels
- Integrating/co-ordinating clinical services to provide greater accessibility and seamless delivery
- Strengthening clinical and financial sustainability
- Making better use of available resources

- Ensuring total population measures and targets are applied to all ethnic groups and that all targets and measures replicated in any other plans (e.g. Māori Health Plans) are consistent with those in Annual Plans and Regional Service Plans.

Four important policy drivers have been identified through which the health sector may best utilise resources to achieve BSMC services.

- ***Better Public Services (including Social Sector Trials)***: DHBs must work more effectively with other parts of the social sector. The Government's *Better Public Services* targets and the Social Sector Trials will help drive this integrated approach that puts the patient and user at the centre of service delivery. DHBs are expected to work closely with other sectors such as education and housing specifically.
- **Regional collaboration:** means DHBs working together more effectively, whether regionally or sub-regionally.
- **Integrated care:** includes both clinical and service integration to bring organisations and clinical professionals together, to improve outcomes for patients and service users through the delivery of integrated care. Integration is a key component of placing patients at the centre of the system, increasing the focus on prevention, avoidance of unplanned acute care and redesigning services closer to home.
- **Value for Money:** is the assessment of benefits (better health outcomes) relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

The Minister of Health's Letter of Expectations for DHBs and Subsidiary Entities 2016/17 identifies the following key focus areas:

- **Refreshed New Zealand Health Strategy** – DHBs need to be focussed on the critical areas to drive change across the five themes (people-powered, closer to home, value and high performance, one team and smart system) and progress work to support the Roadmap of Actions which sets the direction for the next five years.
- **Living Within our Means** – DHBs need to budget and operate within allocated funding and have plans to improve year-on-year performance so that efficiency gains allow investment into new and more health initiatives
- **Working Across Government** – continuation of cross-agency work that delivers outcomes for vulnerable families, children and young people, with an expanded focus on reducing long-term benefit dependence through reducing unintended teenage pregnancies
- **National Health Targets** (Appendix 1)**–** all of the Health Targets are important for driving overall system performance, but there is a particular concern over the overall pace of progress nationally on achieving the targets for Faster Cancer Treatment
- **Tackling Obesity** – actions to reduce the incidence of obesity, including Childhood Obesity initiatives to prevent and manage obesity in children and young people, and supported by a new Health Target
- **Shifting and Integrating Services** – continuation of moves to integrate primary care with other health services and to move services closer to home, with pathways to achieve better co-ordinated health and social services developed and supported by clinical leaders in both community and hospital settings
- **Health Information Technology (IT) Programme 2015-2020** – sector co-design processes leading into 2016/17 and completion of current regional and national IT work currently underway.

Regional Context

DHBs are expected to work together at a regional level to make the best use of available resources, strengthen clinical and financial sustainability and increase access to services. To document DHB's

regional collaboration efforts and align service and capacity planning, regions are required to produce an annual Regional Service Plan (RSP) that includes national priorities for regional delivery, locally agreed regional priorities, and outlines how DHBs intend to plan, fund and implement these services at a regional or sub-regional level. RSPs have a specific focus on reducing service vulnerability, reducing costs and improving the quality of care to patients.

The Central Region is one of four 'regions' in New Zealand that is a collective of the Whanganui, MidCentral, Hawke's Bay, Wairarapa, Hutt Valley and Capital & Coast DHBs which work together on initiatives for the benefit of our regional population. We jointly fund the Central Region Technical Advisory Service (TAS). TAS supports the six Central region DHB's functions so that we are able to meet objectives around regional planning and delivery.

The Central Region's vision is:
"Empowered self-care supported by a fit-for-purpose and interconnected regional network of accessible primary, secondary and tertiary health care services. The right care for the right person for the right reason in the right place at the right time."

The regional planning outcomes sought are:
- Improved, quality, safety and experience of care
- Improved health and equity for all populations
- Best value for public health system resources
- Improved system integration and consistency
- Improved clinical and financial sustainability.

The 2016/17 RSP priority areas are:
- Elective Services
- Cardiac Services
- Mental Health and Addictions
- Stroke Services
- Health of Older People
- Major Trauma
- Hepatitis C
- Cancer Services
- Diagnostic Imaging.

Enablers
- Information Technology
- Workforce
- Quality and Safety.

The Central Region DHBs manage the delivery of the priorities in the RSP through regional programmes of work and clinical networks. Each of the 12 regional programmes has a steering group, which is clinically led and has representation from the appropriate functional disciplines in order to provide advice to the business owner and programme manager.

Sub-Regional Context

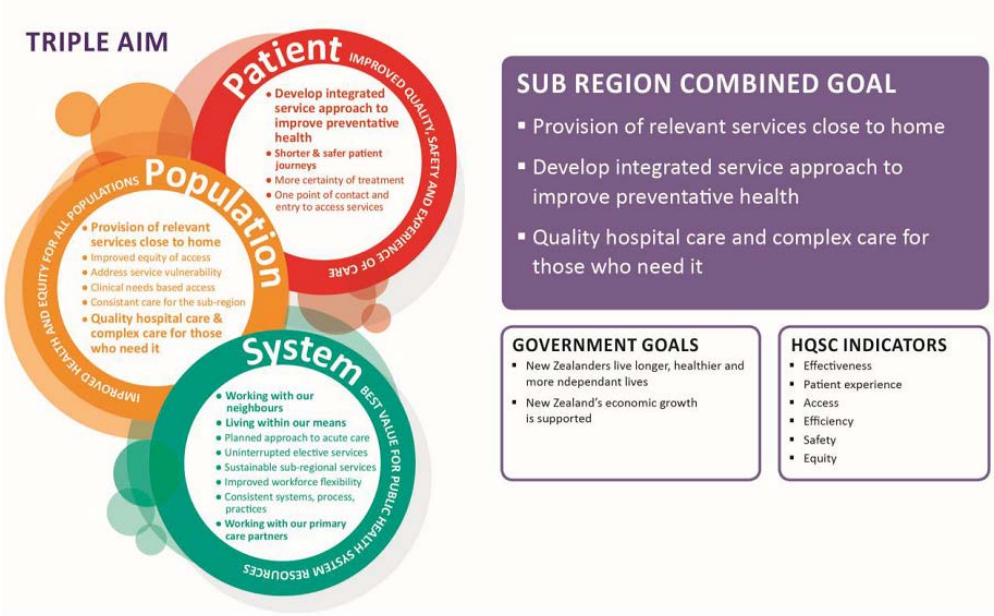
Our sub-regional DHBs, Wairarapa, Hutt Valley and Capital & Coast, share staff and services and treat each other's populations. We have a strong history of working together to continuously improve the quality and safety of the services we provide. In late 2012, the three DHBs committed to an approach to working together to ensure the sustainability of our collective services, both clinical and financial, and we continue to grow integrative activity where feasible.

Triple Aim

Together we are consistent in our planning under the lens of the Triple Aim – an international healthcare improvement policy (adopted in New Zealand by the Health Quality and Safety Commission) that outlines a plan for better healthcare systems by pursuing three aims: improving patient's experience; improving the overall health of our populations; and improving the use of health system resources; as well as integration that enables delivery of each of these aims.

Quality Framework

Our sub-regional approach is described in our quality framework. Our approach to quality improvement is also underpinned with a health equity perspective, as equity cuts across all dimensions of high quality health services.



Sub-Regional Goals and Outcomes

The sub-regional goals sought are:

- Reduced health disparities/improved health equity
- Improved availability, access and quality of service
- Improved sustainability of our services.

Sub-regionally we have selected nine intended outcomes with associated impact measures that we measure over time, in addition to the Minister's Health Targets, to indicate the areas in which our DHBs are making a positive difference and in which areas we need to improve (Appendix 1). These are:

Outcome Measures	**Impact Measures**
1. Reduced ethnic health disparities	• A reduction in Ambulatory Sensitive Hospitalisation ethnic disparity rates • A reduction in amenable mortality ethnic disparity rates
2. Environment and disease hazards are minimised	• A decrease in vaccine-preventable disease notifications • An increase in the percentage of premises visited that are compliant with *Supply of Liquor Act 2012* for sales to minors
3. Lifestyle factors that affect health are well-managed	• A decrease in the obesity prevalence in children and adults • A decrease in the proportion of the Primary Health Organisation enrolled population that is recorded as a 'current smoker' • An increase in the proportion of mothers who are smokefree two weeks post-natal
4. Children have a healthy start in life	• A reduction in Ambulatory Sensitive Hospitalisation rates for 0-4 year olds • An increase in the proportion of children caries-free at 5 years • A decrease in the burden of tooth decay at Year 8
5. Long-term conditions are well-managed	• An increase in the proportion of people with diabetes with satisfactory blood glucose control • A decrease in the hospitalisation rate for cardiovascular disease • A decrease in the hospitalisation rate for chronic obstructive respiratory disease • An increase in the proportion of dispensed asthma medications that were preventers rather than relievers
6. People receive high quality hospital and specialist health services when they need them	• A reduction in the standardised rate of acute readmissions to hospital within 28 days • Maintain or reduce the age-standardised cancer mortality rate
7. People receive high quality mental health services when they need them	• A reduction in the rate of acute readmissions to inpatient mental health services within 28 days • An increase in the percentage of new service users accessing secondary mental health services

Outcome Measures	Impact Measures
8. Responsive health services for people with disabilities	• An increase in the proportion of patients and clinicians that found the Health Passport useful
9. Improve the health, well-being and independence of our older people	• Maintain or increase the proportion of patients receiving home-based support services, of those aged 65+ who receive DHB funded home-based support or aged residential care services • Maintain or increase the average age of entry into residential care

System Integration

We are working together so the people in our sub-region experience an integrated health and disability system, providing appropriate care closer to them, keeping them well at home, and providing responsive services in times of need. System integration will drive improvements in population care, efficiencies and support sustainability while we are facing limited resources and escalating demands on services. The Alliance Leadership Teams (ALTs) across the sub-region are key drivers for and enablers of integration. ALT membership includes clinical leaders and senior managers across the health and disability system who are committed to driving change. Our three sub-regional ALTs are Tihei Wairarapa, Hutt Integrated Network of Care, and the Capital & Coast Integrated Care Collaborative.

To support the ALTs in delivering actual service change there are Service Level Alliances (SLAs) or Steering Groups that lead particular areas of service integration work to improve care across the system. A number of SLAs work across the sub-region covering Information Management, Health Pathways and Youth Health. In addition to the sub-regional SLAs, there are also other specific developments and projects that cover the sub-region and which are supported by their local ALT group. These include Self-Management, Advance Care Planning, Falls, Packages of Care and Medication Management. The ALTs will also be engaged in the process for utilisation of their Flexible Services Pools and other resources available through their development processes.

Health Pathways is a resource that provides guidelines for clinical staff to standardise assessment, management, and referral pathways for particular conditions. A team of local General Practitioner Clinical Editors work with Consultant Subject Matter Experts to tailor the content to reflect sub-regional and local processes. To date around 190 Pathways have been localised and related patient health information resources have also been developed. The Information Management SLA has led the development and implementation of a number of Information and Communication Technology related enablers for the system, including the Shared Electronic Health Record and the Patient Portal. Other key enablers they are also leading include General Practitioner Access to the Hospital Record and the Shared Care Plan which will drive integrated approaches to multidisciplinary care planning.

Clinical Leadership

Sub-regionally we continue to work towards enabling and embedding local clinicians to take a lead role in the establishment of regional clinical networks, local and regional clinical pathways, and towards optimal clinical arrangements for securing specialised hospital capacity between our

neighbouring DHBs. Strengthening clinical leadership is assisted through the activity of the three local ALTs and active involvement of clinicians in the development of collaborative service models. While each DHB has its own Clinical Governance and Clinical Leadership structures, the 3DHB Clinical Governance Group provides oversight of quality and safety for services that are 3DHB, such as radiology and Mental Health, Addictions and Intellectual Disability (MHAID).

Vision 2030: Health System Planning 2016-2030

Sub-regional health system planning encompasses three components:

- Health Service Planning – service capacity planning, including:
    - Hospital capacity modelling by specialty and hospital
    - Developing the role of the Healthcare Home
    - Developing intersectoral/public health services.
- Master Site Planning, including:
    - Prevention, self-management and home-based services
    - Healthcare Homes and community health
    - Hospital clusters and regional services
    - Highly specialised diagnostics and care centres.
- Health System Planning – Planning for the population by major service user groups for 2030, including:
    - Geographic Information Systems analysis and modelling
    - Economic modelling
    - Integrated workforce models
    - Horizon/technology scanning
    - Optimisation modelling.

One system of analysis will enable understanding of linkages, planning of sub-regional and regional services, and building of specific DHB system plans. These will enable sub-regional DHBs to make choices about the facilities, workforce and technology for 2030 and to commission the systems needed to improve health outcomes for the people of their districts, including regional providers of specialist services. Following the completion of workshop process, including options development and analytics, discussions with Boards to refine recommendations will be undertaken in early 2016/17.

Local Context

Alliance Leadership Team (ALT)

The Hutt Valley DHB is part of the Hutt Integrated Network of Care (Hutt INC) ALT. Hutt INC's vision is ***Keeping people in the community healthy*** and its goals are to:

1. Deliver seamless healthcare for people in the Hutt Valley
2. Develop high quality, integrated services that are safe, patient-centred, and effective
3. Identify barriers to communication and care and remove them
4. Better manage preventative services, acute episodes, and long-term conditions.

Hutt INC's integration work programme is grouped into three local clinical networks: Acute Demand, Long Term Conditions and Child Health. Networks have been established with strong clinical leadership in each of these areas to provide oversight and drive integration through working groups.

Other integration initiatives that have a 3DHB component are led through sub-regional Service Level Alliances (SLAs).

Primary Health Organisations

Primary Health Organisations (PHOs) are funded by DHBs to support provision of essential primary health care services through general practices to people who are enrolled with the PHO. PHOs are one vehicle through which the Government's primary health care objectives, articulated in *Better, Sooner, More Convenient Primary Health Care* are implemented in local communities. PHOs vary widely in size and structure, although all are not-for-profit organisations.

A PHO provides services either directly or through its provider members. These services should improve and maintain the health of the entire enrolled PHO population, as well as providing services in the community to restore people's health when they are unwell. The aim is to ensure General Practitioner (GP) services are better linked with other primary health services to ensure a seamless continuum of care, particularly to better manage long-term conditions.

Two PHOs operate within the Hutt Valley DHB district:

- Te Awakairangi Health Network - formed in 2012 following the merger of the Piki te Ora ki te Awakairangi, Valley, Family Care and Tamaiti Whangai PHOs and the management services organisation, Kowhai Health Trust
- Cosine Primary Care Network Trust - formed in 2010 by the merger of Ropata and Karori PHOs.

Clinical Engagement and Leadership

Clinical governance is the organisational systems and processes for setting goals, monitoring, continuously improving and ensuring accountability for clinical quality and safety. Clinical leadership is the operational system that allows health workers to do what is needed based on the goals. Clinical engagement is the formal and informal mechanisms whereby clinicians are involved in organisational decision-making at all levels. Such engagement is essential for effective service improvement, clinical governance and financial stewardship.

In 2015/16, Hutt Valley DHB established a Clinical Council to provide:

1. System-wide oversight of clinical quality and patient safety
2. A forum for formal clinical engagement in organisational decision-making
3. Clinical advice to the DHB Executive Leadership Team and Board on key proposed service changes and measures to use resources more effectively

The principles of the Clinical Council are:

- Balancing the triple aim principles of better health outcomes and reduced health disparities, a better patient journey and living within our means
- A 'Hutt Valley health system' view will be taken, building on the work of the Alliance Leadership Team (Hutt INC)
- Continuous improvement of quality and safety will be a key driver of new initiatives
- Promote the integration of services across service boundaries so that they are organised and delivered based on the needs of people

- Clinical leadership will be embedded at every level of the system to help ensure effective use of resources
- Clinical decisions closest to the point of care will be encouraged
- Clinical input into administrative decisions will be enabled
- Shared accountability (between management and clinicians) for decisions.

The Clinical Council is responsible for advising the local health sector on redesign of the local clinical governance framework across the hospital and primary care to take account of a range of factors including:

1. Clinical involvement at all levels of the organisation and wider Hutt Valley health system
2. Development of decision making and responsibility to the most appropriate clinical unit or team
3. The development of clinical leadership at all levels
4. More systematic use of information about clinical outcomes
5. Ensuring that information from different sources is brought together so that a fuller picture about professionals' practice is properly considered
6. Ensuring local organisations adopt best practice in investigating critical incidents and acting on concerns.

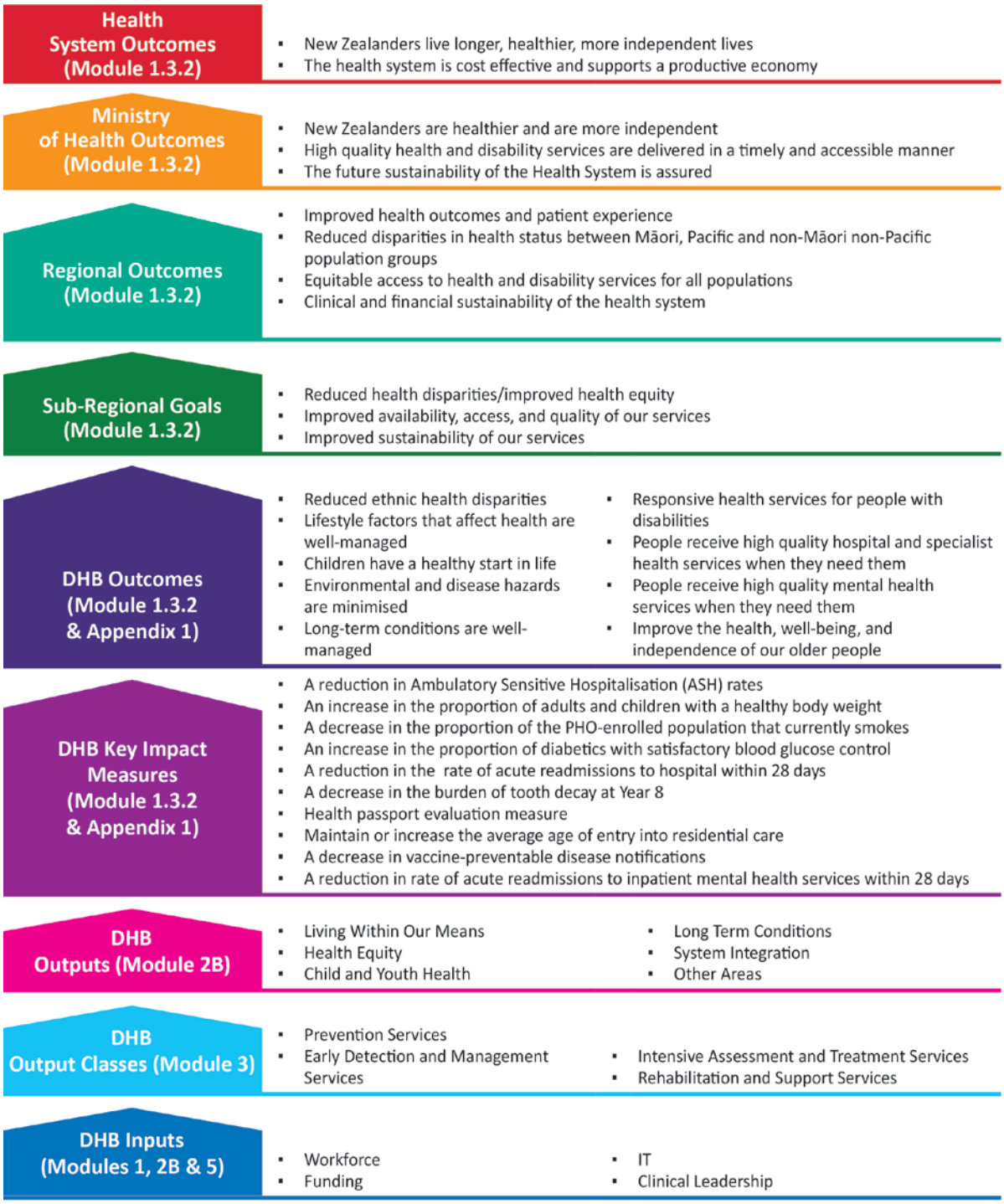
Consumer Engagement

The DHB is currently exploring the establishment of a Consumer Council in the Hutt Valley to work alongside the Clinical Council. This would provide a key mechanism to strengthen consumer engagement and input in the co-design of services changes and improvements.

Intervention Logic

The following diagram shows the connection between inputs, outputs, impact measures and desired outcomes for our health and disability system, building up from a local and sub-regional level to regional and national levels, and indicates the relevant Module of this Annual Plan in which they are described in more detail.

Intervention Logic Diagram



‘MODULE 2A’ IMPLEMENTATION OF THE NEW ZEALAND HEALTH STRATEGY

2A.1 CONTEXT

The New Zealand Health Strategy sets the direction of health services to improve the health of people and communities. Refreshed in 2015/16, the New Zealand Health Strategy: Future direction provides the high-level direction for the health system from 2016 to 2026. It describes the challenges and opportunities faced by the system, what is wanted, and identifies five strategic themes to take the sector forward into the future.

The New Zealand Health Strategy includes eight refreshed guiding principles for the system which reflect the values of New Zealanders and their expectations. These principles are:

1. Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi
2. The best health and wellbeing possible for all New Zealanders throughout their lives
3. An improvement in health status of those currently disadvantaged
4. Collaborative health promotion, rehabilitation and disease and injury prevention by all sectors
5. Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
6. A high-performing system in which people have confidence
7. Active partnership with people and communities at all levels
8. Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing.

2A.2 THEMES FROM THE HEALTH STRATEGY

People-powered - Mā te iwi hei kawe

- Making New Zealanders ‘health smart’; that is, they can get and understand the information they need to manage their care
- Enabling individuals to make choices about the care or support they receive
- Understanding people’s needs and preferences and partnering with them to design services to meet these
- Communicating well and supporting people’s navigation of the system, including through the use of accessible technology such as mobile phones and the internet.

Closer to Home - Ka aro mai ki te kāinga

- Providing care closer to where people live, learn, work and play, especially for managing long-term conditions
- Integrating health services and making better connections with wider public services
- Promoting wellness and preventing long-term conditions through both population-based and targeted initiatives
- Investing in health and wellbeing early in life and focusing on children, young people, families and whānau.

Value and high performance - Te whāinga hua me te tika o ngā mahi

- Delivering better outcomes relating to people's experience of care, health status and best-value use of resources
- Striving for equitable health outcomes for all New Zealand population groups
- Measuring performance well and using information openly to drive learning and decision-making that will lead to better performance
- Building a culture of performance and quality improvement that values the different contributions the public and health workforce can make to improving services and systems
- Having an integrated operating model that makes responsibilities clear across the system
- Using investment approaches to address complex health and social issues.

One Team - Kotahi te tīma

- Operating as a team in a high-trust system that works together with the person and their family and whānau at the centre of care
- Using our health and disability workforce in the most effective and most flexible way
- Developing leadership, talent and workforce skills throughout the system
- Strengthening the roles of people, families, whānau and communities as carers
- The Ministry of Health leading the system effectively
- Collaborating with researchers.

Smart System - He atamai te whakaraupapa

- Discovering, developing and sharing effective innovations across the system
- Taking advantage of opportunities offered by new and emerging technologies
- Having data and smart information systems that improve evidence-based decisions, management reporting and clinical audit
- Having reliable, accurate information that is available at the point of care
- Providing individual online health records that people are able to access and contribute to
- Using standardised technology that allows us to make changes easily and efficiently.

2A.3 STRATEGY ROADMAP OF ACTIONS

The New Zealand Health Strategy: Roadmap of actions 2016 provides 27 areas for action over the next five years, organised under the themes. The DHB is committed to delivering appropriate actions in line with the New Zealand Health Strategy's future direction, themes and the roadmap of actions to ensure that implementation of the refreshed Strategy can begin in 2016/17. The following table shows the alignment between the strategic themes and actions within sections from Module 2B in this plan, including cross references to the 27 action areas.

	New Zealand Health Strategy Themes (and associated action areas)				
Priority Area (Module 2B.2)	**People Powered**	**Care Closer to Home**	**High Value and Performance**	**One Team**	**Smart System**
Māori Health	✓ (2,3,4)		✓ (17)	✓	
Pacific Peoples Health	✓ (2,3,4)		✓ (17)	✓	
Disability	✓ (2)		✓	✓	
Public Health	✓ (2,5)	✓ (8,9)	✓ (18)	✓	
Maternal and Child Health		✓ (8,9)	✓		
Immunisation			✓		
Supporting Vulnerable Children		✓ (9)	✓		✓
Rheumatic Fever	✓		✓		
Youth Health	✓	✓ (8,9)	✓		
Dental/Oral Health Services	✓		✓		

Priority Area (Module 2B.2)	New Zealand Health Strategy Themes (and associated action areas)				
	People Powered	**Care Closer to Home**	**High Value and Performance**	**One Team**	**Smart System**
Long Term Conditions	✓ (1)	✓ (6,8)	✓	✓	✓
Healthy Families New Zealand	✓ (5)	✓ (9)	✓ (18)	✓	
Obesity	✓ (1)	✓ (8,9)	✓		
Diabetes	✓ (1)	✓	✓		
Cardiovascular Disease	✓ (1)	✓	✓		
Tobacco	✓ (1)	✓	✓		
Mental Health and Addictions	✓	✓ (9)	✓		
Service Integration/Configuration	✓ (1)	✓ (6,7,8)	✓ (13,14,15)	✓ (20)	✓ (26)
Screening Services			✓		
Cancer Services			✓		
Stroke Services			✓		
Cardiac Services			✓		
Health of Older People Services	✓	✓ (10)	✓		
Acute Demand	✓	✓	✓		
Whānau Ora	✓	✓ (9)	✓ (18)	✓	
Diagnostics			✓		✓
Pharmacy			✓		✓
Elective Services			✓		✓
Allied Health, Scientific and Technical			✓		✓
End of Life	✓	✓ (11,12)	✓		
Living Within our Means		✓ (6)	✓ (17)	✓	✓ (27)
NZ Health Partnerships Ltd			✓	✓ (20)	
Improving Quality	✓ (3,4)	✓ (7,10)	✓ (13,15,19)	✓ (20,23)	✓ (25)
Workforce	✓	✓ (7)	✓	✓ (20,23,24)	
Information Technology	✓ (1)	✓ (7,8)	✓ (17)	✓ (21)	✓ (25,26,27)
Actions to Support Delivery of Regional Priorities		✓ (8)	✓	✓ (21)	
Hepatitis C			✓		
Major Trauma			✓		✓ (25)

‘MODULE 2B’ DELIVERING ON PRIORITIES & TARGETS

2B.1 PRIORITIES AND TARGETS

2B.1.1 Implementing Government Priorities

The DHB is committed to giving effect to the overarching goals of the New Zealand health and disability sector of Better, Sooner, More Convenient health services for all New Zealanders, including *Better Public Services*, and to the Government priorities as outlined in the Minister’s Letter of Expectations. This includes commitment to:

- Achieving the National Health Targets - Increased Immunisation, Faster Cancer Treatment, Better Help for Smokers to Quit, Childhood Obesity, Shorter Stays in Emergency Departments, Improved Access to Elective Surgery
- Implement actions in 2016/17 from the Spinal Cord Impairment Action Plan 2014–2019
- Engage with the Ministry on the work programme of the former National Health Committee (once the programme is confirmed)
- Deliver on Annual Plan Priority areas and the Minister’s expectations:
    - Child and Youth Health (Reducing Unintended Teenage Pregnancy, Increased Immunisation, Supporting Vulnerable Children, Rheumatic Fever, Prime Minister’s Youth Mental Health Project)
    - Long Term Conditions – Prevention, Identification and Management (Healthy Families New Zealand, Tackling Obesity, Living Well with Diabetes, Cardiovascular Disease, Tobacco, Rising to the Challenge 2012-2017)
    - System Integration (Cancer, Stroke Services, Cardiac Services, Health of Older People, Service Configuration including Shifting Services, System Level Outcome Measures, Shorter Stays in Emergency Departments, Whānau Ora, Improved Access to Diagnostics, Improved Access to Elective Surgery)
    - Living Within our Means (Living Within Our Means, National Entity Priority Initiatives, New Zealand Health Partnerships Ltd)
    - Other (Improving Quality, Actions to Support Delivery of Regional Priorities Implementation of Health Information Technology Programmes).

Actions to support the delivery of Government priorities are included under the relevant areas of the Priority Area Deliverables section below.

2B.1.2 Regional, sub-regional and local actions sponsored/led by the DHB

The DHB is committed to working with regional DHBs to give effect to the actions outlined in the Central Region Regional Service Plan (RSP) 2016/17. This includes the priority areas of Elective Services, Cardiac Services, Mental Health and Addictions, Stroke Services, Health of Older People, Major Trauma, Hepatitis C, Cancer Services, Diagnostic Imaging and the enablers of Information Technology, Workforce and Quality and Safety.

Hutt Valley DHB will also work with its sub-regional partner DHBs, Capital and Coast and Wairarapa, on collective priorities. These include the areas of Laboratory Services, Gastroenterology Service, Blood and Cancer Services, Hospital Imaging Services, Mental Health and Addictions and the enablers of Health Pathways and Information Management.

Local actions to support the delivery of regional and sub-regional work are included under the relevant areas of the Priority Area Deliverables section below.

2B.1.3 DHB Local Priorities

Our Priorities

Our overarching priority is to continue to focus on the 'triple aim plus one':

- For our Patients - Improved quality, safety and experience of care and a better patient journey
- For our Populations - Improved health and equity for all populations
- For the Public - Best value for health system resources and living within our means
- A thriving organisation, including our organisational culture, clinical leadership, engagement and workforce development.

2B.2 PRIORITY AREA DELIVERABLES

Linkages between sections in different priority areas are indicated within square brackets.

2B.2.1 Health Equity

In New Zealand inequities in health exist between ethnic and socioeconomic groups, people living in different geographic areas, people belonging to different generations, and between males and females. These inequalities are not random: socially disadvantaged and marginalised groups have poorer health, greater exposure to health risks, and lesser access to high-quality health services. In addition, indigenous peoples tend to have poorer health. In New Zealand the extent of these inequalities is unacceptable and is a key focus for our DHB.

As in New Zealand more widely, the key drivers of health inequalities in our district are socio-economic factors and differential access to health and disability services. In order to address the key drivers of health inequalities in our district, we aim to:

- Engage the use of high-quality health information, for example, population health data and complete and consistent ethnicity data, to inform organisational decision-making
- Designate appropriate time, resources and information to enable Māori, Pacific and people with disabilities to have input into the design and implementation of health equity initiatives
- Allocate appropriate resources to specifically address access to high quality services with a focus on achieving health equity for Māori
- Ensure that the Code of Rights is visible and that individuals and whānau understand their rights
- Recognise the relevance and importance of te reo and tikanga Māori to high-quality health care
- Ensure that continuing professional development activities undertaken by health practitioners have a robust health equity and cultural competency focus.

Māori Health

He Korowai Oranga, which was refreshed in 2014, sets the direction for Māori health development in the health and disability sector. The strategy provides a framework for the public sector to take responsibility for the part it plays in supporting the health status of whānau. It assists the sector to work together with iwi, Māori providers and Māori communities and whānau to increase the life span of Māori, improve their health and quality of life, and reduce disparities with other New Zealanders. The overall aim of He Korowai Oranga is **whānau ora - Māori families supported to achieve their maximum health and wellbeing**.

The DHB holds a number of key relationships with mana whenua that operate at both governance and operational levels. These important relationships assist in reducing health inequalities and improving the health outcomes of Māori people within the Hutt Valley.

In addition to the national Māori Health priority areas, our Māori Health Plan local priorities are:

- Reducing the high rate of outpatient Did Not Attends (DNAs)
- Gout
- Cardiovascular Disease
- Diabetes.

Māori Health

Regional Actions

- Hold and evaluate Tū Kaha biennial Central Region Māori conference
- Accelerate the performance against the annual Māori Health Plan indicators:
    - Reduce ambulatory sensitive hospitalisation (ASH) rates
    - Reduce rates of heart disease
    - Reduce rates of diabetes.

Local Actions

Māori Health Plan 2016/17

Ethnicity Data Quality [linkage with Service Integration/Configuration]

- Continued use of the Ethnicity Data Audit Toolkit (EDAT) being used in General Practices to improve the accuracy of ethnicity recording and ethnicity reconfirmation. This work will include increasing General Practices' understanding of the necessity to record accurate ethnicity data to identify and address the inequalities and health needs of Māori (Q2-Q3). PHOs will work closely with General Practices and visit each practice within one year of the National Enrolment System (NES) starting. 90% of practices will have EDAT implemented within one year of the NES implementation starting. Once the stage 1 audit checklist is complete, improvements will be tied into the NES rollout based on the Ministry of Health's upcoming 'NHI Best Practice' content, which will accompany the NES rollout.

Access to Care - PHO enrolments [linkage with Service Integration/Configuration]

- Primary Health Organisations (PHOs) will continue to encourage people to enrol in primary care services at a wide range of community events e.g. Te Ra, Tumeke Taita, Christmas in da hood. This aims to increase awareness among the Māori community of the importance and advantages of enrolling and encouragement to enrol at that time. PHOs will report on the numbers of people that they engage with at community events to record how many unenrolled people were encouraged to enrol
- PHOs will maintain an active list of practices outlining which ones are taking new patients on a local website
- Possible research in the Emergency Department to ascertain from people who attend there and who are not enrolled what the barriers are to enrolment [linkage with Acute Demand].

Access to Care – Ambulatory Sensitive Hospitalisations (ASH) [linkages with Service Integration/Configuration & Public Health]

All ASH Conditions

The DHB-wide quality improvement plan to meet the requirements of the System Level Indicators Project focuses on ASH and acute admissions. This will provide an overarching framework and intervention logic for tackling priority ASH conditions in the District. Because the planning work will occur in Q1 some of the actions below may change or may be indicative only:

- Reduce acute exacerbations of Long Term Conditions (LTCs) by improved clinical management and self management by patients
- Ensure that relevant health pathways include referrals to self-management and to community providers or increased patient support
- Reducing DNAs at relevant secondary outpatient clinics.

Respiratory Conditions

- Implement recommendations from the Respiratory Patient Journey Project evaluation (to be completed in June 2016) with aim of enhanced integration, better health outcomes and improving patient experience of navigating the system. Focus is on disparity reduction, particularly for Māori
- Improving primary care access to specialist nurse and/or doctor advice as part of the Respiratory Patient Journey Project
- Asthma primary care quality improvement programme includes:
    - Tracking prescribing of preventers and relievers with aim of correct combination for all Māori asthma patients
    - Focus on management of childhood asthma including inhaler prescribing and consistent management through the consistent use of asthma plans and enhanced parent education.
- Chronic Obstructive Pulmonary Disease (COPD) – action in primary care to improve COPD management includes:
    - Risk stratification to identify patients with COPD
    - Including COPD patients in LTC practice plans
    - Encouraging primary care clinicians to use the relevant HealthPathway
    - Educating GPs on the new LABA/LAMA inhalers
    - Increased self-management support for all “at risk” populations, with upskilling of Whānau Ora navigators, community health worker and kaiawhina workforce, and connecting specific general practices to them, for follow-up support for the patients and whānau. This will link to the Self Management Support Framework under the LTC Network across the 3DHBs.

Skin Infections

- Ensuring that consistent advice is given in primary care about the identification of and care of skin infections. Encouraging primary care and Regional Public Health (RPH) to use existing pathways and the existing skin infection pack so that patients receive the same messages irrespective of where they present
- Increased promotion to the public of actions to prevent and get early treatment for skin infections in time for summer 2016 (Q2) [linkage with Public Health]
- RPH will continue to prevent, identify and treat serious skin infections in children in decile 1-6 primary schools and other vulnerable children in higher decile primary schools via referrals to public health nurses working with primary schools. As this is a demand driven service, RPH will report on numbers of skin related referrals to RPH public health nurses per annum to track aptterns and schools that warrant particular intervention [linkage with Public Health]
- RPH will support te kohanga reo kaimahi to build healthier environments for nga mokopuna through workshops. RPH will report on the number of workshops as this is demand driven
- Review Emergency Department attendances and admissions for cellulitis by general practice, and provide professional development for outlier practices. [linkage with Acute Demand]

Diabetes

- Assess services against the 20 Diabetes quality standards and develop a service improvement plan to address gaps. This work will reference the Atlas of Healthcare Variation, the 20 quality standards and the Quality Standards for Diabetes Care Toolkit. Links to DHB work to develop a diabetes working group to monitor diabetes management in primary care as part of HealthPathways for LTCs that are developed and rolled out
- Linkage to other diabetes actions below.

Breastfeeding [linkage with Maternal and Child Health & Obesity]

- HVDHB will continue to fund / support WCTO providers to deliver the Well Child schedule with a particular focus on improving Māori breastfeeding rates. Each WCTO provider is directly aligned to a PHO. They will support PHOs to implement initiatives aimed at promoting / raising the awareness of breastfeeding
- Maintain the Baby Friendly Hospital Initiative as an on-going initiative to make breastfeeding an easy and obvious option in hospital and after discharge
- DHB to redesign and develop breastfeeding coordinator role with specific focus on increasing rates at 6 weeks, 3 months and 6 months
- Complete a stocktake and survey of current services (Q1) to identify (Q2) and implement (Q3 on) key actions to improve Breastfeeding rates, with a focus on inequalities:
    - DHB to redesign and develop breastfeeding coordinator role with specific focus on increasing rates at 6wk, 3 months and 6 months.
- Health4Life programme upskilling health workers who are caring for women in pregnancy and the first year of life with messages around nutrition, physical activity, smokefree and alcohol
- Introduce a Marae-based pregnancy and parenting programme run by Birth Ed
- Support local breastfeeding networks and work with them to identify key actions to improve Maori Breastfeeding rates
- Implement a Request for Proposal for the provision of Green Prescription (Q1-Q2). This will include the new Maternal Green Prescription which includes a component on improving breast feeding rates
- Monitor (quarterly) and review (at 6 months) the efficacy of the HV community lactation consultants role to ensure targeted approaches to improve breastfeeding are effective for Maori
- Review and strengthen breastfeeding support for Māori women in the DHB facilities to ensure seamless continuity of breastfeeding support from birthing facility into the community
- Targeted Breastfeeding Education and Support (including Safe Sleep Messaging) for Breastfeeding Peer Counsellor Programme Administrators and Peer Counsellors.

Cervical Screening [linkage with Screening]

- Engage with primary care through the Regional Screening Coordination Group to identify women who currently don't get screened:
    - Target promotion of screening services to these women.
- Evaluate the effectiveness of Regional Screening Services support to primary care
- Ensure that Māori and Pacific women are referred to other providers e.g. Mana Wahine and Pacific Health Service for support
- Implement a joint approach with Mana Wahine / PHOs / NGOs to increase Māori screening rates
- Implement a Cervical Screening incentive trial programme targeting Māori
- Promote cervical screening at a minimum of four community events where priority women gather
- Provide staff to undertake active follow up and support of colposcopy services for priority women
- Support Primary Care through assistance with:
    - Use the PHO Cervical Screening Data Match Report to work intensively with a minimum of four general practices to improve coverage in Maori women
    - Provide staff to undertake follow up and recall of priority women.
- Support Primary Care and other relevant providers through providing:
    - Annual colposcopy training
    - Two education evenings
    - Quarterly smear taker workshops.
- Provide quarterly priority women breast and cervical screening days
- All PHOs will utilise their entire annual allocation of volumes for free cervical smears for priority women
- Improve the experience of colposcopy for Māori women:
    - Work with both Independent Service Providers and PHOs to actively engage and support hard to reach Māori wahine through the cervical screening pathway including colposcopy
    - Review written information to patients (e.g. invitation letters to attend colposcopy and leaflets explaining what colposcopy is) to ensure they reflect a patient and Whānau centred approach
- 6 monthly report of completed referrals by ethnicity, attendance, DNR, DNA, cancellations and reschedules

Breast Screening [linkage with Screening]

- Data-matching between the BSA register and PHO registers to identify and followup with women who are unscreened or overdue
- Encourage BreastScreen Central to offer screening clinics in extended hours
- Provide quarterly priority women breast screening days
- Reduce transaction costs by automatically notifying general practices of results for their patients, with opt-off policy
- Increased promotion and public education by DHB Communications team, around Breast Screening month
- Monitor and report indicator performance by ethnicity on a quarterly basis to the Hutt Valley Māori Health Services Development Group
- Out of hours breast screening clinics will be available (e.g. Saturdays)
- Promote Breastscreening at four community events where priority women gather
- One new BSC mobile site to be opened to improve access for priority women.

Smoking [linkage with Tobacco]

- Health4Life programme up-skilling health workers who are caring for women in pregnancy and the first year of life with messages around nutrition, physical activity, smokefree and alcohol
- Engage Ministry of Health to identify a system for monitoring brief advice to quit smoking, acceptance of cessation support and follow-up with pregnant women on smoking
- Monitor and report by ethnicity smoking cessation advice provision performance and smokefree rates at two weeks postnatal on a quarterly basis to the Hutt Valley Māori Health Services Development Group.

Immunisation [linkages with Immunisation & Service Integration/Configuration]

- Continued collaboration across National Immunisation Register (NIR), Primary Care and Outreach Immunisation Service (OIS) to reach whānau and encourage immunisation on time
- Sub-regional maintenance of immunisation governance with responsibility for monitoring implementation and actions to deliver on the national health target on immunisation, including monitoring coverage by ethnicity
- Continue the 3DHB triple newborn enrolment programme
- Identify the immunisation status of children presenting at hospital and refer for immunisation if not up-to-date
- Continue to identify areas where performance could be improved and progress opportunities to address specific areas of concern
- Continue education opportunities provided for nurses and midwives
- Provide an active search for Māori tamariki and whānau in collaboration with the Hutt Valley DHB Whānau Care team, Immunisation team, Māori Health providers and the PHO Community Health Workers to ensure tamariki are actively found, followed through and are presenting to either their GP or OIS for their required immunisations
- Identify eligible patients, particularly Māori, advise of influenza immunisation, and administer influenza immunisation
- DHB, PHO and NGO services to undertake a minimum of two promotional activities to encourage the uptake of influenza immunisation for 65+ with a particular focus on elderly Māori
- Increased promotion of seasonal influenza vaccination by DHB Communications team as part of winter planning (April to June each year).

Rheumatic Fever [linkages with Rheumatic Fever & Service Integration/Configuration]

- Primary care and community pharmacies continue to provide rapid response “sore throat clinics”
- Strengthened model for effective assessment of sore throats (rapid response) across the Hutt Valley through the promotion of rapid response “sore throat clinics”, with increased promotion in winter in line with the DHB’s refreshed sub-regional Rheumatic Fever Prevention Plan
- Link all DHB level activities to the sub-regional Rheumatic Fever Prevention Plan
- RPH will continue to strengthen the sub-regional healthy housing coordination service and interventions programmes, in partnership with the Tu Kotahi Māori Asthma Trust, the Sustainability Trust and He Kainga Oranga, to improve housing and health for our most vulnerable communities. This will reduce functional and structural overcrowding, and improve in home warmth and dryness.

Oral Health [linkage with Dental/Oral Health]

- Analysis of coverage and outcome indicators to meet set arrears target of 10%
- Early Intervention team to work with targeted high need ECE, including Kohanga Reo, to increase enrolments; deliver oral health education and support the centres with healthy food policies
- Continue to match PHO and Bee Healthy registers to identify under-fives who are not enrolled with Bee Healthy and undertake an 'opt-off' process for enrolment.
- Participate in Healthy Families Lower Hutt initiatives to promote 'water only' environments and increase whānau knowledge of healthy eating and drinking [linkage with Public Health & Healthy Families NZ]

Mental Health [linkage with Mental Health and Addictions & Whānau Ora]

- Analysis of Māori uptake of primary mental health services to see how many Māori are using services and whether utilisation aligns with prevalence
- Jointly with the Ministry of Health, identify variance in use of Section 29 by establishing consistent data collection processes for this indicator
- Analyse the degree of variance in use of Section 29 within the DHB by reviewing the rationale for its use
- Report findings of analyses to practitioners and a clinically-led multidisciplinary mental health forum
- Develop guidelines and regular auditing processes to support standardised application of Section 29.

Sudden Unexpected Death of an Infant (SUDI) [linkage with Maternal and Child Health]

- Safe sleep information discussed with women before discharge from hospital. Discussion is recorded in discharge summary
- Continued support from DHB Sleep Safe Champion who ensures that staff are aware of and implement the policy
- Access to pepi pods via Plunket, Kokiri and NET for mothers who wish to have one
- Renew Baby Friendly Hospital Initiative accreditation
- Caregivers provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1
- SUDI prevention information is given at six week immunisation event in primary care
- SUDI information is given at community events – Te Ra etc
- DHB Safe Sleep Champions will provide SUDI Prevention training to all new staff employed in the inpatient child health services and to the DHB core midwives in the maternity postnatal service
- The HVDHB Safe Sleep Policy will be incorporated as part of the SUDI Prevention training.

Did Not Attends (DNA) [linkage with Elective Services]

- Maintain a special focus on outpatient specialties that have the highest DNA rates.
- Support all clinics to have a DNA focus on children 0-4 years.

Gout [linkage with Diabetes]

- Develop an action plan to improve management of gout with the following elements:
    - Sharing specialist knowledge, prioritising activity in practices with high Māori populations
    - Develop a decision support tool to improve consistency of prescribing for gout
    - Collaborative co-design of community support. This will improve health literacy and self-management strategies for Māori men and post-menopausal women
    - Explore links with rongoa Māori services.

Cardiovascular Disease (CVD) [linkages with Cardiovascular Disease, Service Integration/Configuration, Public Health & Health Families New Zealand]

- Increase screening - Focus on Māori men aged 35-44years by linking in with HealthPathways for LTCs that are developed and rolled out.
- Collaborative co-design of community pathways to reduce admission for CVD. This includes education support, wrap-around services and whole of whānau empowerment
- Continue professional development for General Practice clinicians about regular identification and monitoring, especially blood pressure monitoring
- Increased self-management support for all "at risk" populations, with up-skilling of whānau ora navigators, community health worker and kaiawhina workforce, and connecting specific general practices to them, for follow-up support for the patients and whānau. This will link to the development of Self-Management Support Framework under the LTC Network across the 3 sub-regional DHBs
- Building community capacity – improving health literacy and self-management strategies for those Māori identified as at high risk of CVD

- Continued health promotion to reduce risk factors in population, including Healthy Families Lower Hutt
- Use community events to promote and encourage uptake of CVD Risk Assessment, with a particular focus on increasing the number of Māori men aged 35-44 years
- RPH will continue to strengthen the sub-regional healthy housing coordination service and interventions programmes, in partnership with the Tu Kotahi Māori Asthma Trust, the Sustainability Trust and He Kainga Oranga, to improve housing and health for our most vulnerable communities. This will reduce functional and structural overcrowding, and improve in home warmth and dryness
- RPH will continue to establish and support community based fruit and vegetable co-operatives, in areas with high Māori, Pacific and children populations and high socioeconomic deprivation.

Diabetes [linkages with Diabetes & Service Integration/Configuration]

- Better management of diabetes, within the LTC programme rolled out across primary care
- Implement the LTC programme in Te Awakairangi Health Network general practices across the Hutt Valley (12 practices by Q2, 16 practices by Q4 and all by Q1 2017/18). Activities include:
    - Diabetes and pre-diabetes identification will be undertaken in Cardiovascular Disease risk assessment as part of the LTC programme
    - The DHB will assess performance against the Quality Standards for Diabetes Care and recommend actions to address any gaps
    - A diabetes working group will be established to monitor key clinical indicators across primary and secondary care and identify service improvements to improve clinical outcomes and reduce disparities.
    - Increase and improve specialist advice across all primary health care teams
    - Continue to improve the integration of care for children and adults with type 1 diabetes across the Hutt Valley health system
- Increased self-management support for all "at risk" populations, with upskilling of whānau ora navigators, community health worker and kaiawhina workforce, and connecting specific general practices to identify and follow-up patients and support them and their whānau
- Better management of diabetes, with LTC programme rolled out, including PHOs screening for renal disease with blood pressure monitoring and increasing insulin starts where appropriate
- Link with HealthPathways for LTCs that are developed and rolled out.

Measures (see also Modules 3 & 7 and Appendix 1 for other Māori ethnicity monitored DHB measures)

Māori Health Plan

- Monitor and report indicator performance on a quarterly basis to Hutt Valley Māori Health Services Development Group and six monthly to CPHAC.

Māori Health Plan National Indicators

- Ethnicity Data Quality
- Percentage of Māori enrolled in PHOs
- SI1: Ambulatory Sensitive Hospitalisations
- Māori breastfeeding rates (at LMC discharge, at 3 months, at 6 months)
- Cervical screening coverage for Māori women
- Breast screening coverage for Māori women
- Smoking cessation: Percentage of pregnant Māori women who are smoke free at two weeks postnatal
- Percentage of Māori infants fully immunised by eight months of age
- Number and rate of first episode rheumatic fever hospitalisations
- Percentage of Māori pre-school children enrolled in the community oral health service
- Rate of Māori Mental Health Compulsory Assessment and Treatment Act: Section 29 community treatment orders relative to other ethnicities
- Five year rate of Sudden Unexpected Death in Infancy (SUDI) deaths per Māori live births

Māori Health Plan Local Indicators

- Percentage of Māori not attending hospital appointments
- Percentage of Māori men enrolled in the PHO who have had a CVD risk recorded within the past five years
- Percentage of Māori with managed HbA1c levels.

Pacific Peoples Health

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018 sets out sets out the strategic direction to address health needs of Pacific peoples, sets the Government's priority focus areas for Pacific health and specifies new actions to facilitate the delivery of high-quality health services that meet the needs of Pacific peoples. The long term vision of 'Ala Mo'ui is:

Pacific 'āiga, kāiga, magafaoa, kōpū tangata, vuvale and fāmili experience equitable health outcomes and lead independent lives.

The four priority outcome areas of 'Ala Mo'ui are:

1. Systems and services meet the needs of Pacific peoples
2. More services are delivered locally in the community and in primary care
3. Pacific peoples are better supported to be healthy
4. Pacific peoples experience improved determinants of health.

We are building on the foundations that have already been laid across our district with relation to Pacific. We work in partnership with the 3DHB Sub-regional Pacific Strategic Health. Addressing health inequalities requires a population health approach that takes account of all the influences on health and how they can be tackled to improve health. This approach requires intersectoral and integrated actions that address the social and economic determinants of health and action within health and disability services to tackle the root causes of health issues, particularly the social-economic component.

Hutt Valley and Waiarapa DHBs have developed a joint plan for the Pacific people who come under the care of our DHBs, *Pāolo mo tagata ole Moana: Pacific Health Action Plan 2015-2018*. Pāolo mo tagata ole Moana is Samoan for refuge or shelter for people of the ocean. Our vision for the future is for Pacific families to live longer and healthier lives. The key focus for the plan is providing Pacific communities with a better health system that is accessible and affordable, with the aim of reducing the health inequalities between Pacific populations and other groups. The Pacific team works across both the Hutt Valley and Wairarapa DHBs and the four priority focus areas are:

- Child Health – giving every Pacific child the best start in life
- Health Literacy – raising awareness of health messages amongst Pacific people through community based education programmes
- Access to Care – reducing barriers to primary care to ensure equity of access for Pacific people
- Workforce Capacity – increasing the number of Pacific people employed in all levels of the health sector and the development of future workforce.

Pāolo mo tagata ole Moana: Pacific Health Action Plan 2015-2018

Child Health [linkage with Child Health]

- Increase the percentage of Pacific infants who receive all 5 Well Child/Tamariki Ora core contacts in their first year of life
- Immunisation coverage of Pacific infants at 8 months of age (target 95%)
- All Pacific children (aged 2-12) are seen annually by community oral health services
- Investigate opportunities for Pacific specific healthy eating programmes
- Develop a Pacific specific parenting programme about healthier families.

Health Literacy

- Health promotion and information to be delivered at community settings where Pacific people meet
- Facilitate and fund community-based health education sessions and utilise church-based settings

- Explore options of developing a parish nursing approach as an outreach model for engaging with our Pacific churches and families
- Engaging our Pacific churches and community leaders, Pacific providers, PHOs and NGOs to work alongside us to achieve our goals.

Access to Care [linkage with Service Integration/Configuration]

- Investigate Pacific barriers to accessing primary care and make specific recommendations to address barriers
- Investigate options to fund approaches to improving access.

Workforce Capacity [linkage with Workforce]

- Undertake stocktake of current Pacific workforce across both DHB districts
- Grow and strengthen the Pacific workforce by supporting their professional development
- Increase opportunities for recruitment of Pacific people at all levels and in all priority occupational groups
- Continue to invest in Pacific youth development by offering scholarships to young Pacific people to pursue health related studies
- Complete a scoping exercise of existing Pacific cultural awareness programs for all staff in DHBs and PHOs

Measures (see also Modules 3 & 7 and Appendix 1 for other Pacific ethnicity monitored DHB measures)
Pacific Health Plan Local Indicators

- Percentage of infants receiving all 5 WellChild/Tamariki Ora core contacts in their first year of life
- Percentage of Pacific infants fully immunised by eight months of age
- PP13: Improving the number of children enrolled in DHB funded dental services
- SI1: Ambulatory Sensitive Hospitalisations

Disability

Disability is not about what people have – people live with impairments of many kinds; disability is about the interaction of people, services, and systems with the individual and group in a way that disadvantages them. The *New Zealand Disability Strategy*'s vision is of a society that highly values the lives and continually enhances the full participation of disabled people. It provides a framework to guide government agencies making policy and services impacting on disabled people and to influence the attitudes and behaviour of society as a whole. By all New Zealanders considering issues facing people with disabilities and their aspirations, New Zealand can become a fully inclusive society.

Since 2009, the Ministerial Committee on Disability Issues has provided ministerial leadership across government on implementing the *New Zealand Disability Strategy* and the *United Nation's Convention on the Rights of Persons with Disabilities (UN Convention)*. UN Convention reports have identified continuing disparity and the need for considerable improvement in provision of health services to people with disabilities. In 2016 the Office for Disability Issues will be leading a process to revise the *New Zealand Disability Strategy*.

Our sub-regional DHBs have collaborated with our communities and agreed on a five year disability plan "*Valued Lives Full Participation" Wairarapa, Hutt Valley and Capital and Coast District Health Boards Implementation Plan of the New Zealand Disability Strategy and the United Nations Convention of the Rights of Persons with Disabilities 2013-2018*. The plan outlines progressive steps to achieve improved integration and better health outcomes for people with disabilities. The Disability Responsiveness Programme is the mechanism used to lead local and sub-regional work plans. The plan has four focus areas:

1. ***Health*** – Health disparities will be reduced by providing best care and improving, protecting and promoting the health of disabled people
2. ***Inclusion and support*** **–** Our district's will better include and promote the full participation of disabled people and services will ensure the best support for disabled people and their families
3. ***Access*** **–** Disabled people will have more independent access to services to meet their health and support needs
4. ***Leadership*** **–** The three DHBs will provide and share leadership with disability communities and others to develop, adapt and meet current and new expectations.

Two of the tools that are seen as fundamental to the success of the plan are the Health Passport and Disability Alerts.

The Health Passport is a nation-wide tool, sponsored by the Health and Disability Commissioner, to date successfully and consistently implemented throughout the sub-region over a four year period. The Health Passport is a patient-owned, communication tool that can be used in any health setting to express an individual's support needs.

The Disability Alert is an electronic alert on the inpatient Concerto system that serves two purposes. At a strategic level it is a measurement tool; what is being measured includes average length of stay, acute discharges and cross-sectional data such as ethnicity and disability type. The alert allows planners to track progress through the health system and, as data becomes more robust, to better understand the impact of disability on access to the health system, as well as the ways in which the journey could be of greater quality and more cost effective. Internationally there is also a a large gap in disability data and health needs assessments do not prioritise disability, creating an invisible population.

At an operational level the alerts and the Health Passport provide tools for partnership between patients and clinicians. This is achieved by patients identifying the support needs in summary within the alert, backing up the Health Passport which provides a full care plan and disability support needs. Disability Responsiveness 'champions', who are clinical and non-clinical experts, are identified in a publicly available network for people using services and staff needing support in all areas of healthcare. Champions promote alerts and a range of other initiatives to improve services.

Disability

Sub-regional actions

Disability Alerts

- Intensive work to be undertaken to ensure administrative and clinical staff understand and support patients to self-identify needs via Disability Alerts and the Health Passport:
    - Target of 1000 new alerts to be created and completed for Hutt Valley DHB
    - Target of 40% of patients with Disability Alerts to be Health Passport users.
- Disability alerts information will be quality checked and shared with primary care practices: [linkage with Service Integration/Configuration]
    - Target of 500 to be checked and shared for Hutt Valley DHB
- Dashboard of indicators to contribute to equity reporting in 2016/17.

Disability Responsiveness Workforce Development

- Disability Responsiveness eLearning to be shared sub-regionally:
    - eLearning is actively encouraged in Hutt Valley DHB to increase numbers of staff completing prior to mandatory training in 2017/18

- Target Allied Health, Nursing and Year One Registrars.
- Launch video resource across the sub-region
- Develop training package to be shared sub-regionally, and regionally where possible.

Health Passport

- Conduct targeted surveys to generate feedback on Health Passport from users and staff
- Implement a targeted approach with primary care practices to Read code Health Passport information: [linkage with Service Integration/Configuration]
  - Target of 500 people sub-regionally to have Read coded Health Passport.
- Target 40% of patients with Disability Alerts to be Health Passport users
- Support the review of Health Passport in collaboration with the Office of the Health and Disability Commissioner, the Health Quality and Safety Commission and sub-regional clinicians to review, refresh and develop an electronic version of Health Passport for national usage.

Child to Adult Transition

- Implement the electronic Health Pathway
- Trial a transition tool kit created with families in 2015/16 in the Hutt Valley in 2016/17 before expanding this into Capital & Coast in 2017/18.

Learning Disabilities within Primary Care

- In collaboration with the Ministry of Health and the Royal New Zealand College of General Practitioners, develop best practice guidelines to improve the health of people with learning disabilities
- The Child to Adult Transition Health Pathway will interlink with best practice guidelines developed above to provide complimentary system information and resources for families and clinicians.

Deaf Responsiveness

- Develop and implement a plan for stage 2 of the New Zealand Sign Language (NZSL) review
- Improve access to sign language interpreters by realigning current budget spend
- Increased cost effective and efficient access to NZSL interpreters reviewed with participating practices, and considered for wider roll out in 2016-18
- Produce resources to explain medical procedures accessible for NZSL users.

Improve Access to Services

- Implement recommendations from 2015/16 Access audits.
- Access champions each to identify one key area of improvement and implement.

Build Community Resilience and Empowered Self-Care

- Service Integration and Development Unit (SIDU) to partner with disability community leaders to organise and coordinate forums across primary health and community
- To build on SIDU sub-regional consumer group linkages (mental health and disability) to develop effective models of engagement within the co design of health services
- To engage in health literacy development across all services:
  - Produce resources to explain medical procedures accessible for NZSL users as well as mainstream health service users
- Work with Alliance Leadership Teams to engage primary care in more confident collaboration with service users [linkage with Service Integration/Configuration]
- To integrate the disability consumer voice into all projects that draw on consumer consultation.

Measures

3DHB Outcome 8: Responsive health services for people with disabilities (see Appendix 1)

- Proportion of patients and clinicians finding the Health Passport useful.

Statement of Performance Expectations measures (see Module 3):

- The number of sub-regional and HVDHB Disability Forums
- The number of sub-regional Disability Newsletters
- The total number of hospital staff that have completed the Disability Responsiveness eLearning Module
- The total number of Disability Alert registrations.

Public Health - including Health Promotion Agency priorities

Regional public health services are delivered by 12 DHB-owned Public Health Units (PHUs), and a range of non-governmental organisations. PHUs focus on environmental health, communicable disease control, tobacco control and health promotion programmes. Many of these services include a regulatory component performed by statutory officers appointed under various statutes, though principally under the Health Act 1956.

Regional Public Health (RPH) is the sub-regional PHU working with communities across the greater Wellington region. RPH provides services as per the Ministry of Health's service specifications for public health services and contractual agreements with Wairarapa, Hutt Valley and Capital & Coast DHBs and the College of Public Health medicine. RPH works in collaboration with Māori, Pacific peoples, communities, and providers across the health sector (primary health care in particular). To focus action on more equitable health and wellbeing outcomes, RPH links with a wide range of government, non-government and community organisations, addressing barriers and enablers such as access to health care services, housing, income, employment and education.

The RPH annual business plan takes into account the Government's expectations as well as national, central region, sub-regional and local priorities. RPH contributes indirectly to many of the Government's and DHB's health targets and priorities. For example, activities to increase access to healthy food choices can, over time, contribute to preventing diabetes and other long-term conditions. Of the specified Government and DHB health priorities, RPH services directly contribute to: Tobacco, Immunisation, Rheumatic Fever, Supporting Vulnerable Children, Social Sector Trials, Healthy Families New Zealand, Māori Health, Pacific Health, Service Integration/Configuration, Long Term Conditions, Maternal and Child Health, Youth Health, Obesity, and Mental Health.

As detailed in the *Regional Public Health 2016-2017 Business Plan* RPH's vision is to achieve **'better health for the greater Wellington *region'***. RPH has the bold goal of halving the rate of avoidable hospital admissions for Māori, Pacific and children by 2021.
The organisation works according to the following key principles:

- Focusing on the health of communities rather than individuals
- Influencing health determinants
- Prioritising improvements in Māori health
- Reducing health disparities, including a focus on Pacific peoples and vulnerable groups
- Basing practice on best available evidence
- Building effective partnerships across the health sector and other sectors
- Remaining responsive to new and emerging health threats.

Its public health service outcomes sought are:

- A healthier and more productive population
- Reducing health disparities, including a focus on Pacific peoples and vulnerable groups
- Improving Māori health
- Increased safeguards for the public health
- A reduced burden of acute and chronic disease.

RPH priorities are:

- Working with Māori

- Focus on children
- Engagement with primary care.

Regional Public Health (RPH) [Numbering references below to RPH Business Plan]

NB: all actions cover the sub-region of HVDHB, CCDHB and WaiDHB, exceptions are stated)

Health Promotion

1.3 Building healthy social environments (sub-regional)

- RPH will work with health sector and other partners to develop a Community Action Neighbourhood Approach in Wainuiomata. Includes community empowerment in public health programmes to reduce harm from tobacco, alcohol and obesity. [linkages with Child, Youth Health, Healthy Families New Zealand, Long Term Conditions, Obesity & Tobacco]
- RPH will lead a suicide post-vention programme (sub-regional) [linkage with Mental Health and Addictions].

1.4 Community Liaison: Porirua (CCDHB) and Hutt Valley (HVDHB) [linkages with Long Term Conditions & Healthy Families New Zealand]

- RPH will work with high needs communities (Māori, Pacific and low income families) in Porirua and the Hutt Valley to: improve links among RPH staff working in those communities; improve relationships between RPH staff and those communities; provide public health advice to community groups and community projects; and continue to develop community action processes.

2.1 Smokefree Nation 2025 (sub-regional) [linkages with Long Term Conditions, Tobacco, Healthy Families New Zealand & Systems Integration/Configuration]

- RPH will continue to ensure compliance with and support awareness of the Smokefree Environments Act 1990 with the overall goal of a Smokefree Aotearoa by 2025.

3.1 Nutrition and physical activity (sub-regional) [linkages with Long Term Conditions, Obesity & Healthy Families New Zealand]

- RPH will promote healthier lifestyles and improve the environments where people live, learn, work and play.
    - RPH will continue to establish and support community based fruit and vegetable co-operatives, in areas with high Māori, Pacific and children populations and high socioeconomic deprivation.
- RPH will build healthy public policy, create supportive environments and strengthen community action, and focus on the communities of highest need.

4.2 CAYAD (Community Action on Youth and Drugs) [linkages with Youth Health & Mental Health and Addictions]

- RPH will enhance, promote and strengthen the supports provided to rangatahi in the Hutt Valley to improve outcomes for drugs and alcohol, through three core project areas: enhance sector quality and sustainability; promote protective factors to reduce alcohol and drug harm; and challenge local and other drug culture.

5.5 Sexual health promotion [linkages Youth Health, Māori Health & Pacific Health]

- RPH will continue to work with schools and other sector agencies to promote improved sexual health education.

6.2 Promote safe and healthy urban environments [linkages with Long Term Conditions & Rheumatic Fever]

- RPH will influence decisions made in key health, housing and urban planning processes that have the greatest potential to improve Māori, Pacific, and child health.
    - RPH will continue to strengthen the sub-regional healthy housing coordination service and interventions programmes, in partnership with the Tu Kotahi Māori Asthma Trust, the Sustainability Trust and He Kainga Oranga, to improve housing and health for our most vulnerable communities. This will reduce functional and structural overcrowding, and improve in home warmth and dryness. (3DHB).
    - RPH will work with communities, local and central government to influence good urban design and planning.

6.4 Health Promoting Schools [linkage with Healthy Families New Zealand & Child Health]

- RPH will work within schools in communities of high need - Māori, Pacific and low income.

Health Protection

1.5 Promote the health of refugees

- RPH will deliver refugee health services to quota refugees, refugee family support category (RFSC) and asylum seekers including: clinical services to facilitate refugees transitioning into the health system; training and education to build health sector capability (i.e. primary care services); health promotion activities for refugee communities and volunteer support organisations (i.e. Red Cross Refugee Services).

4.1 Alcohol and other drugs [linkages with Child Health, Youth Health, Long Term Conditions & Mental Health and Addictions]

- RPH will work with Police, councils and community agencies to understand and address the issues driving the harmful consumption of alcohol and drug use to reduce harm.

5.1 Communicable diseases [linkage with Systems Integration/Configuration]

- RPH will effectively respond to notifiable diseases and outbreaks by: public health disease surveillance, investigation and control of communicable, waterborne and foodborne diseases; providing robust ethnicity data collection and review of surveillance data by ethnicity to help direct response to the most vulnerable communities including Māori, Pacific and children.

6.1 Minimise environmental hazards promote safe drinking water sustainable resource management

- RPH will deliver regulatory work relating to the physical environment including promote the availability of safe drinking water to all communities; reduce adverse health effects from the use or misuse of hazardous substances; ensure safe recreational water quality; and reduce health inequities through influencing strategic public health policies and through Resource Management Act processes.

6.3 Early childhood [linkages with Healthy Families Lower Hutt (HVDHB), Child Health & Obesity]

- RPH will improve public health outcomes for children attending early childhood services especially Te Kohanga Reo and Pacific services; and work with staff to raise awareness of regulatory requirements, gastroenteric illness and to encourage the uptake of healthy food.

6.6 Border health and response to emergency events

- RPH will work with agencies to assist in reducing risks associated with the introduction to New Zealand of vectors and diseases of public health significance, including in vulnerable communities.
- Through collaborative emergency planning and response, RPH will reduce the impact of emergency events on vulnerable communities (particularly Māori) will be minimised.

Preventative Interventions

1.6 Work with schools to identify and address health needs [linkages with Maternal and Child Health, Supporting Vulnerable Children, Rheumatic Fever, Long Term Conditions, Obesity & System Integration/Configuration]

- RPH Public health nurses in primary and intermediate schools, identify and manage health concerns that arise from the social determinants of health. A broad range of services is provided to all children and their whānau. High deprivation areas and lower decile schools receive more intensive services. Referrals are from parents, schools and other community providers for children with unmet health needs.
    - RPH will continue to prevent, identify and treat serious skin infections in children in decile 1-6 primary schools and other vulnerable children in higher decile primary schools.

1.7 Improving vision and hearing [linkages with System Integration/Configuration, Child Health & Youth Health]

- RPH will focus on reaching Māori and Pacific children and youth; provide vision and hearing screening prior to starting school, and at intervals during school years; provide a referral system to primary or secondary care; and strengthen ear health skills of public health nurses.

5.2 Promote and facilitate immunisation [linkages with Immunisation & Systems Integration/Configuration]

- RPH will deliver immunisation programmes including a focus on education, training, delivery, data collection and promotion of immunisation in the community; and support health professionals and community agencies to provide positive immunisation messages.

5.3 RPH will deliver school-based Year 7 and 8 Boostrix and Gardasil vaccination programmes [linkages with Immunisation & Systems Integration/Configuration]

- RPH will deliver the school-based Year 7 Boostrix programme - diphtheria, tetanus and pertussis

(whooping cough) and the school-based Year 8 Girls Gardasil programme - human papillomavirus viruses.

5.6 Deliver neonatal BCG vaccination [linkage with Immunisation]

- Tuberculosis infection. RPH will offer at risk groups a BCG immunisation in a timely manner; and provide education to caregivers before and after delivery of the immunisation.

Health Assessment and Surveillance

7.6 Public health analytical services

- RPH will provide a range of public health analytical services to support RPH and the wider public health sector; and focus on health assessment, surveillance and public health analytical capacity development core functions.

Public Health Capacity Development

7.1 Business support

- RPH will provide administration, information systems, business support and work with primary healthcare. [linkages include Child Health, Long Term Conditions & System Integration/Configuration]

7.2 Māori action plan [linkage with Māori Health]

- RPH will implement and embed components of the RPH Māori Strategic Plan.

7.3 Pacific Peoples action plan [linkage with Pacific Health]

- RPH will strengthen RPH responsiveness to Pacific communities. Focus on developing organisational capacity and building staff capability including Pacific cultural competency training.

7.4 Public Health Infrastructure [linkages with Workforce & Quality]

- RPH will provide services for workforce development and public health governance.

7.8 Communications support and health information dissemination

- RPH will provide communications support and health education resource dissemination including resource development, media advice, web content management and distribution of health education resources.

7.9 Central region public health advice

- RPH will support central region public health services and provide regional leadership through: providing specialist and technical public health advice for central region public health units ; facilitating training relevant to the needs of the public health units; facilitating and leading collaboration with the central region public health units through the Central Region Public Health Clinical Network (CRPHCN);and providing specialist public health advice and/or representation to the Ministry of Health or other relevant central government agencies.

8.1 Standalone contracts

- RPH will support to the national Public Health Clinical Network; and provide supervision for registrars on the NZ College of Public Health Medicine vocational training programme in the central region.

Measures

3DHB Outcome 1: Reduced ethnic health disparities (see Appendix 1)

- A reduction in Ambulatory Sensitive Hospitalisation rates
- A reduction in amenable mortality rates.

3DHB Outcome 2: Environment and disease hazards are minimised (see Appendix 1)

- A decrease in vaccine-preventable disease notifications
- An increase in the percentage of premises visited that are compliant with Supply of Liquor Act 2012 for sales to minors.

3DHB Outcome 3: Lifestyle factors that affect health are well-managed (see Appendix 1)

- A decrease in the obesity prevalence in children and adults
- A decrease in the proportion of the Primary Health Organisation enrolled population that is recorded as a 'current smoker'
- An increase in the proportion of mothers who are smokefree two weeks post-natal.

Statement of Performance Expectations measures (see Module 3):

- The number of disease notifications investigated
- The number of environmental health investigations
- The number of premises visited for alcohol controlled purchase operations
- Number of submissions providing strategic public health input and expert advice to inform policy and

public health programming in the sub-region
- Number of new referrals to Public Health Nurses in primary/intermediate schools
- The percentage of Year 7 children provided Boostrix vaccination in schools in the DHB
- The percentage of Year 8 girls vaccinated against HPV (final dose) in schools in the DHB.

DHB Performance Measures (see Module 7)
- PP21: Immunisation coverage
- SI1: Ambulatory Sensitive Hospitalisations.

The Health Promotion Agency (HPA) is a Crown entity established in 2012 through the merger of the Alcohol Advisory Council, Health Sponsorship Council and some health promotion functions previously delivered by the Ministry of Health. HPA leads and delivers health promotion programmes to enable people to increase control over and improve their health, as well as undertaking functions specific to providing advice and research on alcohol issues.

Health Promotion Agency
- The DHB will support national health promotion activities around the Health Targets
- The DHB will support alcohol screening and brief intervention in pregnancy
- The DHB will support the provision of routine and consistent advice to women of child bearing age about alcohol and pregnancy.

Measures
Refer to Public Health measures above.

2B.2.2 Child and Youth Health

Maternal and Child Health

Across the three DHBs, there is an increased focus on working with children and young people to support long-term outcomes of improved health and wellbeing for our population. In 2014/15 the Alliance Leadership Teams identified child and maternal health as a key focus area. We have planned with our wider sector including Primary Care providers, Lead Maternity Carers, Well Child/Tamariki Ora providers and Community Oral Health Services actions to deliver improvements. We have considered quality improvement activities at the sector level rather than the service level, and support integration between services to achieve improved outcomes and improved value for money. We are increasingly aiming for:

- Early intervention to prevent disease e.g. focus on immunisation and primary mental health services for youth
- Ensuring treatment is as close to home as possible e.g. increasing services available in the primary care setting
- Working with our intersectoral partners to ensure people receive services from the most appropriate provider and, where possible, minimise duplication of services by different entities.

In the Hutt Valley we are working with Healthy Families Lower Hutt to improve health outcomes by taking an intersectoral approach (see Healthy Families New Zealand section below for more detail). We are also focussing on early treatment of sore throats to prevent rheumatic fever across the sub-region.

The DHB recognises breastfeeding as a cost effective health strategy which contributes positively to maternal and infant health and has an important role to play in reducing inequalities especially for

Māori and Pacific. It is an essential tool in the fight against obesity, diabetes, heart disease, gastro-intestinal, urinary, ear and respiratory infections, Sudden Unexplained Death in Infants (SUDI) and many other conditions.

As part of a sub-regional child health project, the three DHBs are exploring opportunities to work together more closely to improve child health outcomes across the sub-region. One of the initial areas of focus is opportunities to better integrate Child Development services across the sub-region, address variability in access, and to prepare for any changes that might arise from the Ministry of Health's national review of Child Development services that is currently underway. The sub-region will also be exploring how Child Protection services could be better aligned and integrated across the three DHBs, including greater alignment with national expectations in relation to child protection. This will include considering opportunities for more co-operation in the development and delivery of training, greater alignment of policies and procedures, information collection and reporting systems.

The sub-regional child health project also recognises the need for the three individual DHBs to lead specific projects to improve child health outcomes and to improve the quality and efficiency of service delivery. This includes regional and sub-regional work as CCDHB explores current and future patient flows from referring DHBs for more complex children's services as part of their hospital campus master plan developments.

Maternal and Child Health

Sub-regional actions

- Undertake sub-regional child health project towards:[linkage with Supporting Vulnerable Children]
    - Better integration of Child Development services and implementing changes from national review of Child Development services
    - Better alignment and integration of Child Protection services.
- Develop sub-regional governance of obesity prevention initiatives [linkage with Obesity]
- Development of Maternal Green Prescription [linkage with Obesity]
- Continue to improve information sharing between the Before School Checks (B4SC) programme and Primary care and increased support for the B4SC programme and the new Health Target [linkage with Obesity]
- Monitor the implementation of all recommendations from Gestational Diabetes Mellitus National Clinical Guideline [linkage with Diabetes]
- Support local Breastfeeding Networks
- Actively engage with the WCTO quality improvement programme
- Maintain the Maternity Quality & Safety Programme (MQSP) and demonstrate the DHBs are identifying and addressing local and national quality improvement priorities [linkage with Quality]
- Increasing access to oral health services for under 18 year olds. [linkage with Dental section]
- See also Rheumatic Fever section.

Local actions

- Continue to implement the work programme of the Hutt Clinical Network Child Health [linkage with Service Integration/Configuration – see Child Health Network actions]
- Support for Māori women from early in pregnancy and parents/whānau with infants aged less than 12 months. [linkage with Māori Health]
- See also Healthy Families NZ section
- See also Māori Health (Child Health & Access to Care – Ambulatory Sensitive Hospitalisations) section.

Sudden Unexpected Death of an Infant (SUDI) [linkage with Māori Health]

Sub-regional actions

- Implement the Hutt Valley DHB 'Safe Sleep' Pathway as a 3DHB initiative.

Local actions

- Caregivers provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1
- SUDI prevention information is given at six week immunisation event in primary care. [linkage with Immunisation]

Measures

Minister's Health Targets (see Appendix 1):

- By December 2017, 95% of obese children (BMI > 98th percentile) identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

3DHB Outcome 4: Children have a healthy start in life (see Appendix 1)

- Ambulatory Sensitive Hospitalisation rate, 0-4 years
- An increase the proportion of children caries-free at 5 years
- A decrease in the burden of tooth decay at Year 8.

Statement of Performance Expectations measures (see Module 3):

- A decrease in the obesity prevalence in children and
- An increase in the proportion of mothers who are smokefree two weeks post-natal
- A reduction in Ambulatory Sensitive Hospitalisation rates for 0-4 year olds
- An increase in the proportion of children caries-free at 5 years
- A decrease in the burden of tooth decay at Year 8
- An increase in the proportion of dispensed asthma medications that were preventers rather than relievers.

DHB Performance Measures (see Module 7)

- PP10: Oral health: Mean Decayed/Missing/Filled Teeth score at year 8
- PP11: Children caries-free at 5 years of age
- PP12: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including 17 years
- PP13: Improving the number of children enrolled in DHB funded dental services
- PP21: Immunisation coverage
- PP27: Supporting Vulnerable Children
- PP28: Reducing Rheumatic Fever
- SI1: Ambulatory Sensitive Hospitalisations (ASH)
- SI5: Delivery of Whānau Ora.

Increased Immunisation

Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for children, with the outcome of longer and healthier lives. The changes required to reach the target immunisation coverage levels will lead to better health services for children, because more children will be enrolled with and visiting their primary care provider on a regular basis. It will also require primary and secondary health services for children to be better co-ordinated. These actions support and encourage the implementation of the Primary Health Care Strategy, and strengthening of the primary care workforce.

Increased Immunisation [linkages with Māori Health, Pacific Health & Public Health]

Sub-regional Actions

- Maintain the Immunisation Governance Group that is responsible for monitoring and maintaining actions across the sub-region to continue to deliver on the national Health Target
- Education sessions to health professionals on immunisation and cold chain will continue
- Regional Public Health (RPH) will deliver support for immunisation programmes, including a focus on education, training, delivery, data collection and promotion of immunisation in the community; and support health professionals and community agencies to provide positive immunisation messages
- RPH will deliver the school-based Year 7 Boostrix programme - diphtheria, tetanus and pertussis

(whooping cough) and the school-based Year 8 Girls Gardasil programme - human papillomavirus viruses
- RPH will offer at risk groups a BCG immunisation in a timely manner; and provide education to caregivers before and after delivery of the immunisation.

Local Actions

- Local Immunisation Network groups will continue to be supported
- Local Immunisation teams will collaborate with B4SC providers to ensure parents are provided with immunisation information and encourage age 4 immunisation
- See also Māori Health (Immunisation) and Pacific Health sections:
    - Provide an active search for Māori tamariki and whānau in collaboration with the Hutt Valley DHB Whanau Care team, Immunisation team, Māori Health providers and PHO Community Health Workers to ensure tamariki are actively found, followed through and are presenting to either their GP or Outreach Immunisation Services for their required immunisations.

Measures

Minister's Health Target: Increased Immunisation (see Appendix 1):

- 95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.

Statement of Performance Expectations measures (see Module 3):

- The percentage of two year olds fully immunised
- The percentage of eight month olds fully vaccinated
- The percentage of Year 7 children provided Boostrix vaccination in schools in the DHB
- The percentage of Year 8 girls vaccinated against HPV (final dose) in schools in the DHB

DHB Performance Measures (see Module 7)

- PP21: Immunisation coverage (24 months, age 5, and HPV for girls).

Māori Health Plan Indicators (see section 2B.2.2 Māori Health)

- Percentage of Māori infants fully immunised by eight months of age.

Pacific Health Plan Indicators (see section 2B.2.2 Pacific Health)

- Percentage of Pacific infants fully immunised by eight months of age

Supporting Vulnerable Children

The Children's Action Plan provides a high level programme in response to the Government's White Paper for Vulnerable Children (2012). It outlines a range of cross-government interventions targeting vulnerable children who are at risk of harm now or in the future. The Vulnerable Children Act 2014 (VCA) contains workforce requirements relating to child protection policies and worker safety checks. We have a VCA working group chaired by a sub-regional Quality Team to ensure adherence to VCA requirements across the sub-region.

Supporting Vulnerable Children

Sub-regional actions

- Support Vulnerable Children's Act requirements across the sub-region
- Maintain accreditation for National Child Protection Alerts System and align with other child protection information systems in all sub-regional hospitals
- Support implementation of Rising to the Challenge [linkage with Mental Health and Addictions]
    - Undertake sub-regional child health project towards better alignment and integration of child protection services. [linkage from Maternal and Child Health].

Local actions

- Continue rollout and evaluation of Violence Intervention Programme (VIP) training to all DHB professionals
- Co-ordination of partner and child abuse and neglect programmes to support increased identification of vulnerable children
- Continue to support rollout of the Shaken Baby Prevention Programme:
    - Measurement of the implementation of this programme will be under-taken via the VIP

continuous quality audit process.

- Continued support of service planning and development activities work to provide an effective continuum of services across primary and referred health services to meet the needs of: [linkage with Service Integration/Configuration]
  - Pregnant women with complex needs
  - Vulnerable children and their families/whānau
  - Children referred to Gateway Programme
  - Vulnerable Women and Unborn Baby Multidisciplinary Teams (MDTs).
- Support Vulnerable Pregnant Women and Children multidisciplinary team processes
- Strengthen and develop the existing local inter-sectoral forum (Child Health Intersectoral Referral Pathway - CHIRP) and response to vulnerable high needs children
- Continue awareness raising and training for primary care professionals in relation to child protection.

Measures

DHB Performance Measures (see Module 7)

- PP27: Supporting Vulnerable Children.

Shaken Baby Prevention Programme

- Target of 70% of Registered Nurses and Registered DHB Midwives employed in Maternity Post-natal and Special Care Baby Unit (SCBU) services having received the training and 60% of whānau/caregivers having received the education in Maternity Post-natal and SCBU services.

Rheumatic Fever

Rheumatic fever is a serious but preventable illness. It mainly affects Māori and Pacific children and young people (aged 4 and above), especially if they have other family members who have had rheumatic fever. Rheumatic fever can develop after a 'strep throat', a throat infection caused by Group A Streptococcus bacteria. Most strep throats get better and don't lead to rheumatic fever. However, in a small number of people an untreated strep throat leads to rheumatic fever one to five weeks after a sore throat. This can cause the heart, joints, brain and skin to become inflamed and swollen. While symptoms of rheumatic fever may disappear on their own, the inflammation can cause rheumatic heart disease, where there is scarring of the heart valves. People with rheumatic heart disease may need heart valve replacement surgery. Rheumatic heart disease can cause premature death in adults.

In 2015 a sub-regional Rheumatic Fever Prevention Plan (RFPP) was revised with the aim to reduce the incidence of Rheumatic Fever through a programme of work focussed on prevention, treatment, and follow-up. The plan has been updated to reflect:

- The decline in rates of rheumatic fever across the 3 DHBs
- A reduced funding package from the Ministry of Health from 2016
- Preliminary findings of the national evaluation of school-based throat swabbing and rapid response sore throat management programmes.

Our sub-regional DHBs are committed to achieving our DHB-specific rheumatic fever targets (see Module 7, PP28) by delivering the actions outlined in our prevention plan. The governance of this plan will continue to be provided by the sub-regional RFPP Steering Group, who will oversee the implementation of the updated plan.

Rheumatic Fever

Sub-regional actions

- Ensure patients with a history of rheumatic fever receive monthly antibiotics not more than 5 days after their due date:

- Rheumatic fever cases in the region are recruited to a register, which monitors compliance of four weekly antibiotics
- Outreach nurses work to performance guidelines which require timely antibiotics
- Annual meetings with clinical stakeholders to ensure optimal functioning of register
- An annual audit of secondary prophylaxis coverage is undertaken, including timeliness by age group to ensure confidence in compliance with secondary prophylaxis after 21 years of age
- Undertaking an annual audit of rheumatic fever secondary prophylaxis coverage for children aged 0-15 years, youth aged 15-24 years, and adults aged 25+ years and report to the Ministry in the Quarter 4 report.

- Ensure that all cases of acute rheumatic fever are notified to the Medical Officer of Health with complete case information within seven days of hospital admission:
  - Annual training and reminders to paediatric and physicians to ensure timely notification
  - Annual audit, including timeliness of notification
  - Undertake case reviews for all rheumatic fever cases (first episode and recurrent), address systems failures and provide a report quarterly to the Ministry
  - Identifying and following-up known risk factors and system failure points in cases of rheumatic fever (both first episode and recurrent)
  - Training of Paediatricians and Physicians (target 50% will have undertaken annual training by Q4)
- Identify and follow-up known risk factors and system failure points in cases of rheumatic fever:
  - Annual audit of all cases presented at sub-regional paediatric forum
  - Follow up of audit where system failures are identified
  - Following-up on any issues identified by the 2015/16 audit of recurrent hospitalisations of acute rheumatic fever and unexpected rheumatic heart disease.
- Providing a funding investment for rheumatic fever prevention from July 2017 and providing an investment plan in Quarter 2
- Identify Māori and Pacific Health services to assist with the promotion of rapid response service and incorporate the requirement into future service contracts from 1 July 2017
- Regional Public Health will continue to strengthen the sub-regional healthy housing coordination service and interventions programmes, in partnership with the Tu Kotahi Māori Asthma Trust, the Sustainability Trust and He Kainga Oranga, to improve housing and health for our most vulnerable communities. This will reduce functional and structural overcrowding, and improve in home warmth and dryness. [linkage with Public Health]

Local actions

- See also Māori Health (Rheumatic Fever) section
- Strengthened model for effective assessment of sore throats (rapid response) across the Hutt Valley.

Measures

DHB Performance Measures (see Module 7)

- PP28: Reducing Rheumatic Fever

Māori Health Plan Indicators (see section 2B.2.2 Māori Health)

- Number and rate of first episode rheumatic fever hospitalisations.

Youth Health - including Prime Minister's Youth Health Project and Unintended Teenage Pregnancy

The three sub-regional DHBs have a Youth-Specific Service Level Alliance (SLA) comprising key clinical leaders and managers appointed by the Alliance Leadership Teams, that leads the planning and delivery of youth health services. The Youth SLA oversees the implementation of the 2016/17 DHB Annual Plans for Youth Health services, including the Prime Minister's Youth Mental Health Project and youth health services in Primary Care.

The Youth SLA will continue to implement and oversee activities to improve the health and wellbeing of the DHB's youth population, particularly those young people at risk of poor

health/social outcomes (e.g. those engaging in risky behaviour and/or those who may be "distressed") by focusing on:

- Implementing health workforce development strategies making services more youth friendly and responsive to the needs of youth
- Improving care pathways for young people
- Improving service integration and service responsiveness
- Promoting quality improvement initiatives
- Measuring the impact and outcomes of service initiatives
- Partnering with young people in order to set direction, inform decision making, review progress and disseminate information.

The Youth SLA has identified primary sexual health service development as a priority. It involves a multi-pronged approach that combines:

- Comprehensive sexuality education
- Youth-focused primary health care
- Ready access to condoms and contraceptives.

Access to long acting reversible contraception (LARCs) appears to be having a positive impact. Good progress has been made with the birth rate for young women and termination rates are trending down for all three DHBs in the sub region.

Youth Health [linkages with Mental Health and Addictions & Service Integration/Configuration]

Sub-regional actions

Health Pathways

- Support the development of youth-related Health Pathways.

Improved Human papillomavirus (HPV) Vaccine (Gardasil) Coverage [linkages with Public Health & Immunisation]

- Continue to deliver school-based HPV vaccine programmes
- Improve awareness and response of general practice to recall and follow up girls who have not received the HPV vaccine at school.

Reducing Unintended Teenage Pregnancy

The Youth SLA will undertake a sub-regional project to improve access to contraceptives and contraceptive advice and termination of pregnancy for vulnerable young people by:

- Developing an implementation plan to address barriers and workforce capacity and capability issues (Q3), including:
    - Identifying barriers to services
    - Assessing primary and secondary care workforce training needs to improve access to long acting reversible contraception.
- Maintaining and improving access to low and no cost sexual health services for vulnerable groups
- Better targeting services to vulnerable groups, including Māori and Pacific young people, and improving access to primary sexual health services
- Monitoring the impact of service change through pregnancy, birth and termination rates.

Local actions

The Hutt Valley DHB will continue to ensure access to sexual health services targeting services to vulnerable groups including Māori and Pacific young people by:

- Improving service linkages with Family Planning services in the Hutt Valley
- Enhancing VIBE Youth One Stop Shop's network of free sexual health services to young people aged under 25 years within school-based health services, teen parent units and alternative education facilities
- Supporting the development of healthy relationship skills initiatives such as Mates & Dates within secondary schools.

Prime Minister's Youth Mental Health Project [linkage with Mental Health and Addictions]

The Prime Minister's Youth Mental Health Project is a four-year project that began in July 2012 and which remains a priority in 2016/17.

Sub-regional actions

School Based Health Services

Build on what has been achieved and shown to be effective School Based Health Services (SBHS):

- Maintain SBHS in decile 1-3 secondary schools, teen parent units, and alternative education facilities and continue SBHS in higher decile secondary schools where these services are in place
- Strengthen SBHS continuous quality improvement initiatives and promote the resulting quality improvement innovations across the SBHS clinical network
- Support SBHS workforce development by coordinating training initiatives utilising sub regional clinical networks and clinical champions
- Strengthen 'out-of-school' youth health services and youth friendly primary practice options for young people to enhance service access.

Youth Primary Mental Health

Improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to:

- Improve wait times
- Increase numbers of youth receiving assessment and appropriate treatment
- Ensure there are appropriate youth friendly primary care service options.

Utilise the results of the Ministry of Health's evaluation of the Prime Minister's Youth Mental Health Project to identify initiatives to improve:

- Early identification of mental health issues
- Equity of access across the district
- Better access to timely and appropriate treatment and follow up
- Target Māori, Pacific, and low decile youth populations.

Review and improve the follow-up care for those discharged from Child and Adolescent Mental Health Services (CAMHS) and Youth Alcohol and Other Drug (AOD) services

- Improve follow-up in primary care of youth aged 12-19 years discharged from secondary mental health and addiction services by providing follow-up care plans to primary care providers.

Improve access to CAMHS and Youth AOD services through integrated case management and monitoring wait times

- Implement actions to meet the waiting time targets.

Youth Alcohol and Other Drugs/Co-Existing Problems (AOD/CEP) Model of Care implementation plan

- Develop a Youth AOD/CEP Model of Care implementation plan for the sub-regional DHBs identifying where resources can make the greatest impact on the greatest number of young people, with an emphasis on up-skilling professionals and services that young people interact with.

Measures

DHB Performance Measures (see Module 7)

- PP7: Improving mental health services using transition (discharge) planning
- PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds
- PP25: Delivery of the Prime Minister's youth mental health initiative
- PP26: Rising to the Challenge: The Mental Health and Addiction Service Development Plan.

Dental/Oral Health Services

The Bee Healthy Regional Dental Service is the community-based dental service for the Wellington Region. They provide support, education and free dental care for children from birth until their 18th birthday. For children up to the end of school year 8, dental therapists provide most services. Dental assessments and treatments usually take place in community-based clinics, often located on school sites, or in mobile dental units. Some treatments are not free, such as orthodontics (e.g.

braces). For adolescents from school year 9 up until their 18th birthday, a range of free basic dental services is funded by the DHB, usually through private dentists. A limited range of dental services are funded for some adults:

- People with disabilities or medical conditions such as mouth cancer may be referred to a hospital for their dental treatment by their usual dental practitioner or General Practitioner
- People on low incomes who have a Community Services Card may be able to get emergency dental care, such as pain relief or extractions.

Dental/Oral Health Services [linkage with Child Health]

Child Oral Health

Sub-regional actions

- Increasing access to oral health services for under 18 year olds
- Use the balanced scorecard to ensure all enrolled children older than 2 years have a dental examination
- Implement the recommendations from the 2015 Data-match project plan
- Engage with private dentists (who participate in the Combined Dental Agreement) to identify and reach adolescents who currently don't get annual examinations.
- Implement the oral health action plan
- Reduce arrears to meet targets
- Increase preschool enrolment rates and access to services, particularly amongst Māori and Pacific children
- Implement the oral health workforce plan that addresses work flow and capacity within the service.

Local actions

- See also Māori Health (Oral Health) section
- See also Pacific Health section.

Measures

3DHB Outcome 4: Children have a healthy start in life (see Appendix 1):

- An increase in the proportion of children caries free at five years
- A decrease in the mean number of decayed, missing or filled teeth at Year 8.

Statement of Performance Expectations measures (see Module 3):

- The percentage of children under 5 years enrolled in DHB-funded dental services
- The percentage of adolescents accessing DHB-funded dental services.

DHB Performance Measures (see Module 7):

- PP10: Oral health: Mean Decayed/Missing/Filled Teeth score at year 8
- PP11: Children caries-free at 5 years of age
- PP12: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including 17 years
- PP13: Improving the number of children enrolled in DHB funded dental services
- SI5: Delivery of Whānau Ora – Oral Health.

Māori Health Plan Indicators (see section 2B.2.2 Māori Health)

- Percentage of Māori pre-school children enrolled in the community oral health service.

2B.2.3 Long Term Conditions – Prevention, Identification and Management

Long-term conditions comprise the major health burden for New Zealand now and into the foreseeable future. This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Māori and Pacific peoples. As the population ages, and lifestyles change, these conditions are likely to increase significantly. Cardiovascular disease (CVD) includes heart attacks and strokes. Both CVD and diabetes are substantially preventable with lifestyle advice and treatment for those at moderate or higher risk. Diabetes is important as a major and increasing

cause of disability and premature death. The monitoring of CVD and diabetes provides good indicators of the responsiveness of a health service to the people in most need.

The previous national health target, 'more heart and diabetes checks', continues as a DHB performance measure of the systematic assessment to detect all people either at risk of or already affected by CVD and/ or diabetes in their eligible population. Indicators of performance for CVD and diabetes will include several key indicators of management, output and outcomes, covering diabetes, CVD and stroke. By increasing the percentage of people being checked and improving the on-going management of their care, the DHB will speed up the implementation of the Primary Health Care Strategy by ensuring primary health care is better able to contribute to improved health outcomes.

Long term Conditions

Sub-regional actions [linkage with Service Integration/Configuration]

- Health Pathways for Long Term Conditions will continue to be developed and rolled out
- To continue to focus on Advance Care Planning through our Long Term Conditions Service Level Alliances, profiling this piece of work and ensuring it is embedded in all relevant projects this year [linkage with End of Life]
- The sub-regional Long Term Conditions (LTC) Service Level Alliances (SLAs) will lead a piece of work to increase the access people have to Self-Management Support. This will involve a review of a range of mechanisms and tools that can be used to support self-management e.g. smart phone apps, telephone coaching, group and one-on-one options, Health Navigator:
    - Promotion of the finalised self-management support framework (Q1)
    - Establish self-management working group to design and implement key activities, including raising consumer understanding and awareness of the tools and resources available to assist them self-manage aspects of their LTC (Q1)
    - Implement activities to target long term conditions and diabetes self-management programmes to high need populations.

Local actions [linkages to Healthy Families New Zealand, Service Integration/Configuration & Obesity]

- Utilising the existing Hutt Valley Governance Group (which is a multi-sector, local council and community forum) the DHB will work in partnership to develop a Hutt Valley Obesity Prevention Plan, the draft being completed by 31 March 2017. Engagement with Healthy Families Lower Hutt will help inform the Plan development. Progress against the development of the plan will be reported through the Hutt Valley DHB Child Health and Long Term Condition Networks on a quarterly basis.
- Continue to implement the work programme of the Hutt Valley LTC clinical network, including the rollout of the PHO LTC programme
    - For detailed actions, please refer to the Service Integration/Configuration section.
- Support the Ministry of Health's Musculoskeletal Mobility Action pilot
- Provide oversight and facilitate Diabetes integration activities [linkage with Diabetes]
- Provide oversight and facilitate Cardiovascular Disease integration activities. [linkage with Cardiovascular Disease]
- See also Māori Health (Cardiovascular Disease and Diabetes) section.

Measures

3DHB Outcome 5: Long-term conditions are well managed (see Appendix 1):

- An increase in the proportion of people with diabetes with satisfactory blood glucose control
- A decrease in the hospitalisation rate for cardiovascular disease
- A decrease in the hospitalisation rate for chronic obstructive respiratory disease
- An increase in the proportion of dispensed asthma medications that were preventers rather than relievers.

Statement of Performance Expectations measures (see Module 3):

- The percentage of practices with a current Diabetes Practice Population Plan (or a current LTC plan which includes diabetes)

- The percentage of the eligible population assessed for Cardiovascular Disease risk in the last five years
- The number of people registered with a Long Term Conditions programme in a pharmacy
- The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy.

DHB Performance Measures (see Module 7):

- PP20: Improved management for long term conditions
- SI5: Delivery of Whānau Ora – Respiratory.

Healthy Families New Zealand

Healthy Families NZ is a key part of the Government's wider approach to helping New Zealanders live healthy, active lives. It is a large-scale initiative that brings community leadership together in a united effort for better health. Healthy Families NZ aims to improve people's health where they live, learn, work and play in order to permanently slow the growth of obesity and chronic diseases, including some cancers, type 2 diabetes and cardiovascular disease. It is being designed and implemented in ten locations throughout the country and Lower Hutt is one of ten chosen Healthy Families NZ communities. In each location, a skilled prevention workforce will work with local leaders to create healthy change.

Healthy Families Lower Hutt aims to address the underlying causes of poor health in the community and involves working across the multiple systems that influence everyday lives including workplaces, early childhood education centres, schools, sports clubs, marae and churches as well as the media, food, transport and planning systems so good health and wellbeing becomes easier and more accessible for all. The key outcomes sought from Healthy Families NZ are:

- Improved nutrition
- Increased physical activity
- More people smokefree
- Reduced alcohol related-harm.

Healthy Families NZ [linkages with Public Health, Maternal and Child Health, Long Term Conditions, Obesity, Tobacco & Service Integration/Configuration]

Healthy Families New Zealand aims to improve people's health where they live, learn, work and play in order to prevent chronic disease. Hutt Valley District Health Board will support Hutt City Council, the lead agency for Healthy Families Lower Hutt, and participate through:

- Senior DHB executive membership, leadership and commitment on the Healthy Families Lower Hutt Governance Group
- Membership and engagement on the Healthy Families Lower Hutt Prevention Partnership
- Leadership in food system change through championing healthy food and beverage policies
- Becoming a health promoting workplace and creating an environment where the healthy choice is the easy choice
- Aligning, where appropriate, existing health promotion/preventative activity with a systems-based approach
- Working collaboratively with Healthy Families Lower Hutt workforce and stakeholders on preventative health initiatives
- Increasing awareness of Healthy Families Lower Hutt within the DHB and through external networks
- DHB staff working strategically with the Healthy Families Lower Hutt workforce
- Data analysis support.

The approach for Healthy Families NZ is a systems-based approach and is a move away from projects and programmes to a whole-of-community approach. Areas where engagement has commenced include:

- Working alongside communities to identify issues and solutions for sustainable change

- Encouraging healthy tuckshops, menus, vending machines and catering, in children's settings, workplaces and other key community settings
- Encouraging food growers, producers and sellers to increase access to fresh, healthy and affordable food
- Influencing sports clubs to promote drinking of alcohol in moderation and healthy food and beverage choices
- Showing leadership in smokefree environments around workplaces and other public places such as parks and playgrounds
- Working with schools to promote participation in physical activity and a reduction of sedentary behaviour
- Identifying ways to make active transport such as walking and cycling more accessible
- Supporting communities to have a voice around Council plans and policies
- Mapping food, alcohol, physical activity and tobacco environments and looking at opportunities to make positive change
- Advocating and advising decision makers for change, across government departments
- Development of a Hutt Valley Obesity Prevention Plan. [linkages with Obesity & Long Term Conditions]

Measures

A Quarter 4 confirmation and exception report against the examples of participation identified.

Obesity

Currently one third of the New Zealand population is obese. The World Health Organisation's Commission on Ending Childhood Obesity and the Ministry of Health are now actively making recommendations for not only the health sector, but also education, the food industry and the public in general as a way to begin to combat the growing epidemic that is obesity. A new health target has been implemented 'By December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.' The target was selected as the B4SC focuses on early intervention to ensure positive, sustained effects on health. Families referred through the B4SC programme will have improved access to nutrition and physical activity programmes, such as Active Families.

Obesity [linkages with Maternal and Child Health & Public Health]

Sub-regional actions

- Actively engage with Before School Check (B4SC) providers to ensure they are supported to meet the Health Target, building on the existing referral pathway for weight management in children:
    - The DHB will connect B4SC providers with relevant PHO, NGO and DHB providers to ensure appropriate referrals are made (Q2)
    - Implement Active Families to support the B4SC target for obese children (Q3)
    - Further development of the referral pathway from the B4SC programme to appropriate (including cultural) services and information collection systems for obese children (Q4).
- Ensure Gestational Diabetes Mellitus Management Guidelines are translated into business as usual [linkage with Diabetes]
- Development of Maternal Green Prescription, initially supporting pregnant women with pre-diabetes
- Encourage health professionals to attend the nationally funded Gravida 'Healthy Conversations' training (Q2).

Local actions [linkage with Service Integration/Configuration]

- Utilising the existing Hutt Valley Governance Group (which is a multi-sector, local council and community forum) the DHB will work in partnership to develop a Hutt Valley Obesity Prevention Plan, the draft being completed by 31 March 2017. Engagement with Healthy Families Lower Hutt will help inform the Plan development. Progress against the development of the plan will be reported through the Hutt Valley DHB Child Health and Long Term Condition Networks on a quarterly basis.
- The first steps in the development of the Plan will be to garner support from the Governance Group and

build on the recent stocktake of all activities in the community and across the health sector continuum, which could contribute to the Plan's desired outcomes
- Continue to support the B4SC provider to further integrate with primary care through data matching and smooth referral and feedback processes
- The DHB will continue to support and engage with Healthy Families Lower Hutt. [linkage with Healthy Families New Zealand]

Measures

Minister's Health Target: Childhood Obesity (see Appendix 1):
- By December 2017, 95% of obese children (BMI > 98th percentile) identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

Statement of Performance Expectations measures (see Module 3):
- The percentage of infants fully or exclusively breastfed at 3 months
- The number of adult referrals to the Green Prescription programme in the sub-region.

DHB Performance Measures (see Module 7):
- SI5: Delivery of Whānau Ora – Obesity.

Diabetes

Diabetes is important as a major and increasing cause of disability and premature death, and it is also a good indicator of the responsiveness of a health service for people in most need. A diabetes test is included as part of the overall Cardiovascular Disease risk assessment. This test is different from a diabetes annual review, which takes place when a patient, who has been previously diagnosed with diabetes, is seen by their health professional to review the management of their disease. Diabetes is a health issue that is growing in prevalence with increasing incidence in younger people - gestational diabetes is increasing, in parallel with the national rise in obesity.

Adequate treatment targeting multiple risk factors can prevent or slow the progression of complications in people with diabetes. Despite improvements observed in several processes of diabetes care in the past decade, the control of risk factors remains challenging. Effective models of chronic care emphasise the need for a collaborative approach between patient and healthcare providers to achieve effective disease management. Our goal is to enable our people living with diabetes to be regarded as leading partners in their own care within systems that ensure they can manage their own condition effectively with appropriate support.

The DHB will establish an improved system to monitor the continued implementation of the diabetes care improvement plan at general practice level, ensuring alignment with the priorities set out in Living Well with Diabetes, including:
- Establishment of an appropriate clinical group
- Agreed clinical indicators and reporting template
- Implement regular monitoring.

Diabetes [linkages with Long Term Conditions, Service Integration/Configuration, Obesity, Cardiovascular Disease & Māori Health]

<u>Sub-regional Actions</u>
- Retinal screening service agreements to be updated to incorporate revised guidelines due to be published in 2015/16
- Health Pathways for diabetes will be developed and implemented
- Implement a Self-Management Support framework across the sub region (see Long Term Conditions section for details).

Local Actions

- Implement the LTC programme in Te Awakairangi Health Network general practices across the Hutt Valley (12 practices by Q2, 16 practices by Q4 and all by Q1 2017/18)
- Diabetes and pre-diabetes identification will be undertaken in Cardiovascular Disease risk assessment as part of the Long Term Conditions programme
- Complete the gap analysis against the against the Quality Standards for Diabetes Care and recommend actions to address any gaps (Q1)
    - Identify four standards to take action to address identified gaps (Q1) and implement.
- A diabetes working group will be established to monitor key clinical indicators across primary and secondary care and identify service improvements to improve clinical outcomes and reduce disparities.
- Increase and improve specialist advice across all primary health care teams
- Continue to improve the integration of care for children and adults with type 1 diabetes across the Hutt Valley health system
- See also Māori Health (Diabetes) section.

Measures

3DHB Outcome 5: Long-term Conditions are well-managed (see Appendix 1):

- Proportion of people with diabetes 15-74 years old with good blood glucose control

Statement of Performance Expectations measures (see Module 3):

- The percentage of practices with a current Diabetes Practice Population Plan (or a current LTC plan which includes diabetes).

DHB Performance Measures (see Module 7)

- PP20: Cardiovascular Disease (CVD risk assessment includes diabetes)
- PP20: Improved management for long term conditions - Diabetes Services.

Cardiovascular Disease

The aim is to maintain the momentum generated from the previous Minister's Health Target More Heart and Diabetes Checks, which has been replaced by the Childhood Obesity Health Target from 2016/17. Cardiovascular Disease (CVD) risk assessments (CVDRAs) will continue as DHBs continue to deliver cardiovascular services to utilise the final year of Budget 2013 funding. The primary care sector has been able to generate significant awareness of CVD risk factors, improvements in health literacy and self-management.

Cardiovascular Disease (CVD) [linkages with Long Term Conditions, Service Integration/Configuration & Māori Health]

Sub-regional Actions

- Implement a Self-Management Support framework across the sub region (see Long Term Conditions section for details)
- Incorporating CVDRA as part of Long Term Condition practice plans (Q1)
- Ensure systems are in place to enable practices to identify people requiring an assessment
- Providing free or subsidised checks to target groups
- Support practices to maintain the target, including quarterly feedback on performance

Local Actions

- Primary Health Organisations will continue their activities to achieve and maintain the CVD risk assessment 90% target, with a particular focus on high need groups, including Māori men aged 35-44 years:
    - Aim to reduce coverage gap for Maori and Pacific to reach 90% target by Q2.
- Implement the LTC programme in Te Awakairangi Health Network general practices across the Hutt Valley (12 practices by Q2, 16 practices by Q4 and all by Q1 2017/18)
- See also Māori Health (Cardiovascular Disease) section.

Measures

3DHBOutcome 5: Long-term Conditions are well-managed (see Appendix 1):

- A reduction in the hospitalisation rate for cardiovascular disease.

Statement of Performance Expectations measures (see Module 3):

- The percentage of the eligible population assessed for Cardiovascular Disease risk in the last five years.

DHB Performance Measures (see Module 7):

- PP20: Improved management for long term conditions –Cardiovascular Disease.

Tobacco

At present, tobacco smoking places a significant burden on the health of New Zealanders and on the New Zealand health system. Tobacco smoking is related to a number of life-threatening diseases, including cardiovascular disease, chronic obstructive pulmonary disease and lung cancer. It also increases pregnant smokers' risk of miscarriage, premature birth and low birth weight, as well as their children's risk of Asthma and Sudden Unexplained Death in Infants.

Delivery against the Minister's Health Target 'Better Help for Smokers to Quit' supports the health and disability system outcome of 'New Zealanders living longer, healthier and more independent lives', as well as the intermediate outcome of 'a more unified and improved health and disability system'. The measure also supports the Government's aspirational goal of a Smokefree New Zealand by 2025. Achieving a Smokefree New Zealand will mean that: our children and grandchildren will be free from exposure to tobacco and tobacco use; the prevalence of smoking across all populations will be less than 5%; and, tobacco will be difficult to sell and supply.

Tobacco [linkages with Public Health, Māori Health, Pacific Health, Maternal and Child Health, Service Integration/Configuration & Healthy Families New Zealand]

Smokefree 2025

The DHB commits to progressing towards achieving the Government's Smokefree 2025 goal (that less than 5% of the DHB's population will be a current smoker) through the implementation of the sub-regional 3DHB Tobacco Control Plan 2015-2018.

Sub-regional Actions

Better Help for Smokers to Quit

The DHB develops and implement plans in accordance with national strategies and the health target Better Help for Smokers to Quit. In conjunction with Regional Public Health, Primary Health Organisations and the Service Development and Integration unit, actions include:

- Continually update and improve ABC data collection processes and systems to capture advice and support being offered to identified smokers
- Continually review, update and promote referral pathways to quit smoking services
- Monitor and analyse Māori, Pacific and pregnant women referrals and service uptake, to ensure that there is no disparity of care, and to inform service planning for priority populations
- Enhance current Smokefree policy and contractual obligations for service providers to provide effective cessation support to smokers.

Local Actions

- Provide technical advice and support on smoking cessation to primary and secondary care health services
- See also Māori Health (Smoking) section.

Measures

Minister's Health Target: Better help for smokers to quit (see Appendix 1):

- 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
- 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.

3DHB Outcome 3: Lifestyle factors that affect health are well-managed (see Appendix 1)

- A decrease in the proportion of the PHO-enrolled population that is recorded as a 'current smoker'
- An increase in the proportion of mothers who are smokefree two weeks post-natal.

Statement of Performance Expectations measures (see Module 3):

- The percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer being offered brief advice and support to quit.

DHB Performance Measures (see Module 7):

- SI5: Delivery of Whānau Ora – Tobacco.

Māori Health Plan National Indicator (see section 2B.2.2 Māori Health)

- Smoking cessation: Percentage of pregnant Māori women who are smoke free at two weeks postnatal.

Mental Health and Addictions - Rising to the Challenge

Ahakoa te momo mate, whakanuia tangata

This proverb speaks of hope, regardless of illness or disease, people deserve dignity and respect and the opportunity to become well again.

Mental illness is extremely common. In any 12-month period, more than 20% of people in New Zealand are likely to experience some form of mental illness; and 47% of New Zealanders are likely to experience a form of mental illness at some point in their lives. Suicides are often linked to mental illness and New Zealand has some of the highest rates in the OECD.

There have been significant transformations in Mental Health and Addiction services in the past two decades, and we continue to strive for health services that work alongside families/whānau and communities so that children and young people experience healthy beginnings, adults of all ages who experience mental health and addiction issues can access appropriate treatment, recover rapidly, and flourish. Services that work beside users of mental health services, their families and whānau and the community are the gold standard that the 3DHBs strive to continue to provide.

The recent move to a 3DHB Mental Health, Addictions, & Intellectual Disability Service (MHAID 3DHB) has already provided opportunities for greater integration between the 3 DHBs. This includes the on-going development of enhanced and more responsive services for Māori and Pacific people, closer working connections with the community-based mental health and social service sector agencies (Non-Governmental Organisations - NGOs), strengthening relationships with primary care and improved experiences for all people who access services across the life course.

Key actions for 2016/17 will focus upon development of critical elements of co-design of service developments, which in turn will be guided by *Blueprint II* in aiming for the following:

- Better use of resources/value for money
- Deliver increased access for all age groups
- Cement and build on gains in resilience and recovery (including developing services for children of parents with mental illness and addictions)
- Improve integration between primary and specialist services.

Mental Health and Addictions [linkage with Youth Health - Prime Minister's Youth Mental Health Project]

Regional Actions

The Central Region will consider the way services are delivered (including Service Action Plans), enhance data use, and support higher levels of integration between primary and secondary care.

Youth Services

Improve youth services across the Central Region to ensure the provision of quality service options that improve people's wellbeing by being seamless, integrated, navigable and easily accessible:

- Evaluation of requirements, including for models of care and/or service delivery models, for all regional workstreams
- Implement the Community Youth Forensic Plan (Q1)
- Analyse access data for youth forensic services quarterly (across court liaison, Child Youth & Family youth justice residences and community) and for eating disorder services, to demonstrate regional access.

Adult Services

AOD services will deliver a stepped care model that people can access services that match their needs:

- Adult residential AOD model of care implementation process meeting milestones, including service change, peer support, whānau ora and workforce development (this will incorporate the implications of the replacement legislation for the Alcoholism and Drug Addiction Act 1966):
    - Complete a Business Case for model implementation, including procurement processes
    - Workforce development and service change plans created
    - Begin implementation across the Central Region.
- Maternal and Perinatal services will continue providing enhanced integrated acute care responses, access to a broader range of services, and be supported by the Clinical Network:
    - Maternal and Perinatal services will fully implement the additional Ministry of Health funding requirements, including workforce development.
- Adult forensic services will look into processes to enhance the delivery of timely and responsive services:
    - Quarterly monitoring to ensure a reduction in waiting lists and times for people in prisons requiring assessment by forensic services.

Physical Wellbeing and High, Complex Needs Linkages

Increase the physical wellbeing of people who have high and complex needs using Mental Health and Addiction services through enhanced integration between primary and secondary care:

- Two regional forums (involving primary care, including NGO, secondary, kaupapa Māori and Pasifica services) to be held to improve integration between primary and secondary care (Q2 & Q4), findings to be disseminated and incorporated in future planning and development.

Workforce

Implement the 2015-2020 Workforce Plans:

- Report quarterly to Mental Health and Addictions Regional Leadership and Te Pou with identified workforce requirements for new service delivery models
- Implement workforce development needs for the region aligned with the National Workforce Centres for Mental Health (Q3 on).

Sub-regional and Local Actions

Key actions for 2016/2017 will continue to focus on the co-design and development of services across the life course, as per the *Blueprint II* guidelines.

Better Use of Resources/Value-for-Money

- Continue to support, review, and report on the national Mental Health and Addictions Plans/Frameworks to identify, plan, develop and implement any gaps against key priority actions
- Complete the 3DHB Strategic Framework and plan (Roadmap) for the design and delivery of integrated Mental Health and Addiction services across the sub-region to 2030, with an emphasis on actions to be taken in the next five years
- Support the implementation of the 3DHB refreshed Addictions Action plan, and the development and implementation of the 3DHB Mental Health Addiction and Intellectual Disability Strategic Plan, in partnership with the Consumer Leadership and Mental Health and Addictions Integration Leadership Groups
- Implement the full suite of Mental Health and Addiction equity indicators, to be included in the 3DHB's quarterly Equity Indicator Monitoring report, so that the report includes Community Did Not Attend (DNA) Rates, Seclusion and Physical Health checks.

Deliver increased access for all age groups [linkages with Maternal and Child Health & Youth Health]

- Refresh the Implementation Plan for the 3DHB Perinatal, Maternal and Infant Mental Health Strategy
- Develop an implementation Plan for the Youth AOD Model of Care (Youth AOD Exemplar)

- Continue to support the implementation of the Wairarapa, Hutt Valley and Capital & Coast District Health Board's endorsed Wellington Region Suicide Prevention and Postvention Plans 2015/17, including the establishment of the Wellington Region Suicide Prevention and Postvention Governance Structure.

Cement and build on gains in resilience and recovery (including developing services for children of parents with mental illness and addictions)

- Co-design Models of Care for Adult and Youth services to ensure that a whole of system approach enables timely access to services across the continuum of care and seamless transition to improve crisis response for people experiencing an acute mental health problem (including older people)
- Work collaboratively with Primary Care, NGO and Secondary services to reduce health disparities, through improved access, experience and outcomes across the service continuum, particularly for Māori and Pacific service users [linkages with Māori Health & Pacific Health]
- Continue to monitor and develop solutions for the reduction rate of Māori on the Mental Health Act: section 29 community treatment orders relative to other ethnicities consistent with the 3DHB Māori Health Plans [linkages with Māori Health & Whānau Ora]
- Implement Supporting Parents Healthy Children (Children of Parents with Mental Illness and/or Addiction - COPMIA) for the sub-region. This is aligned to the guidance document for support for families and children when there is a parent with a mental illness and/or addiction
- Fully implement and evaluate the Opioid Substitution Treatment (OST) Model of Care to support the sustainability of Capital & Coast and Hutt Valley DHB's OST service capacity and alignment to Substance Addiction (Compulsory Assessment and Treatment) [linkage with Whānau Ora]
- Evaluate the Community Based Offenders Single Point of Entry with a view to improving service capacity and provision in partnership with NGOs, Primary Care and the Justice Sector

Improve integration between primary and specialist services [linkage with Service Integration/Configuration]

- Use an alliance approach with Primary Health Organisations and other partners to facilitate integrated responses to improving the physical health needs for people with low prevalence mental health and/or addiction disorders
- Scope Health Care Pathways to support timely and adequate access to secondary/specialist mental health and addiction service advice and intervention where needed
- Support improved occupation (employment) service rates for people with mental health and addiction issues (including young adults) through collaboration with cross-sector partners to ensure social determinants of health (e.g. access to housing, employment) are addressed as part of a comprehensive, integrated approach to care and recovery.

Crisis Response Services [linkage with Acute Demand]

- Implementation of crisis response services (Q1), including staff based at the Police Central hub and staff based at Emergency Departments.

Outcome and Commissioning Frameworks

- We will support the shift in the Ministry of Health's outcome and commissioning frameworks.

Māori Health

- See also Māori Health (Mental Health) section.

Measures

3DHB Outcome 7: People receive high quality mental health services when they need them (see Appendix 1):

- Percentage of the population seen by specialist Mental Health and Addictions services across the sub-region
- A reduction in the rate of acute readmissions within 28 days to Mental Health Services
- Proportion of secondary mental health service users that were new to the service.

Statement of Performance Expectations measures (see Module 3):

- The number of people accessing secondary mental health services
- The percentage of people accessing secondary mental health services
- The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks
- The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks

- The percentage of people admitted to an acute mental health inpatient service that were seen by mental health community team in the 7 days prior to the day of admission
- The percentage of people discharged from an acute mental health inpatient service that were seen by a mental health community team in the 7 days following the day of discharge.

DHB Performance Measures (see Module 7):

- PP6: Improving the health status of people with severe mental illness through improved access
- PP7: Improving mental health services using transition (discharge) planning
- PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds
- PP25: Prime Minister's youth mental health project
- PP26: Rising to the Challenge: The Mental Health and Addiction Service Development Plan
- SI5: Delivery of Whānau Ora – Mental Health.

Māori Health Plan National Indicator

- Rate of Māori Mental Health Compulsory Assessment and Treatment Act: Section 29 community treatment orders relative to other ethnicities.

Regional Service Plan Measures (see Central Region Regional Service Plan 2016/17):

- Quarterly report on progress against RSP milestones.

2B.2.4System Integration

A health system that is well integrated provides a sustainable system where people receive services from the right person, at the right time and in the right place. This requires a one team approach for service planning and development, including DHBs, Primary Health Organisations and Non-Governmental Organisations. A sustainable health and disability system into the future requires one team providing:

- Care closer to home
- Early intervention
- Interventions that avoid hospitalisation
- Reductions in acute demand.

This includes the optimal configuration of Primary Care for our district. We are working through our Alliance Leadership Team to ensure that Primary Care is fit-for-purpose to take on increasing responsibility for health services and that the optimal configuration is developed and implemented.

Service Integration/Configuration - including Shifting Services and System level Outcome Measures

For our population, an integrated health system will provide appropriate care closer to them, help keep them well at home, and provide responsive services in times of acuity; for the system, it will drive efficiencies and support sustainability within the limited health resource and escalating demands of services. The Alliance Leadership Teams (ALTs) across the sub-region are key drivers for integration and for delivering on the Triple Aim for the three sub-regional DHBs. While maintaining a whole of system view, the ALT programmes have been developed through focusing on the complexity within the populations (Acute Demand & Long Term Conditions), targeted work specific to particular age groups (Frail Elderly, Youth, Children) and enablers that underpin the system (Health Pathways, Information Management, Primary Care Sustainability and Medication Management) across the DHBs.

With the complexity of patients' needs and the need for integrated systems there are clear overlaps across the focus areas, which are managed through good communication across work streams; there

is also overlap within DHB work streams and across the DHBs that requires good management and active involvement. The ALTs, Primary Health Care leads, and Hospital leads are partners in planning service developments across the sub-region. Engagement is progressed and maintained through workshops and discussion forums including Service Level Alliances and Clinical Network meetings. Our local ALT and PHOs contributed to and endorse the development process, direction, and deliverables of our DHB Annual Plan.

The sector is working to lift performance measurement from a transactional approach to one based on outcomes. System level measures tied to financial incentives through the Primary Health Organisation Service Agreement are being implemented in 2016/17.

Service Integration/Configuration

Information Management Service Level Alliance [linkage with Information Technology]

Sub-regional actions

- Embedding the Shared Electronic Health Record (SEHR) which enables the sharing of patient information across the system by providing identified and approved hospital clinicians access to a summary of people's primary health care record, the SEHR
- Increasing the use and uptake of the Patient Portal to enable patients and practices to interact via the secure portal
- Further development of the Shared Care Plan to enhance its functionality to improved coordinated and collaborative care with providers and the patient, including:
    - Initial trial of the Shared Care Plan tool with targeted primary care practices and associated community-based services (Q1)
    - Review and document learnings from trial (Q1-Q2)
    - Rollout to Hutt Valley DHB Primary Care practices (Q2-Q4)
    - Begin development of process and a staged plan for the addition of other key documents into the overall Shared Care Plan, e.g. the Chronic Obstructive Pulmonary Disease Plan.
- Progress the development of a multi-provider and sustainable electronic referrals platform to create efficiencies in obtaining specialist advice and care:
    - Standards that will enable multi-provider e-referral processes (Q2)
    - Investigate and pilot radiology eReferral Integration with HealthPathways (Q3-Q4)
- Review options for secure electronic messaging across the sector to provide an efficient alternative to current communication regarding patient care across the sector (Q3)
- Mobile technology [linkage with Information Technology].
    - Plan for roll-out and support policies.

Health Pathways

Sub-regional actions

- Completion and publication of additional pathways – localised or full developments
- Developing a pathway revision plan for pathways that are currently active and require review (Q1)
- Improving and embedding pathways to drive primary care utilisation and specialist engagement in development
- Develop a communications plan (Q1) that will support the promotion of particular pathways that are higher priority in the integration space, including:
    - Frail but Stable Older Person Pathway
    - Medication Management in the Older Person Pathway
    - Child Respiratory Pathway
    - Falls Pathway
    - Advance Care Planning Pathway
    - Cellulitis
    - Deep Vein Thrombosis
    - Minor gynaecology procedures.
    - Key engagement strategies to be delivered via subscription updates, Grand Rounds, primary care

practice visits, engagement meetings with specialist services & professional development sessions.

- Improving the impact of Health Pathways and ensuring on-going quality improvement processes:
    - Develop (Q2) and implement an annual audit and evaluation plan agreed by the Governance Group
    - Quarterly evaluation reporting to the Governance Group
- Promoting the utilisation of the Health Navigator patient information website and supporting development and revision of information as required. The uptake and promotion of this site will be also linked with the individual Long Term Conditions SLAs/Networks:
    - Develop communications plan strategies targeted at clinicians and the community (Q1)
    - Develop a utilisation monitoring framework (Q1).

Primary Care Packages of Care

Sub-regional actions

Increase the uptake and flexibility of existing primary care packages of care to deliver care closer to the patient, focussing on increasing packages delivered for cellulitis, deep vein thrombosis and minor gynaecological procedures.

Local actions

- Maintain the Person-centred Acute Community Coordination (PACC) service to extend general practice care of patients, to assist with achieving the ED health target, reducing hospital admissions, and promoting primary care uptake of Primary options for Acute Care (POAC), Health Pathways and other local acute demand initiatives
- Increase the flexibility of primary care packages of care and broaden the range of conditions to better manage acute patients:
    - Engagement and support for primary care to increase the uptake of existing packages of care - cellulitis, DVT & minor gynaecological procedures (Q1-Q4)
    - Investigate and develop proposals for increasing the type of packages of care available in primary care (Q2-Q3). This will be presented to the Acute Demand Network and Health Pathways Governance group for approval
    - Implement additional packages of care as determined by the process above (Q4).

Youth Health Service Level Alliance [linkage with Youth Health]

Sub-regional actions (see Youth Health section for details)

- Support the development of youth-related Health Pathways
- Improve Human papillomavirus (HPV) vaccine coverage
- Undertake a sub-regional project to improve access to contraceptives and contraceptive advice and termination of pregnancy for vulnerable young people:
    - Implementation plan to address barriers and workforce capacity and capability issues (Q3).

Local actions

The Hutt Valley DHB will ensure on-going access to sexual health services targeting vulnerable groups including Māori and Pacific young people by:

- Improving service linkages with Family Planning services in the Hutt Valley
- Enhancing VIBE Youth One Stop Shop's network of free sexual health services to young people aged under 25 years within school-based health services, teen parent units and alternative education facilities

Medication Management [linkages with Pharmacy & Health of Older People]

Sub-regional actions

- Develop a Medication Management Health Pathway for the Frail Elderly (Q1) to assist primary care in optimising the prescribing of medicines and to provide advice on the utility of commonly prescribed long-term medicines:
    - Develop a list of triggers to prompt a medicines review
    - Integrate existing clinical guidance and tools into the development of medicines optimisation advice.

Local actions

- Integration of pharmacist facilitation and community pharmacist services (medicines adherence and optimisation, e.g. Te Awakairangi Health Network best practice prescribing) into the Medication

Management Health Pathway for the Frail Elderly, In accordance with the objectives of the Pharmacy Action Plan:

- Referral criteria developed for pharmacist facilitation and community pharmacist services in the Medication Management Health Pathway for the Frail Elderly (Q1).

Falls and Fractures

Sub-regional actions [linkage with Health of Older People]

- Advance the Falls Management Model for Older People (Q1), including:
  - Complete and launch 3DHB Health Pathway for 'Fragility fracture'
  - Develop processes to identify fragility fractures through the hospital data system from admissions and ED presentations
  - In partnership with integrated working group, develop options for a new model of care for falls management
  - Engage with ACC to explore potential Support and Balance initiatives, subject to funding.
- Establish a new model of care aligned to the national falls monitoring and prevention framework In partnership with integrated working group (Q2), including:
  - Establish baseline & targets measures for agreed model
  - Outline the process for primary health care to complete falls risk assessment as per the Fragility pathway
  - Develop a process to access DEXA scans (subject to funding)
  - Identify roles of primary health care and community based allied health in fall management including referral to strength and balance exercises
  - Promotion and education of the Fragility fracture pathway.
- Implement the new model of care, subject to ALT approval (Q3):
  - Establish a process for on-going falls management monitoring and review in the sub-region utilising Alliance Leadership groups.
- On-going monitoring of the new model of care (Q4).

Advance Care Planning [linkage with End of Life]

Sub-regional actions

- **Increase Awareness of Advance Care Planning**
  - Engage the community through DHB participation in the annual Conversations that Count day (16 April 2017) and public presentations to develop momentum for increased requests from patients for ACP
  - Promote ACP through a workforce that are aware of it and its benefits:
  - Increase the number of staff who complete level 1 ACP training (via eLearning), targeting staff working with older people and people with long term and life limiting conditions and including nursing, allied health and doctors
  - Provide training and mentoring to build workforce competence and confidence in introducing ACP & leading difficult conversations with patients.
- **Embed Advance Care Planning in targeted practices and services**
  - Embed ACP within 8 target services sub-regionally
  - Develop processes and system infrastructure to support ACPs being completed, stored, coded and accessible within targeted services:
  - Incorporation of ACP into models of practice
  - Enabling electronic alerting, storage and access of ACP in Shared Care Record and Concerto. [linkage with Information Technology]

Local actions

- Embed ACP in one General Practice and one hospital service
- To continue to focus ACP throughout our Long Term Conditions network, profiling this piece of work and ensuring it is embedded in projects [linkage with Long Term Conditions]
- Commit to at least 2 new clinicians attending ACP training who will then join our local ACP monthly forum and link with the ACP Service Integration & Development Unit role to ensure continuity of approach and educating others over time
- Continue to work with Hospice representatives to embed ACP into their in-house presentations.

Self-Management Support [linkage with Long Term Conditions]

Sub-regional actions

- Promotion of the finalised self-management support framework (Q1)
- Establish self-management working group to design and implement key activities, including raising consumer understanding and awareness of the tools and resources available (e.g. Health Navigator) to assist them self-manage aspects of their LTC (Q1)
- Implement activities to target long term conditions and diabetes self-management programmes to high need populations.

Measures

Statement of Performance Expectations measures (see Module 3):

- The number of new and localised Health Pathways in the sub-region
- The number of visits to the HealthPathways website in the last month of the financial year.

DHB Performance Measures (see Module 7)

- PP22: Delivery of actions to improve system integration
- SI1: Ambulatory Sensitive Hospitalisations.

Information Management

- Percentage of patients within Primary Care Practices that have enabled the Shared Care Record:
  - Targets:Q1 90%, Q2-Q4 94%.
- Percentage of hospital clinicians using the Primary Care Shared Care Record:
  - Targets Q1 10%, Q2 15%, Q3 20%, Q4 20%.
- Number of Primary Care Practices that have enabled the Patient Portal:
  - Targets Q1 8, Q2 10, Q3 13, Q4 15.
- Percentage of patients able to access the Patient Portal (in practices that have this service enabled):
  - Targets Q1 55%, Q2 62%, Q3 73%, Q4 75%.
- Number of Primary Care Practices using the Shared Care Plan tool:
  - Targets Q2 1, Q3 2, Q4 3.
- Percentage of Primary Care clinicians with access to the hospital health record:
  - Web browser solution already in place.

Health Pathways

- Number of new pathways gone live:
  - Target 50 by end Q4.
- Percentage increase in page views and sessions
- Number of existing pathways revised:
  - Target 50 by end Q4.
- Increased uptake of pathways (as per website analytics).

Packages of Care

- Number of packages of care delivered:
  - HVDHB Targets (cumulative) Q1 50, Q2 110, Q3 175, Q4 250.

Advance Care Planning

- Number of Level 1 ACP eLearning registrations
- Number of Level 2 ACP trainees
- Number of ACP presentations.

Hutt Integrated Network of Care (Hutt INC)

Overall Programme Development

- Continue to develop and implement Hutt INC's integration work programme through the Networks and 3DHB Service Level Alliances (SLAs)
- Refine and utilise the Alliance Leadership Team (ALT) outcomes and reporting framework to govern and monitor the impact of the integration work programme (Q2)
- Review the role of the ALT in relation to the Hutt Valley DHB Clinical Council (Q1-Q4):
  - This will be an on-going process throughout 2016/17 to prevent duplication in roles and work programmes. This will be raised during both the Hutt INC and Clinical Council meetings.

Acute Demand Network [linkage with Acute Demand]

- Develop (Q1), implement (Q1-Q2) and evaluate (Q3) the system-wide 2016/17 winter plan for the Hutt Valley with a focus on key integration activities between primary and secondary care. This includes the

following key winter planning projects:
  - ED facilitating GP appointments
  - Active follow up of repeat respiratory admissions
  - Implementation of ED risk screening tool for frail elderly in primary care
  - Improve direct acute access to specialist medical advice
  - Implement wellness Communication plan
  - Improve GP access to acute paediatric specialist advice
  - Implement efficient staff management plan and active bed management process
  - Improve the management of patients with behaviours of concern; and promotion of flu vaccination across staff and community.
- Develop a 2017/18 winter plan based on findings of the 2016/17 winter plan evaluation
- Continue the Person-centred Acute Community Coordination (PACC) pilot service to extend general practice care for patients, to assist with achieving the ED health target, reducing hospital admissions, and promoting primary care uptake of Primary options for Acute Care (POAC), Health Pathways and other local acute demand initiatives
- Develop a project scope to identify improvements in the Early Supported Discharge model (Q2) and develop rapid discharge and reablement options (Q3-Q4)
- Review and develop the Primary Care acute care model across the Hutt Valley (Q3-Q4).

Improve Primary Care Capacity and Capability

- Develop a business case to pilot a Health Care Home like model in the Hutt Valley to support both proactive care of complex patients and improve primary care responsiveness to acute demand (Q4).

Child Health Network [linkage with Maternal and Child Health]

- Implement a Quality Improvement Programme (QIP) to improve childhood asthma management in primary care:
  - Implement the QIP utilising the revised asthma Health Pathway throughout general practices in the Hutt Valley focusing on high priority practices (Q1-Q2)
  - Monitor the impact of the QIP on childhood asthma outcomes in the Hutt Valley (Q3-4)
  - Review the childhood asthma QIP and the need to extend asthma quality improvement programmes across secondary and community services and in other age groups.
- Evaluate the existing respiratory model of care across the system in conjunction with the LTC Network to improve integration and ensure services are provided in the right place for the patient, provide value-for-money and are outcome focussed:
  - Complete evaluation and identify opportunities for improvement for children and adults (Q1)
  - Develop an options paper for the reconfiguration of respiratory service (Q2)
  - Implement an agreed revised model of care (Q3-Q4).
- Develop an integrated child health model between primary and secondary services to improve primary care access to specialist input and reduce the reliance on outpatient services:
  - Develop and implement a pilot initiative to improve primary care access to specialist advice, e.g. virtual acute advice, electronic referral for specialist advice, shared care plans and case collaboration for complex paediatric patients (Q3-Q4)
  - Identify opportunities and pilot initiatives that provide outreach and outpatient paediatric services closer to home (Q3-Q4).

Long Term Conditions (LTC) Network [linkages with Long Term Conditions, Healthy Families New Zealand & Pharmacy]

- Implement and monitor the LTC programme in Te Awakairangi general practices across the Hutt Valley (12 practices by Q2, 16 practices by Q4 and all by Q1 2017/18)
- Evaluate the existing respiratory model of care across the system in conjunction with the Child Health Network to improve integration and ensure services are provided in the right place for the patient, provide value-for-money and are outcome focussed:
  - Complete evaluation and identify opportunities for improvement for children and adults (Q1)
  - Develop an options paper for the reconfiguration of respiratory service (Q2)
  - Implement a revised model of care (Q3-Q4).
- Improve primary care access to specialist input and reduce the reliance on outpatient services:
  - Survey access to specialist advice across 2 selected services (Q1)
  - Consider options for improving specialist advice to primary care in 2 selected services (Q2)

- Develop the appropriate tools/processes to improve specialist advice to the 2 selected services (Q3)
- Implement direct specialists advice across 2 selected services.

- Provide oversight to 3DHB Self-Management Support Framework and service development
- Support, provide oversight and report on the Ministry of Health's Musculoskeletal Mobility Action pilot
- Provide oversight and linkages with Diabetes, Cardiovascular Disease, Obesity and Healthy Families Lower Hutt, Health of Older People integration activities. [linkages with Diabetes, Cardiovascular Disease, Obesity, Healthy Families New Zealand & Health of Older People]

Primary Care Access to Diagnostics [linkage with Diagnostics]

- Improve access to funded community radiology – fully fund access to appropriate investigations for all Deprivation Quintile 5 residents (Q1)
- Continue to identify opportunities for improving primary care access to diagnostics:
  - Utilise localised Health Pathways to identify opportunities for improving appropriate access to radiological investigations.
- Review community referred radiology services funding and governance for the sub-region (Q2) and fully implement community radiology clinical access criteria across the sub-region (Q4 on).

Integration of Community Health Services [linkage with Allied Health, Scientific and Technical]

- Develop an approach and two year incremental plan to implement a single point of entry to provider arm community health services and transition to geographical locality teams (Q4)
- Develop clinical governance and training plans for community-based health workers:
  - Develop clinical governance plan and implement structure to provide oversight (Q2-Q4)
  - Develop training plan for community assistants (Q4).
- Community health services delivered in community and primary care settings:
  - Complete proposal for a pilot plan (Q2)
  - Implement plan and delivery of pilot sites (Q3)
  - Review pilots and develop plan for improvements and expanded service delivery (Q4 on).

System Level Measures Framework

- The alliancing partners are committed to the joint development of an Improvement Plan to support achievement of System Level Outcome Measures (Q1):
  - Publication of approved Improvement Plan (Q2)
  - Implementation of approved Improvement Plan (Q2-Q4).

Māori Health

- See Māori Health section.

Investment Strategy

Our investment strategy in 2016/17 continues from previous years, including:

- Shared resourcing across the members of the alliance to support the integration work programme for 2016/17. This will support the development of integration enablers and reconfiguring services and changing models of care in the areas of acute demand, child health and long term conditions
- POAC funding with greater flexibility to allow additional packages of care to be delivered in primary care for acute conditions PACC funding to support continuation of the pilot for 2016/17
- A business care for redirecting existing health expenditure into the Health Care Home like model in the Hutt Valley will also be developed to inform our direction for 2017/18.

Measures

Acute Demand Network

- Emergency Department attendances (self referred and not admitted)
- Ambulatory Sensitive Hospitalisations (0-74 total, Māori & Pacific, 0-4 years)
- Percentage acute readmissions within 28 days (total and 75+ years).

Child Health Network

- Emergency Department attendances for respiratory conditions
- Acute admissions for respiratory conditions (total, 0-4 years and 5-14 years).

Long Term Conditions (LTC) Network

- Number of Practices which have implemented LTC programme
- Cardiovascular Disease risk assessment (high needs and total)

- HBA1c control in people with diabetes
- Flu vaccination coverage (65+ and medicated asthma/COPD patients).

Health of Older People

- Admissions due to falls.

Integration of Community Health Services

- A reduction in DNAs for community health workforce.

Other

- Average length of stay in Medical Ward (total, stroke and respiratory patients)
- % of PHO enrolled population who are current smokers (15-74 years and high needs)
- Cervical screening coverage
- % of patients enrolled in the Patient Portal.

System Level Measures/DHB Performance Measures (see Module 7)

- PP22: Delivery of actions to improve system integration
- SI1: Ambulatory Sensitive Hospitalisations (0-4 year olds)
- SI7: Total acute hospital bed days per capita
- SI8: Patient experience of care
- SI9: Amenable mortality rate
- DV6: Youth access to and utilisation of youth appropriate health services
- DV7: Number of babies who live in a smoke-free household at six weeks post-natal.

Population Screening Services

Screening services test people with no symptoms for a particular disease or condition in order to reduce future mortality or morbidity. Screening may be for disease risk (an assessment of the probability that an individual may develop a disease in the future) or for an early asymptomatic stage of disease that is amenable to treatment. Delivery of screening services occurs as part of organised screening programmes or opportunistically during contact with health services. National screening programmes are overseen by the National Screening Unit and include the National Cervical Screening Programme and BreastScreen Aotearoa. Other opportunistic screening for chronic diseases, e.g. cardiovascular disease and diabetes, are largely driven by primary care services and are included in other sections.

Screening Services

Cervical Screening [linkage with Cancer Services]

Sub-regional Actions

- Engage with primary care through the Regional Coordination Group to identify and reach women who don't currently access screening services
- Evaluate the effectiveness of Regional Screening Services support to primary care
- Implement and review a 3DHB Colposcopy Stakeholders Group.

Local Actions

- Ensure that Māori and Pacific women can be referred to other providers for support, e.g. Mana Wahine and Pacific Health Service
- See also Māori Health (Cancer Screening) section.

Breast Screening [linkage with Cancer Services]

Sub-regional Actions

- Implement the recommendations from the 2015-16 Breast Screen Aotearoa interim audit
- Engage with primary care through the Regional Coordination Group to identify and reach women who don't currently access screening services
- Re-set the mobile unit roster to locations closer to high needs communities to reach women who currently don't get screened.

Local Actions • See also Māori Health (Cancer Screening) section. **Bowel Screening** [linkage with Cancer Services] • In conjunction with Wairarapa and Waitemata DHBs, prepare for commencement of Bowel Screening in the Hutt Valley in July 2017.
Measures **Statement of Performance Expectations measures** (see Module 3): • The percentage of eligible women (25-69 years) having cervical screening in the last 3 years • The percentage of eligible women (50-69 years) having breast screening in the last 2 years. **Māori Health Plan National Indicators** (see section 2B.2.2 Māori Health): • Cervical screening coverage for Māori women • Breast screening coverage for Māori women.

Cancer Services

Cancer is a leading cause of death and a major cause of hospitalisation. Prompt treatment is more likely to ensure better outcomes for patients and avoid unnecessary stress on patients and family at an already difficult time; it is also important that people have a clear expectation of how quickly they will receive treatment. We want to improve the quality of care and the patient's experience across the cancer pathway. Radiotherapy and chemotherapy are of proven effectiveness in reducing the impact of a range of cancers; delay to radiotherapy and chemotherapy is likely to lead to poorer outcomes of subsequent treatment.

The Faster Cancer Treatment programme is designed to reduce waiting times for appointments, tests and treatment and standardise care pathways for cancer patients, wherever they live. The programme links with the whole range of initiatives designed to improve the prevention, diagnosis and treatment of cancer and support for patients and their families. Faster cancer treatment takes a pathway approach to care, to facilitate improved hospital productivity by ensuring resources are used effectively and efficiently. The Minister's Health Target 'Faster Cancer Treatment' (see Appendix 1) supports our aims of maintaining high quality care and improving quality of life for people with cancer; effectively, equitably and sustainably meeting the future demand for cancer services, and ensuring fiscal responsibility of the health system. It has a whole of pathway approach covering all tests and investigations needed to confirm a diagnosis, as well as all forms of treatment including surgery.

Cancer networks operate regionally to improve outcomes for patients by:

- Reducing the incidence and impact of cancer
- Increasing equitable access to cancer services and equitable outcomes with respect to cancer treatment and cancer outcomes.

Implementing the priorities of the *New Zealand Cancer Plan: Better, faster cancer care 2015–2018* is the priority for regional planning for cancer services through the Central Cancer Network (CCN) to improve:

- Equity of access to cancer services
- Timeliness of services across the whole cancer pathway
- The quality of cancer services delivered.

Cancer Services [linkage with Screening]

Regional actions

Faster Cancer Treatment (FCT) Target

- DHB/Cancer Clinical Network (CCN) to continue to develop systems to enable active patient tracking and management aligned with Regional Health Informatics Programme and NZ Cancer Health Information Strategy
- DHBs to continue to monitor monthly and actively investigate breaches against the target
- DHBs/CCN to continue implementation of the six projects across the region supported by Ministry FCT funding
- Work with the Regional Radiology Group to develop (Q1) and implement a project plan to identify and implement initiatives to improve timeliness of access to diagnostics. [linkage with Diagnostics]

National Tumour Standards

- CCN, in partnership with DHBs, to co-ordinate reviews of services against two national tumour standards and identify key activities to address issues identified as a result of completed national tumour standard reviews.

Multidisciplinary Meetings (MDMs)

- DHBs to implement MDM clinical resourcing business cases
- To scope the feasibility (Q2) of implementing NZ Cancer Health Information Strategy MDM Project (in progress) recommendations for 2016/17 and 2017/18.

Equity

- Partner with Midcentral DHB to develop Equity Framework tools to support health service planners and providers to implement the *Equity of Health Care for Māori: A framework* resource.
- Continue implementing and evaluate the CCN Supportive Care Framework
- Continue service development work related to the Psychological and Social Support roles initiative and participate in national evaluation

Faster Cancer Treatment (FCT) in Primary Care [linkage with Service Integration/Configuration]

- Continue to build on initiatives to drive a strategic approach to FCT in primary care through an implementation plan, taking advice from regional DHB Alliance Leadership Teams (ALTs):
    - Implementation plan for 2016/17 developed by August 2016.
- The CCN Priority Clinical Pathway project continues, including implementing the prostate cancer management and referral guidance.

Access to Radiotherapy and Chemotherapy

- The two cancer centres will collaborate as appropriate on regional service development opportunities related to the implementation of the updated National Radiation Oncology Plan and Medical Oncology Model of Care:
    - Initiatives identified by August 2016.

Colonoscopy/Endoscopy [linkage with Diagnostics]

- Continue implementation of sub-regional colonoscopy service plans.

Sub-regional actions

- Review cancer models of care to improve local responsiveness to ensure patients can appropriately access services closer to home
- Implement and integrate sub-regional initiatives - development of a Pacific Faster Cancer treatment plan and ensuring a robust pathways for patients presenting in ED with colorectal cancer by working with clinicians
- Embedding sub-regional roles for Psychology/social work
- Continue quarterly sub-regional review of all 62 day breaches
- Sub-regional Endoscopy [linkage to Diagnostics]
    - Development and implementation of a single sub-regional service for endoscopy to improve waiting times and service quality
    - Explore a single reporting mechanism for sub-regional endoscopy.

Local actions

- Work with clinicians in Wairarapa to implement the prostate cancer management including referral guidance and plan documentation
- Implement ProVation solution (endoscopy reporting system)
- Undertake a tumour stream audit on colorectal cancer to identify delays in achieving 62 day target.

Measures

Minister's Health Target: Faster Cancer Treatment (see Appendix 1)

- 85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks (note target to move to 90 percent by June 2017 for reporting in 2017/18).

3DHB Outcome 6: People receive high quality hospital and specialist health services when they need them (see Appendix 1):

- Maintain or reduce the age-standardised cancer mortality rate.

Statement of Performance Expectations measures (see Module 3):

- The percentage of patients, ready for treatment, who waited less than four weeks for radiotherapy or chemotherapy
- The percentage of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred.

DHB Performance Measures (see Module 7)

- PP30 Part A: Faster cancer treatment – 31 day indicator
- PP30 Part B: Shorter waits for cancer treatment – radiotherapy and chemotherapy.

Māori Health Plan National Indicators (see section 2B.2.2 Māori Health):

- Cervical screening coverage for Māori women
- Breast screening coverage for Māori women.

Regional Service Plan Measures (see Central Region Regional Service Plan 2016/17):

- Quarterly report on progress against RSP milestones.

Stroke Services

Stroke falls under the category of long term conditions and are a significant cause of disability and premature death. Stroke can be prevented by timely risk assessment and detection of cardiovascular disease with early intervention to manage hypertension and arteriosclerosis. For those who have strokes, a comprehensive treatment and rehabilitation plan is required with management in accordance with the New Zealand Clinical Guidelines for Stroke Management 2010.

Stroke Services

Regional actions

- Strengthen consumer representation on the Central Region Stroke Network
- Identify options to improve overall data management and collection, which will support decision making, service delivery and drive service improvement.

Tele-stroke [linkages with Diagnostics & Acute Demand]

All people with a stroke have access to 24/7 thrombolysis supported through the use of tele-stroke:

- Central Region DHB's complete participation in the Ministry tele-stroke pilot (Q2)
- Allocation of required resources to support 24/7 access to thrombolysis using tele-stroke is determined:
    - Includes collaboration with Radiology services, Emergency Departments, Emergency services (ambulance) and support use of transport options if required to access thrombolysis.
- Annual audit to be undertaken by all DHBs
- DHBs to contribute to stroke thrombolysis quality assurance procedures, including processes for staff training and audit
- Determine required resources to sustain 24/7 tele-stroke, including any impact on DHB radiology services.

Communication Plan [linkage with Service Integration/Configuration]

Develop a Central Region Stroke Network Communication Plan, including strategies to support the Transient

Ischemic Attack tool in Primary Care:

- Undertake engagement with Primary Care (PHOs), NGO's and Iwi Health Providers prior to the development of the Communication Plan (Q3)
- Strengthen linkages with Stroke Central Region, including improving communication and feedback loops.

Rehabilitation

All people <65 years with stroke have access to rehabilitation:

- Undertake a needs analysis to determine the requirements for rehabilitation for stroke patients <65 years of age, which takes into consideration requirements for vocational rehabilitation and family/whānau participation and support
- Identify the feasibility of a regional centre for <65 years rehabilitation
- DHB's to identify the process requirements to support data collection on the proportion of patients admitted with acute stroke who are referred to community rehabilitation and the proportion of those undergoing face-to-face community assessment within 5 days of discharge from hospital.

Thrombectomy

Determine requirements to support a thrombectomy service based at CCDHB, including transport requirements and funding implications (Q2):

- Start collection of regional thrombectomy data.

Data Management and reporting

Support improved data management processes to enhance decision making, drive service improvement and service delivery:

- Quarterly data capture from each DHB and reporting
- Identify options to improve and facilitate data collection, including information technology requirements.

Training and Education

All members of interdisciplinary stroke team participate in on-going education and training according to the Stroke Guidelines:

- Hold annual Stroke Education Study Day.

Workforce

Lead Clinicians such as Physicians, Nurses and Allied Health are supported to participate in the Central Region Stroke Steering Group:

- Maintenance of attendance records.

Local Actions

- Continued implementation of stroke initiatives, including new Model of Care, to improve the patient journey and outcomes, and to reduce average length of stay.
- Improve community responsiveness to stroke management with improved referral pathways, model of care changes, and utilisation of workforce including rehabilitation assistants.

Measures

DHB Performance Measures (see Module 7)

- PP20: Improved management for long term conditions – Stroke Service.

Regional Service Plan Measures (see Central Region Regional Service Plan 2016/17):

- Quarterly report on progress against RSP milestones.

Cardiac Services

Heart disease affects many people in New Zealand. Patients with more severe heart disease may benefit from cardiac surgery; sometimes to reduce the risk of premature death, but usually to relieve symptoms of angina or prevent heart failure. As heart surgery carries substantial stress and risks for patients, it is not undertaken without serious consideration. However, because heart disease is a common cause of death and can occur suddenly with little or no warning, waiting for cardiac surgery is particularly stressful for patients and their families and those who care for them.

One aim of our work is to address delays in diagnosis and treatment of Acute Coronary Syndrome; to ensure patients presenting signs of cardiac chest pains will have a significantly reduced risk of dying through rapid and improved access to assessment and treatment. To improve the quality of cardiac services we need good data on what is happening to cardiac patients in New Zealand. Collecting national data on the cardiological assessment of elective and acute patients, prioritisation, and pre-operative, intra-operative and post-operative care is the essential ingredient for ensuring continuous quality improvement. There are five cardiac surgery centres across New Zealand – Auckland, Waikato, Wellington, Christchurch, and Dunedin.

Cardiac Services

Regional actions

Implementation of the New Zealand Expected Cardiac Clinical Standards, including an Acute Coronary Syndrome Action Plan

- The Cardiac Network will work with each DHB in the region to complete an initial gap analysis to assess the DHBs' performance against the New Zealand Expected Cardiac Standards and then develop DHB Action Plans to implement these standards and the echocardiography guidelines (Q2-Q4):
    - Minimum Standards gap analysis report completed:
    - All regional clinical leads actively lead the development and implementation of Minimum Standards action plans within their DHB
    - Each DHB clinical lead engages primary care to implement Minimum Standards.
- Review and audit of Accelerated Chest Pain Pathways in Emergency Departments
- Identify the activity data that will inform the development of a Regional Action Plan to address barriers and timely access to Acute Coronary Syndrome (ACS) services:
    - Review ACS protocols
    - Develop greater transparency of patient waiting times
    - Implement a regional risk stratification referral score
    - Develop an ACS action plan to be presented to the Network to assess feasibility and viability of services.

Development of a Cardiac Services System of Care across the Central Region

- Develop a Cardiac Services System of Care across the Central Region:
    - Stage one will include collecting and analysing information to better understand cardiac services in the Central Region
    - Stage two will describe the current model of care across home, primary, secondary and tertiary settings in relation to workforce and technology
    - Stage three will develop options for future models of care based on a horizon scan and modelling
    - Stage four will assess the clinical and financial sustainability of options according to impact on affordability, clinical safety and equity for all population groups
    - Stage five will be conducted by Central Region Chief Operating Officers and General Managers of Planning and Funding, towards presenting a future model for cardiac services to Chief Executives.

Sub-regional actions

- Commitment to sustaining performance in line with cardiac surgery waiting list management expectations
- Commitment to managing patients within nationally agreed urgency timeframes and to using the national CPAC tool
- Commitment to ensuring appropriate access to cardiac diagnostics
- Strengthen relationships with local and regional cardiology services to ensure robust cardiac surgery referral information and diagnostic tests are undertaken
- Strengthen relationships and explore different models of care delivery with private providers
- Service review and improvement project continues
- Provision of Pacing Clinics to Wairarapa.

Local Actions

- Trial a 'phone consult' service to specialist advice for primary care as an alternative to First Specialist Assessment referrals [linkages with Service Integration/Configuration & Cardiovascular Disease]
- Complete an audit of the Accelerated Chest Pain pathway to ascertain impact and benefits of the pathway (Q2)
- Work with the Regional Network and CCDHB to sustain improvements in the door to catheter time indicator (Q2), including:
    - Early referral systems, more formalised prioritisation of referrals, and contingency plans for spikes in referrals
    - Use of the Interventional Radiology Ward for Hutt transfers, to increase same day transfers back.

Measures

DHB Performance Measures (see Module 7)

- PP20: Improved management for long term conditions – Acute Heart Service
- PP29: Improved waiting times for diagnostic services - Elective Coronary Angiography
- SI4: Standardised Intervention Rates.

Regional Service Plan Measures (see Central Region Regional Service Plan 2016/17):

- Quarterly report on progress against RSP milestones.

Health of Older People Services

While on average people are living longer, not all of this time is spent in good health. Older adults have an increased risk for poor health outcomes including falls, skin fragility, incident disability, hospitalisation, and mortality. Our population is ageing and the prevalence of frailty will increase as the population ages. We are working sub-regionally and regionally on initiatives to protect vulnerable older people, provide good support and information for self-management, integrate and wrap services around the consumer to improve access and utilisation, up-skill our workforce, and to improve communication and patient management systems.

Health of Older People Services

Health of Older People Steering Group and Ministry of Health

National actions

- Benchmarking of health of older people indicators and expenditure
- Contribute to developments and projects through representation on this group, e.g. Aged Residential Care (ARC) workforce, national ARC contract review.

Health of Older People/Aged Residential Care Joint Steering Group project

National actions

Improved integration of care for Aged Residential Care (ARC) residents:

- Contribute to project strands through DHB work, e.g. improving discharge and admission planning for acute hospital care for ARC residents.

interRAI (Resident Assessment Instruments) Comprehensive Clinical Assessment in residential care and in home and community support settings

National actions

New Zealand InterRAI Project Group – Benchmarking of InterRAI indicators to inform population planning:

- Contribute to national developments through representation on this group.

Regional actions

Proactively monitor and share InterRAI population and service data across the continuum to influence service improvements:

- Publish regional benchmarking infographic, which is aligned to the New Zealand Health of Older People (HOP) strategy, ensuring equity is reflected within infographic (Q1)

- Establish survey tool to determine reach into relevant sectors, such as primary care, community care, NGO sector, of the infographic (Q2)
- Launch survey and analyse results (Q3)
- Evaluate the quality indicators in the infographic in response to survey and data trends and amend accordingly
- Revise communications plan for infographic (as necessary) based on survey results
- HOP Network review of regional InterRAI data and share finding with Portfolio Managers, reference groups and other relevant stakeholders
- Share results from the 3DHBs activity on the development of InterRAI outcomes measures through the Home and Community Support Sector (HCSS) provider agreements.

Sub-regional actions

- Ensure equitable access to interRAI assessment based on proportion of population groups over 65 years accessing contact and home care services (Q2, Q4)
- Use InterRAI for analysis, benchmarking, and population planning
- interRAI data will be used to inform other quality improvement changes, e.g. falls prevention, Enduring Power of Attorney, Advance Care Planning, Medication Management.

Dementia Care

Regional actions

Complete a current state analysis of educational and support programmes to support people living with dementia and their informal carers that are in operation in the region:

- Develop stocktake tool and engagement strategy to assess current state of education and support programmes, ensuring equity is reflected within the data sought (Q2)
- Collaborate with the non-government sector and community providers to complete current state analysis (Q2)
- Develop findings of the stocktake, including identification of innovations, and report to relevant stakeholders (Q3)
- Develop a regional proposal that establishes an agreed set of principles and approaches to education and support programmes for people living with dementia and their informal care givers.

Delivery of dementia awareness and responsiveness education programmes for primary health care clinicians to improve awareness and responsiveness in primary health care:

- Launch the Henry Brodaty e-learning modules across the region in primary and secondary care (Q2)
- Embed e-learning (Henry Brodaty) modules developed through the National Dementia Education Collaboration into General Practice
- Provide regional representation to the National Dementia Education Collaboration – Primary Care Dementia Education, to strengthen the national response to primary care education
- Report on the number of education sessions provided regionally to improve dementia awareness and responsiveness in primary care.

Provide DHBs with on-going support and overview so that DHBs identify and strengthen components of dementia care pathways within the parameters of the New Zealand Framework for Dementia Care:

- Utilise the expertise of the Chief Advisor for Health of Older People at the Ministry of Health to develop principles for clinical leadership for Health of Older People (Q2)
- Develop a regional proposal which supports enhanced clinical leader for older people (Q3)
- DHBs will provide access to “Living Well with Dementia resource” to the person with dementia and their family and whānau (Q3)
- Review content and update local DHB webpages to better support information for people with dementia and their family/whānau (Q3)
- Update DHB locator pages on the Alzheimers New Zealand website.

Sub-regional actions

- Cross match interRAI data re carer stress and use of carer support service for people to inform service planning and 2017/18 Annual Planning
- Embed health professional protocols relating to supporting people who choose to live with risk at home:
    - ‘Living with Risk’ protocol applied for supporting people who choose to live at home (from Q1)

Local actions

- Assist primary care practices to use dementia care pathway effectively through support from specialists (e.g. case reviews, support resources):
    - Establishment of clear processes to support primary care, e.g. specialist phone advice.

System Integration [linkage with Service Integration/Configuration]

Regional actions

- Establish and maintain national relationships with cross sector agencies and regional networks to better understand opportunities for system integration and connected services at a local or regional level for older people and their family/whānau
- Promote a shared understanding of integration utilising the Central Regions Integration Framework (2012) and associated resources.

Sub-regional actions

- DHB specialists (e.g. geriatricians, gerontology nurse specialists) to provide clinical advice and education for health professionals in primary care and aged residential care
- Develop a Medication Management Health Pathway for the Frail Elderly (Q1) to assist primary care in optimising the prescribing of medicines and to provide advice on the utility of commonly prescribed long-term medicines: [linkage with Pharmacy]:
    - See Service Integration/Configuration section (Medication Management) for details.

Local actions

- Provide input to Health of Older People integration activities, including:
    - Advance Care Planning integration activities [linkage with End of Life]
    - ED risk screening tool for frail elderly in primary care [linkages with Acute Demand & Service Integration/Configuration]
    - Falls reduction.

Home and Community Support Services for Older People

Regional actions

- Investigate and utilise approaches/tools which support transitions of care across the system for older people
- Investigate the barriers and needs of the carer in supporting the older person's wellbeing and function.

Sub-regional actions

- Identify any adverse impacts arising from In-Between Travel (IBT) arrangements, especially exceptional travel arrangements for Home & Community Support Services:
    - We commit to implement Part A of the IBT settlement agreement arrangements and to participate in the development of Part B.
- Use sub-regional and regional DHB benchmarking and case mix to monitor support of older people to live in the community:
    - Quarterly monitoring of first entry to residential care
    - Regional benchmarking report (Q3).
- Embed health professional protocols relating to supporting people who choose to live with risk at home.

Local actions

- Implement new contract for Home & Community Support Services from 1 September 2016 (Q2)
- Review NASC service model and development of service specification with a view to service redesign in late 2017
- Use sub-regional and regional DHB benchmarking and case-mix to monitor support of older people to live in the community.

Regional Models for Older People

Regional actions

- Utilise relevant datasets and business intelligence to inform the development of models of care which align to national strategy and support older people to live well, stay well and get well.

Falls and Fractures

Sub-regional actions [linkage with Service Integration/Configuration]

- Advance the Falls Management Model for Older People (this includes the previous Fracture Liaison

Service). We have been developing our approach to the provision of a fracture liaison services to a broader approach to overall falls prevention and management. There is continuing discussion about how best to integrate the elements of the existing services related to fall identification, prevention and intervention across the three DHBs. The model will build on these existing elements and identify where further developments are required to deliver an effective overall model of care for falls for the older people:

- See Service Integration/Configuration (Fractures and Falls) section for details.

Measures

3DHB Outcome 9: Improve the health, well-being and independence of our older people (see Appendix 1):

- Maintain or increase the proportion of patients receiving home-based support services, of those aged 65+ who receive DHB funded home-based support or aged residential care services
- Maintain or increase the average age of entry into residential care.

Statement of Performance Expectations measures (see Module 3):

- The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan
- The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home
- The percentage of the population aged 75+ who are in Aged Residential Care (including private payers)
- The percentage of residential care providers meeting three or more year certification standards.

DHB Performance Measures (see Module 7)

- OS8: Reducing Acute Readmissions to Hospital, 75+ years
- PP23: Delivery of actions to improve Wrap Around Services for Older People
- SI1: Ambulatory Sensitive Hospitalisations.

Regional Service Plan Measures (see Central Region Regional Service Plan 2016/17):

- Quarterly report on progress against RSP milestones.

Acute Demand – including Emergency Department Services

Long stays in Emergency Departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients. Improving our delivery against the 'Shorter Stays in Emergency Departments' health target supports the health and disability system outcome of 'New Zealanders living longer, healthier and more independent lives'. It will also result in a more unified health and disability system, because a coordinated, whole of system response is needed to address the factors across the whole system that influence ED length of stay.

Acute Demand [linkage with Service Integration/Configuration]

Local actions

- Develop, implement and evaluate the system-wide 2016/17 winter plan for the Hutt Valley with a focus on key integration activities between primary and secondary care (Q1-Q3). This includes the following key winter planning projects:
  - ED facilitating GP appointments
  - Active follow up of repeat respiratory admissions
  - Implementation of ED risk screening tool for frail elderly in primary care
  - Improve direct acute access to specialist medical advice
  - Implement wellness Communication plan
  - Improve GP access to acute paediatric specialist advice
  - Implement efficient staff management plan and active bed management process
  - Improve the management of patients with behaviours of concern; and promotion of flu vaccination across staff and community.
- Develop a 2017/18 winter plan based on findings of the 2016/17 winter plan evaluation
- Continue the Person-centred Acute Community Coordination (PACC) pilot service to extend general practice care for patients, to assist with achieving the ED health target, reducing hospital admissions, and

promoting primary care uptake of Primary options for Acute Care (POAC), Health Pathways and other local acute demand initiatives

- Develop a project scope to identify improvements in the Early Supported Discharge model (Q2) and develop rapid discharge and reablement options.
- Review and develop the Primary Care acute care model across the Hutt Valley (Q3-Q4).

Emergency Department (ED)

Local actions

- Continue implementation of the recommendations from the 2016 ED Review, the visit from the ED Target Champion and changes identified during phase one (February to July 2016) of the 'Effective ED' Project:
    - Completing restorative workshops with ED staff (Q1)
    - Establishing an ED staff survey (Q1)
    - Primary Care Liaison role (part time) in place (Q1)
    - Changes to patient registration processes (Q1)
    - Changes to ambulance and walk-in triage processes (Q1)
    - Introducing new ED nurse initiated pathways (Q2)
    - Scoping establishment of a rapid assessment function (Q1)
    - Piloting an ED Observation area (Q2)
    - Changes to processes and staffing roles/responsibilities to improve flow within the ED (Q2)
    - Introducing an agreed hospital pathway for abdominal and pelvic pain (Q2)
    - Introducing an agreed hospital pathway for traumatic head injury
    - Organisational agreement on services to be provided by ED and response to ED overload
- Ensure processes and systems are in place to monitor the mandatory and non-mandatory measures of the ED Quality Framework
- Begin reporting of Health Target performance to Ministry by Maori and Pacific ethnicity (Q1) and refine data collection and reporting processes
- Implementation of crisis response services (Q1), including Mental Health staff based at ED. [linkage with Mental Health and Addictions]

Measures

Minister's Health Target: Shorter Stays in Emergency Departments (see Appendix 1):

- 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours of presentation.

3DHB Outcome 6: People receive high quality hospital and specialist health services when they need them (see Appendix 1):

- A reduction in the standardised rate of acute readmissions to hospital within 28 days.

Statement of Performance Expectations measures (see Module 3):

- Health Target: The percentage of patients admitted, discharged or transferred from ED within six hours
- The standardised inpatient average length of stay (ALOS) in days, Acute.

DHB Performance Measures (see Module 7):

- SI1: Ambulatory Sensitive Hospitalisations
- OS3: Inpatient average length of stay – Acutes
- OS8: Acute readmissions to hospital.

Whānau Ora

Whānau (kuia, koroua , pakeke, rangatahi and tamariki) is recognised as the foundation of Māori society. As a principal source of strength, support, security and identity, whānau plays a central role in the wellbeing of Māori individually and collectively. He Korowai Oranga: the Māori Health Strategy asks the health and disability sectors to recognise the interdependence of people, that health and wellbeing are influenced and affected by the 'collective' as well as the individual, and the importance of working with people in their social contexts, not just with their physical symptoms.

A Whānau Ora approach to health and social service delivery has been developing since 2010 in response to persistent disparities in well-being between Māori and non- Māori populations. Underpinned by Māori values, the whānau (family) centred approach seeks to achieve the goal of whānau ora (well-being of the extended family) and requires health services to work across traditional sector boundaries to improve client health.

Whānau Ora is a key cross-government work programme jointly implemented by the Ministry of Health, Te Puni Kōkiri and the Ministry of Social Development. It is an approach that places families/whānau at the centre of service delivery, requiring the integration of health, education and social services. The programme of work is led by Te Puni Kōkiri to support whānau to build their capacity and capability, and empower whānau to determine their own aspirations and take control of their own futures. Three Whānau Ora Commissioning Agencies operate to purchase a range of whānau-centred initiatives at a local level.

Currently in the Hutt Valley district there are no Whānau Ora services funded by the Commissioning Agencies. What is available in the Hutt Valley are Māori health services applying the Whānau Ora approach. This approach places the individual/whānau at the centre of service delivery as a whole health system approach.

Whānau Ora [linkage with Māori Health]

- The DHB is committed to engaging with local commissioning agencies, in particular Te Pou Matakana (North Island Commissioning Agency) and Pasifika Futures, to identify and implement opportunities in planning, service development and funding of joint programmes:
    - Invite all relevant commissioning agencies to a sub-regional joint hui/fono (Q1) to discuss and agree the mechanism(s) and timing for on-going collaborative relationships between each of the Capital & Coast, Hutt Valley and Wairarapa DHBs and the relevant commissioning agencies
    - We will be represented at the July 2017 Whānau Ora Conference for North Island Whānau Ora Partners. This will assist our three sub-regional DHB's to engage with the Commissioning Agencies and to determine where our opportunities lie in the future for joint planning, funding and implementation
    - Additional engagement with relevant Commissioning Agencies at least three times a year through the Tumu Whakarae forum to identify areas of collaboration in planning, joint funding and service development.

Mental Health – see Māori Health, Public Health, Mental Health and Addictions & Youth Health sections for planned actions.

Asthma – see Māori Health, Public Health & Service Integration/Configuration sections for planned actions.

Oral Health – see Māori Health, Pacific Health, Public Health & Oral Health/Dental Services sections for planned actions.

Obesity – see Māori Health, Pacific Health, Public Health, Maternal and Child Health, Healthy Families New Zealand & Obesity sections for planned actions.

Tobacco – see Māori Health, Pacific Health, Public Health, Maternal and Child Health, Healthy Families New Zealand & Obesity sections for planned actions.

Measures

Minister's Health Target: Childhood Obesity (see Appendix 1):

- By December 2017, 95% of obese children (BMI > 98th percentile) identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

3DHB Outcome 4: Children have a healthy start in life (see Appendix 1):

- An increase in the proportion of children caries free at five years.

3DHB Outcome 3: Lifestyle factors that affect health are well-managed (see Appendix 1)

- An increase in the proportion of mothers who are smokefree two weeks post-natal

- An increase in the proportion of dispensed asthma medications that were preventers rather than relievers.

Statement of Performance Expectations measures (see Module 3):

- The percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer being offered brief advice and support to quit.

DHB Performance Measures (see Module 7):

- SI5: Delivery of Whānau Ora:
- PP11: Children caries-free at 5 years of age
- SI1: Ambulatory Sensitive Hospitalisations.

Māori Health Plan National Indicators (see section 2B.2.2 Māori Health):

- Rate of Māori Mental Health Compulsory Assessment and Treatment Act: Section 29 community treatment orders relative to other ethnicities.
- Smoking cessation: Percentage of pregnant Māori women who are smoke free at two weeks postnatal.

Diagnostics – including Radiology and Laboratory Services

Radiology

Diagnostic imaging supports clinical decisions which enhance the patient journey and enable us to meet current and new national targets. It allows the adoption of new models of care, such as clinical pathways and virtual clinics, which can improve patient care and achieve greater efficiency across the system.

Work continues on developing our 3DHB radiology service. The focus for 2016/17 remains on planning for maximum productivity within available resource; implementing agreed demand management strategies with key referrers, ensuring wise use of limited resources, and confirming the capacity and level of service. Development of business information will continue to better inform future plans. These developments will require close working relationships with the Service Integration and Development Unit, General Practitioners, and referring services.

Key enablers to the radiology service such as Regional Radiology Information System (RRIS) and implementation of Community Referred Access Criteria (CRAC) will support improved access to radiology. The 3DHB radiology asset plan will be further refined, to align investment in radiology with growth and development in other clinical services.

Radiology Services [linkages with Cancer & Electives Services]

The DHB is committed to meeting government targets, Ministry of Health priorities, regional and local DHB priorities. The key workstreams will address workforce, access and demand, and IT infrastructure. The sub-regional radiology services will continue to work towards an integrated single service by 2018.

Regional actions

The sub- regional radiology service will participate in the delivery of the regional radiology service plan:

- IT Infrastructure [linkage with Information Technology]
    - Develop a regional structure to govern (Q2) and support the implementation of the Regional Radiology Information System.
- Workforce [linkage with Workforce]
    - Develop and implement regional recruitment, training and retention initiatives to address vulnerable workforces, commencing with Sonographers.
- Service Improvement [linkage with Cardiac Services]
    - To work with the Central Region Cardiac Network to develop a pilot framework that will assess the costs/benefits of coronary Computed Tomography to maximise non-invasive cardiac imaging and reduce coronary imaging.

Sub-regional actions

- Maximise efficient use of existing resources to contribute to achievement of waiting time targets for all services (Faster Cancer Treatment, electives, diagnostics)
- Review community referred radiology services funding and governance for the sub-region (Q2) and fully implement community radiology clinical access criteria across the sub-region (Q4 on) [linkage with Service Integration/Configuration]
- Continue implementation of the sub-regional Radiology service
- Participate in activity relating to the implementation of the National Patient Flow (NPF) system, including adapting data collection and submission to allow reporting to the NPF as required
- Working with regional and national clinical groups to contribute to development of improvement programmes

Local actions

- Install a replacement CT at Hutt Hospital by November 2016
- Improve access to funded community radiology – fully fund access to appropriate investigations for all Deprivation Quintile 5 residents (Q1) [linkage with Service Integration/Configuration]
- Continue to identify opportunities for improving primary care access to diagnostics: [linkage with Service Integration/Configuration]:
    - Utilise localised Health Pathways to identify opportunities for improving appropriate access to radiological investigations.

Measures

Minister's Health Target: Faster Cancer Treatment (see Appendix 1):

- Short waits for cancer treatment.

DHB Performance Measures (see Module 7):

- PP29: Improving waiting times for diagnostic services:
    - Elective Coronary Angiography
    - Computed Tomography
    - Magnetic Resonance Imaging
    - Urgent Diagnostic Colonoscopy
    - Non-Urgent Diagnostic Colonoscopy
    - Surveillance Colonoscopy.

Regional Service Plan Measures (see Central Region Regional Service Plan 2016/17):

- Quarterly report on progress against RSP milestones.

Gastroenterology

Colonoscopy/Endoscopy [linkages with Cancer & Screening]

Sub-regional actions

- Further development of a sub regional Gastroenterology Service working under a collaborative model which includes:
    - Agreement to proceed to a shared wait list, nurse triage
    - Shared triage criteria across the sub-region to assist with equity of access and support each other through shared wait list management
    - Develop areas of sub-speciality service delivery.

Measures

Minister's Health Target: Faster Cancer Treatment (see Appendix 1):

- Short waits for cancer treatment.

DHB Performance Measures (see Module 7):

- PP29: Improving waiting times for diagnostic services:
    - Computed Tomography
    - Urgent Diagnostic Colonoscopy
    - Non-Urgent Diagnostic Colonoscopy
    - Surveillance Colonoscopy.

Laboratory Services

From November 2015 all hospital and community laboratory services for Capital & Coast, Hutt Valley and Wairarapa DHBs have been contracted from Wellington Southern Community Laboratories (WSCL). The initial contract period is for five years and this includes Key Performance Indicators to covering Turn Around Times, attendance at Multidisciplinary Meetings, referrer satisfaction, etc. Significant saving are expected and flexibility has been built into the contract to allow new tests to be introduced, in liaison with Alliance groups drawn from the sub-regional DHBs, community referrers and WSCL.

Laboratory Services

Sub-regional Actions

- Continued monitoring of the quality and performance of sub-regional laboratory services, including through the Laboratory Alliance Leadership Team.

Local actions

- Laboratory information system to change to WSCL's Ultra system
- Consider options for further consolidation of functions at the Wellington Regional Hospital Laboratory to reduce current costs to Hutt Valley DHB potentially duplicating some services on site.

Measures

Laboratory contract Key Performance Indicators.

Pharmacy

Pharmacist services are a critical part of the NZ health system and are the experts in medicines management. Hospital pharmacists contribute to medicines optimisation in a multidisciplinary team environment and community pharmacist services could be better integrated with the wider health system to enable a wider team approach and to put consumer needs more at the heart of the service. Pharmacist services need to support the delivery of health services across hospital, primary care and community settings and deliver on key government strategies such as the NZ Health Strategy, Implementing Medicines NZ, and the Pharmacy Action Plan. DHBs will work towards different contracts for the provision of community pharmacist services by working with consumers and a range of other stakeholders to develop options for service delivery.

Pharmacy

National actions

- The DHB is committed to supporting the objectives of the Pharmacy Action Plan, through its engagement in the National Pharmacy Programme of work outlined below, which seeks to make the best use of pharmacists' expertise in the safe and effective use of medicines in an integrated health environment
- We will continue to support the work being done nationally by the 20 DHBs to develop a National Framework for Pharmacy Services in the Community, and commit to the implementation and contracting of the services outlined in this framework as required to meet the needs of the DHB's local population.

DHB Shared Services National Pharmacy Programme

- Develop and implement medicines adherence and optimisation services of high quality that must include targeted volumes for each service by year end:
    - Further development of the Community Pharmacy Long Term Conditions service to align with the new service model – informed by a quarterly review of registration volumes
    - Review national provision of Medicine Therapy Assessments, including stocktake and recommendations report (Q3)
    - Review the delivery services that optimise specific medicines, including Community Pharmacy Anti-Coagulation Management Service (CPAMS), quarterly monitoring and recommendations

report.

- Supporting the development and implementation of an efficient medicines supply chain:
  - Implementation of an interim solution to address pharmaceutical margins anomalies (Q1)
  - Completion of section 26 & section 29 Request for Information (Q2)
  - Development of options for a longer term solution to address the margins anomalies.
- Commission services to best meet the identified demand and local needs:
  - Assist to allocate additional DHB funding for pharmacist services managed locally (Q3)
  - Development of a different service and funding model to deliver more co-ordinated patient centred pharmacist services to New Zealanders and putting contract(s) in place for the integration of pharmacist services in the community aligned with wider integration work with primary care
  - Contracts in place for the stratification of pharmacist-related patient-centric services, including in age-related residential care.

Sub-regional actions

- Develop a Medication Management Health Pathway for the Frail Elderly (Q1) to assist primary care in optimising the prescribing of medicines and to provide advice on the utility of commonly prescribed long-term medicines: [linkages with Service/Configuration & Health of Older People]:
  - See Service Integration/Configuration section (Medication Management) for details.
- Potential standardisations of policies and procedures across the sub-region, where appropriate
- Further development and implementation of sub regional antimicrobial stewardship programme
- Implementation of hospital e-Pharmacy (Hutt Valley DHB Q3, Wairarapa & CCDHB Q4). [linkage with Information Technology]

Local actions

- Complete the redesign and build of the Hutt Hospital pharmacy department to improve work flow & storage of medicines and to meet Ministry of Health audit requirements (Q1)
- Strengthen the Medication Safety programme at Hutt Hospital
- Continue to work with the Ministry of Social Development to evaluate and potentially extend a local project for improving access to prescription medications by reducing financial barriers.

Measures

Statement of Performance Expectations measures (see Module 3):

- The number of initial prescription items dispensed
- The percentage of the DHB-domiciled population that were dispensed at least one prescription item
- The number of people registered with a Long Term Conditions programme in a pharmacy
- The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy
- The rate of identified medication errors causing harm, per 1,000 bed days.

Elective Services

Elective services, including cardiac, are an important part of the health care system for the treatment, diagnosis and management of health problems. Timely access to these services is also considered a measure of the effectiveness of the health system. Elective surgery is important to New Zealanders as these are essential services to reduce pain or discomfort, and improve independence and wellbeing, particularly for surgery such as cardiac, cataract, and major joint replacement. Electives are not delivered in isolation; a focus on one element of a service or one step in the pathway will lead to missed opportunities for change and ultimately prove unsustainable; therefore, system-wide thinking is an essential aspect in this area, leading to the growth of integrated care pathways and development models to better manage workflow between services that are acute and those that are elective.

Elective Services

Regional actions

Individual DHBs continue with work in relation to theatre utilisation and productivity programmes, which are being initiated to improve access for patients, maximise theatre utilisation and efficiency across the region, and ensure DHBs are able to meet their elective targets:

- Results shared across Central Region DHBs to inform planning and collaborative improvement
- Opportunities for shared improvements across the region.

To continue to collaborate regionally to implement elective services initiatives in progress, such as regional clinical pathways for clinical conditions, and to identify areas where regional collaboration could contribute to improved patient outcomes:

- Framework in place for elective services to ensure consistency across elective services, including having a Governance Group in place to provide leadership and consistency across all elective services initiatives (Q1)
- Regional networks in place for specialty groups which are representative and include Māori, Pacific, Primary Care, Consumer, Allied Health
- Key stakeholders, the Governance Group and regional networks to identify clinical pathway development that would support improved patient access and quality of care and service delivery
- Completion and implementation of an First Specialist Assessment triage tool for Ophthalmology
- Completion and implementation of a model of care for Avastin
- Collation of population, workforce and productivity data and information to inform planning
- Ensure the Central Region Elective Services Health Targets are met
- Regional networks to identify options to develop services with known issues
- Barriers to regionalisation discussed and solutions developed
- Patient satisfaction surveys developed and initiated to inform on-going planning and service development.

Local actions

The DHB is committed to:

- Delivery on the agreed volume schedule, including elective surgical discharges, to deliver the Electives Health Target
- Delivery of agreed additional elective orthopaedic and general surgery discharges
- Actions to support improvements in electives access (including equity), quality of care, patient flow management and that maximise available capacity and resources, including:
    - Continued development and implementation of primary care referral pathways
    - Continue the focus on patient flow management in order to maintain reduced waiting times for electives, with patients waiting no longer than four months for first specialist assessment or treatment
    - Allocation of electives funding to support increased levels of elective surgery, specialist assessment, diagnostics, and alternative models of care.
    - Work more closely with Primary care to enable phone consult access and improve secondary care referrals and process
- Improving the consistency of prioritisation of patients by:
    - Implementing national prioritisation tools as they become available in Plastics, Orthopaedics, Ophthalmology and General Surgery
    - Prioritising all patients using nationally recognised tools and treating patients in accordance with assigned priority and waiting time.
- Participation in activity relating to all phases of National Patient Flow, including:
    - Business process and system change to meet collection requirements
    - Data quality activities, including validation of submitted data
    - Identification of, and engagement with, local, regional and sector-wide quality improvement opportunities.

Theatre Efficiency Project

- Undertake a Theatre efficiency project to improve access, patient flow and maximise utilisation.

Dermatology

- Recruit a Dermatologist as a joint appointment with Capital & Coast DHB.

Measures

Minister's Health Target Improved access to elective surgery (see Appendix 1):

- Volume of elective surgery will be increased each year:
    - Delivery against agreed volume schedule, including a minimum of 5,906 DHB elective surgical discharges and 101 Regional component elective discharges (totalling 6,007 discharges), and a further 57 additional elective orthopaedic and general surgery discharges.

Statement of Performance Expectations measures (see Module 3):

- Health Target: The number of surgical elective discharges
- The standardised inpatient average length of stay (ALOS) in days, Elective
- The percentage of "DNA" (did not attend) appointments for outpatient first specialist assessments
- The percentage of "DNA" (did not attend) appointments for outpatient follow-up specialist appointments.

DHB Performance Measures (see Module 7):

- SI4: Elective Services Standardised Intervention Rates
- OS3: Inpatient average length of stay – Electives.

Elective Services Patient Flow Indicators

- Data reported into the National Patient Flow collection in line with specified requirements.

Regional Service Plan Measures (see Central Region Regional Service Plan 2016/17):

- Quarterly report on progress against RSP milestones.

Allied Health, Scientific and Technical

Allied Health, Scientific and Technical staff encompasses almost 50 professional groups working within a wide variety of health and disability services at the DHB. They deliver vital services, treatments and assessments and utilise technology to provide measurement, testing and treatment of patients. Our devolved model of clinical leadership has been utilised to develop a shared sub-regional approach for Allied Health, Scientific and Technical professionals. This is detailed in the plan Designing our Future Together: Allied Health Scientific & Technical 3DHB Strategic Approach 2015-2025. Key priority areas towards meeting 10 year goals are:

- Working with our partners to develop and implement new models of care
- Quality
- Leadership
- Workforce development
- Business development
- Strategic innovation
- Improving health outcomes by increasing health equity.

Allied Health, Scientific and Technical

Regional actions [linkages with Workforce & End-of-life]

- Introduce Central Region Health Workforce New Zealand co-ordinated trainee funding
- Advance Care Planning (ACP) – agree and target areas for ACP level 1 eLearning:
    - Embed ACP level 1 eLearning into orientation for relevant professional groups.
- Vulnerable Workforces Plan for echocardiography and sonography workforces.

Sub-regional actions

- Increase integration of Allied Health services into community settings [linkage with Service Integration/Configuration]
- Build on the new Quality Framework for AHS&T to develop Quality Measures for AHS&T [linkage with Quality]
- Implementation of the Allied Health Career Framework: Service Needs Analysis to identify service need for designated positions which provide clinical leadership [linkage with Workforce]
- Develop accurate capacity and demand data to enable optimising of AHS&T workload and deployment

- Improve data quality and utilisation to enable decision making for change in practice
- Allied Health Scientific and Technical 3DHB Awards to be held in late 2016 [linkage with Workforce]
- Health Pathways – active role in clinical editing to ensure accurate, comprehensive and high quality pathways [linkage with Service Integration/Configuration]
- Allied Health Networking Forum – connecting AHS&T professionals from across the sector.

Local actions

- Work actively with the community providers to enhance health outcomes for Māori [linkage with Māori Health]
- Community Integration Project to explore options for deploying allied health workers with community health providers [linkage with Service Integration/Configuration]
- Complete pilot of Allied Health Trendcare IT tool in inpatient services [linkage with Information Technology]
- Explore Allied Health use of Care Capacity and Demand Management (CCDM):
    - CCDM is a programme that supports DHBs to achieve their core mandate to safely and consistently match and balance the demand it places on its services (care required by patients) with the resources required to meet this (staff, knowledge, equipment, facility). CCDM is about improving the quality of care for patients, the work environment for staff and the organisational efficiency.

Measures

- Number of staff with level 1 Advance Care Planning training.

End of Life – including Advance Care Planning and Palliative Care

Advance Care Planning (ACP) is a process of discussion and shared planning for future health care. Giving competent adults the opportunity to discuss and document advance care plans is part of person-centred practice. ACP is particularly relevant for older people or people with chronic or life-limiting conditions.

ACP aligns with integrating primary care with other parts of the health sector for better management of long term conditions and an aging population, as required by the Minister's Letter of Expectations. It also aligns with the New Zealand Health Strategy (see Module 2A) in terms of encouraging and empowering people to be more involved in their health and focusing on people with chronic and long term conditions.

ACP is part of integrated workstreams in the 3 DHBs. Specifically it connects to Tihei Wairarapa (Wairarapa DHB), the Long Term Conditions Network (Hutt Valley DHB) and the Long Term Conditions/Health of Older People Service Level Alliance (Capital & Coast DHB).

Advance Care Planning (ACP) [linkages with Service Integration/Configuration, Long Term Conditions, Health of Older People & Workforce]

Regional actions

Improve regional ACP awareness and training in identified high-need priority areas.

- Continue increasing level one uptake of ACP training in Nursing, Allied Health, Scientific and Technical and RMO/SMO Workforces in high need service areas through publication of module and utilising DHB intranets
- Regional ACP Group to work in conjunction with DHB Learning and Development teams to enable phased regional transfer of ACP planning and support back into DHBs.

Sub-regional actions

Increase Awareness of Advance Care Planning

- Engage the community through DHB participation in the annual *Conversations that Count* day (16 April

2017) and public presentations to develop momentum for increased requests from patients for ACP
- Promote ACP through a workforce that are aware of ACP and its benefits:
    - Increase the number of staff who complete level 1 ACP training (via eLearning), targeting staff working with older people and people with long term and life-limiting conditions and including nursing, allied health and doctors
    - Provide training and mentoring to build workforce competence and confidence in introducing ACP & leading difficult conversations with patients.

Embed Advance Care Planning in targeted practices and services

- Embed ACP within 8 target services sub-regionally
- Develop processes and system infrastructure to support ACPs being completed, stored, coded and accessible within targeted services:
    - Incorporation of ACP into models of practice
    - Enabling electronic alerting, storage and access of ACP in Shared Care Record and Concerto.

Local actions

- Local targeted services for embedding ACP to include one General Practice and one hospital service
- To continue to focus ACP throughout our Long Term Conditions network, profiling this piece of work and ensuring it is embedded in projects
- Commit to at least 2 new clinicians attending ACP training who will then join our local ACP monthly forum and link with the ACP Service Integration & Development Unit role to ensure continuity of approach and educating others over time
- Continue to work with Hospice representatives to embed ACP into their in-house presentations.

Measures

- Number of Level 1 ACP eLearning registrations
- Number of Level 2 ACP trainees
- Number of ACP presentations.

End-of-life care is the provision of supportive and palliative care in response to the assessed needs of the patient and family/whānau during the end-of-life phase. It focuses on maximising the living while preparing for an anticipated death and managing the end stage of a life-limiting or life-threatening condition. This includes care during and around the time of death, and immediately afterwards. It enables the supportive and palliative care needs of both the person and their family and whānau to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms, and provision of psychological, social, spiritual and practical support to the patient and support for the family. The Central Region is signalling the intention to take a more regionally coordinated and strategic approach to palliative care, including end of life care planning, in the region. Whilst 2016/17 planning guidance does not include specific initiatives related to palliative care, key work has been prioritised at a regional level.

Palliative Care service development to date has primarily been driven at the national and district levels. At the regional level the Central Cancer Network (CCN) has resourced the Central Region Palliative Care Network (CRPCN) to meet to share initiatives, contribute to national pieces of work and deliver a few regional projects as resources have allowed.

There is an emerging regional conversation related to taking a more integrated approach to palliative care and end of life care service planning across all clinical networks in the region, particularly within Health of Older People and Long Term Conditions service development. During 2016/17 the region will identify specific initiatives that would benefit from a regional approach and the appropriate infrastructure to deliver these from 2017/18 onwards. In addition, the region will

address the vulnerability of the palliative medicine workforce by implementing additional Resident Medical Officers (RMO) trainees.

Palliative Care

Regional actions [linkage with Workforce]

Improve sustainability and resiliency of workforce:

- Identify potential funding streams for additional palliative medicine registrar training positions with DHB Chief Operating Officer, Chief Medical Officer, RMO Unit Manager and associated hospices for CCDHB and MCDHB
- Establish a minimum of one additional palliative medicine training position for the region for start end of 2016 year with plans in place for further training position for end of 2017 year
- Stocktake of current palliative medicine training positions in the region.

Sub-regional actions

The Lower North Island Palliative Care Managed Clinical Network will:

- Consult on a palliative care strategic plan for the sub-region
- Develop and implement necessary clinical pathways to support the roll out of the Innovation Hospice funding
- Support implementation of the Innovation Hospice funding
- Assess current palliative care configuration of services against agreed strategic plan.

Local actions

- Implementation of approved initiatives using the Innovation Hospice funding.

Measures

Regional Service Plan Measures (see Central Region Regional Service Plan 2016/17):

- Quarterly report on progress against RSP milestones.

2B.2.5 Living Within our Means

Keeping to budget is important as it allows investment into new and more health initiatives. We will manage our finances prudently and ensure that all financial plans for 2016/17 and out-years are aligned with agreed results.

Living Within our Means

By focussing on quality, reducing waste and strengthening clinical engagement, we are working hard to get back to a breakeven budget position so that we will be well placed to plan and deliver the future health services our population needs. Living within our funding envelope is not an end within itself but a means by which we can sustainably make real differences to the health and well-being of our populations.

Living Within our Means

Local Actions

We are committed to:

- Operating within our agreed budget and funding capital investment from internal sources
- Supporting and/or participating in National Entity Priority Initiatives
- Proactively managing cost growth, in particular by managing growth in personnel numbers and improved use of workforce across the Hutt Valley Health System
- Implementing a revised delegations policy to ensure appropriate financial controls are in place
- Identifying more effective and efficient ways of delivering services
- Fostering and supporting a culture of improvement and innovation
- Provider leadership training for our clinical leaders to ensure they understand their wider stewardship

responsibilities
- Strengthening financial accountability through the organisation
- Undertaking a review of operating theatre efficiency and implementing initiatives that will improve this
- Delivering our system-wide programme to strengthen and improve acute care.

Measures

DHB Performance Measures (see Module 7)
- SI3: Ensuring delivery of Service Coverage
- OS3: Inpatient Average Length of Stay (ALOS), standardised
- OS8: Reducing Acute Readmissions to Hospital
- Output 1: Output Delivery Against Plan.

NZ Health Partnerships Ltd

NZ Health Partnerships is a multi-parent Crown subsidiary owned by New Zealand's 20 DHBs. Established and operated as a co-operative undertaking, NZ Health Partnerships' purpose is to enable DHBs to collectively maximise shared services opportunities for the National Good. Core operations centre on the continued development and implementation of four programmes – Finance Procurement and Supply Chain, the National Infrastructure Platform, Food Services and Linen & Laundry Services.

NZ Health Partnerships Ltd

The DHB commits to working in partnership with NZ Health Partnerships to progress the following initiatives. The DHB will commit resources to the decisions reached in relation to the implementation of the programmes and will factor in expected budget benefit impacts.

National Financial Management Solution *(formerly Finance, Procurement and Supply Chain)*
- The National Financial Management Solution will design and build a single financial management information system ready for DHB implementation. The designing of the processes and the system of the National Oracle Solution programme will be done through a co-creation approach with the sector, leveraging existing DHB expertise.

Food Services
- NZ Health Partnerships will support DHBs in considering the Food Services business case; Hutt Valley DHB is considering the option of participating in this business case as it considers future options for provision of food services
- Relocation of Hutt Valley DHB food and cafeteria services during 2016/17 to address earthquake risk.

Linen and Laundry Services
- Hutt Valley DHB became a shareholder in the regional laundry service (Allied Laundry) in 2015/16 and successfully transitioned over to the Allied Laundry Service in December 2015.

National Infrastructure Platform
- Hutt Valley DHB will participate in the National Infrastructure Platform.

Measures
- Savings delivered through participation in NZ Health Partnerships initiatives.

2B.2.5 Enablers

Improving Quality – including Health Quality Safety Commission

Sub-regionally we have adopted a "whole of system" approach to quality improvement through improving patient flow across the health care continuum. Our organisational development framework supports new knowledge and leadership development, innovation, research and quality

improvement methodologies; this supports our strategic goal of 'effective, efficient and high quality services'.

The Wairarapa, Hutt Valley, and Capital & Coast DHB's Quality Improvement, Patient Safety and Risk Teams work collaboratively, sharing resources, learnings from events and best practice. We are continually improving our understanding of the 'patient experience' as it is vital to improving patient safety and the quality of service delivery - shown to be a sound indicator of the quality of health and disability services. Growing evidence indicates that better experience, developing partnerships with consumers, and patient and family-centred care are linked to improved health, clinical, financial, service, and patient satisfaction outcomes. By capturing and integrating the lessons from patient experiences in a quality improvement framework we will increase the chances of sustainable service improvement.

The Central Region Quality and Safety Alliance (CRQSA) was established June 2014, with the over-arching aim of achieving consistent high quality and safety of care and positive patient experiences for people and their families/ whānau. Partnership between the CRQSA, Health Quality and Safety Commission (HQSC), ACC and Ministry of Health quality programmes has been established and will be strengthened through active participation, information sharing and collaborative initiatives that improve the health and wellbeing of communities. Clinical leadership and person / family centred care are internationally recognised as key drivers of improved patient outcomes and effective clinical governance. Clinical governance systems within health care form the foundation of safer processes for people and their families/whānau and staff. The aim for the central region is to work in partnership as a region to improve the quality of care and to reduce patient harm.

Quality Improvement

Regional actions

Strengthen alliance with primary care participation in the Central Region:

- Scope opportunities for further engagement points with Primary Health Organisation and DHB Clinical Governance Boards (Q1), develop and agree Future Engagement Strategy (Q2-Q3) and implement (Q3-Q4).

Improve patient outcomes through collaboration on areas of high patient harm with support from HQSC programmes:

- Utilise HQSC regional data to identifying areas of improved patient outcomes and areas of risk
- Develop a regional shared learning framework for improving patient outcomes (Q3-Q4).

Support the regional approach of person and whānau-centred care consumer partnerships with implementation of Relationship Centred Practice training:

- Co-ordinate information on consumer structures and approaches utilising regional linkages to create an agreed consumer approach across the region (Q1)
- Develop a training package to support the implementation of a person and whānau-centred approach (Q2-Q3)
- Regional phased implementation of Relationship Centred Practice training (Q4 on).

Continue to strengthen partnerships with the quality and safety programme of the HQSC, ACC and the Ministry of Health to promote shared learnings:

- Scope opportunities for shared learning events (Q1)
- Collaborate with national partners to contribute to HQSC 'Open Book'
- Support projects that improve the quality of care, reduce patient harm, and contribute to the national patient safety campaign 'Open for Better Care'
- Updates produced and initiatives/resources shared across the region and sub-region
- Regional quarterly face-to-face patient safety meetings.

Sub-regional and Local Actions

Falls (a Quality & Safety Marker – QSM) [linkage with Health of Older People]

- Clinically-led, multidisciplinary, Falls Prevention Group maintained to ensure focus remains on an integrated approach across each DHB:
    - Promotes hospital-wide programme for clinicians by clinicians
    - Allied Health professionals support prevention work with primary care clinicians
    - Nursing leadership works with Quality teams, carrying out real-time audits.
- Commitment to meet and/or sustain achievement at/or above identified QSM threshold for falls risk assessment and individualised care plan
- Commitment to an integrated approach across the DHBs to falls and fracture prevention, aligned with the work of the Ministry of Health's 'Health of Older People' team and including a systematic approach to health of older peoples' care pathway
- Quarterly review of falls QSM results and implementation of any required improvements, with the aim of reducing falls with serious harm in the older person.

Hand Hygiene (a QSM)

- Meet and/or sustain achievement at/or above the identified QSM threshold for hand hygiene compliance
- Gold Standard Auditor training to improve front-line ownership; focus of Infection, Prevention and Control Team to provide short, sharp education sessions on critical moments when hand hygiene should be performed
- Quarterly review of audit results and actions taken to improve compliance
- On-going training to increase the number of gold hand hygiene auditors sub-regionally
- Actively promoting the message for consumers "it's OK to ask your healthcare professional if they have cleaned their hands"
- Quarterly review of Hand Hygiene QSM results and implementation of any required improvements, with the aim of increasing hand hygiene compliance, awareness and improving patient safety.

Safer Surgery (a QSM)

- Introduce briefing and debriefing as per HQSC's DHB schedule
- Wairarapa, Hutt Valley and Capital & Coast DHBs participating in the new programme
- Work with HQSC to implement a new safer surgery QSM for public reporting in 2016/17
- Evaluate audit results and implement strategies to improve compliance
- Checklist to be used as a communication tool
- Commitment to working with HQSC to continue to implement and embed briefing and debriefing for each theatre list
- Quarterly review of Safer Surgery QSM results and implementation of any required improvements, with the aim of increasing surgical safety
- Commitment to sustain achievement at or above the old QSM threshold of all 3 parts of the WHO surgical safety checklist (sign in, time out and sign out) are being used in a minimum of 90% of operations.
- Commitment to ensure that the checklist is being used in a paperless form, as a team work and communication tool rather than an audit tool.

Surgical Site Infection (a QSM)

- Meet/sustain achievement at/or above the identified QSM threshold for the clinical standards specified by the Surgical Site Infection Improvement Programme, and that they are being adhered to in all hip/knee arthroplasty procedures
- Commitment to examining results and taking action to improve quality and safety
- Embed as part of regular audit schedule with oversight by Infection Prevention and Control Committees
- Support the Surgical Site Infection programme, including the National Infection Surveillance Data Warehouse and Infections Management systems
- Meet infection control expectations in accordance with Operational Policy Framework, Section 9.8
- Continue development of infection prevention and control systems at a local DHB level
- Quarterly review of Surgical Site Infection QSM results and implementation of any required improvements, with the aim of increasing surgical safety.

Patient Experience (QSM)

- On-going participation in the National Patient Experience survey
- Supporting HQSC's implementation of the PHO patient experience survey (Primary Care patient experience survey and reporting system):
    - In line with the proposal for the national in-patient experience survey to be used by PHOs
    - Help measure and report how consumers and patients experience the health system from a primary care perspective (using the National Enrolment System as a sampling base).
- Commitment to establish and support a Consumer Council to advise the DHB
- Implement actions from monthly reports of consumer feedback from electronic survey as appropriate.

Leadership and Capability

- Capability and Leadership Programmes that support improvement science and increased clinical leadership are in place to support sector capability and a culture of quality and safety improvement:
    - Support for Frontline Leadership programme.
- Participate in the HQSC Clinical Leadership and Patient Safety Programme for emerging leaders – Hutt Valley DHB has several staff members participating
- Commitment to maintain the necessary infrastructure to support patient safety initiatives at the local level and to meet the expectations in Operational Policy Framework Section 9.3 & 9.4.6
- Participation in the Patient Safety Week 2016 and active promotion of key messages.

Pressure Injuries

- Support the introduction of a national pressure injury prevention programme (currently under development by the HQSC)
- Encourage clinicians to complete ACC45 and ACC 2152 (treatment injury claims) forms for all grades of pressure injury (except grade one) to provide a more accurate picture of the incidence of pressure injuries occurring while patients are in our care
- Report to HQSC all pressure injuries grade three and above as serious adverse events
- Commitment to measure and report pressure injury prevalence regularly and consistently
- Improve classification and documentation of pressure injuries by grade in the patient record and ensure they are coded
- Implement a structured risk assessment to support clinical judgement and evidence based prevention approaches.

Deteriorating Patients

- Support for the introduction of a national deteriorating patient quality improvement programme (currently under development by the HQSC). Proposed programme is to have four work streams, with rollout phased over the course of a four year term.

Patient Safety

- Reporting of all serious and sentinel adverse events, through the HQSC leading the Annual Adverse Events Report
- Develop sub-regional clinical policies and protocols to mitigate risks associated with staff working across three sites/different policies, where appropriate.

Quality Accounts

- Hutt Valley DHB has an action plan to publish annual Quality Accounts and commits to regularly report on quality to relevant DHB Board Committees.

e-Medicine reconciliation [linkages with Pharmacy & Information Technology]

- Explore the best options for an efficient and effective implementation of electronic medicine reconciliation, in discussion with the National Health IT Board and their planning priorities and the HQSC's national implementation plans.

Mortality and Morbidity Review

- Undertake local, and support national, mortality and morbidity reviews
- Use Health Round Table data to identify more targeted activity.

Measures

Quality & Safety Markers

QSM updates collected and published by the Health Quality & Safety Commission (HQSC) and included in

DHB local quality accounts

Falls

- Percentage of older patients aged 75 and over (Māori & Pacific Islanders 55 and over) are given a falls risk assessment (target 90%)
- Percentage of older patients assessed as being at risk receiving an individualised care plan which addresses their falls risk (target 98%)

Hand Hygiene

- Compliance with good hand hygiene practice (target 80%).

Safer Surgery

- Percentage of operations where all three parts of the surgical safety checklist (sign in, time out and sign out) are being used (target 100%) with levels of team engagement with the checklist at 5 or above, as measured by the 7-point Likert scale (target 95%).

Surgical Site Infection

- Percentage of hip and knee replacement patients receiving cefazolin ≥2g or cefuroxime ≥1.5g as surgical prophylaxis (target 95%)
- Percentage of hip and knee replacement patients receiving prophylactic antibiotics 0-60 minutes before incision (target 100%).

Medication Safety

- Implementation of the electronic medicine reconciliation platform.

Statement of Performance Expectations measures (see Module 3):

- The rate of inpatient falls causing harm, per 1,000 bed days
- The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days
- The rate of identified medication errors causing harm, per 1,000 bed days
- The weighted average score in the Patient Experience Survey.

DHB Performance Measures (see Module 7):

- SI8: Patient experience of care.

Patient Safety

- Reporting into HQSC's Annual Adverse Events Report.

Quality Accounts

- Annual Quality Accounts, produced in accordance with HQSC guidance.

Regional Service Plan Measures (see Central Region Regional Service Plan 2016/17):

- Quarterly report on progress against RSP milestones.

Workforce – including Health Workforce NZ

All three sub-regional DHBs have a focus in 2016/17 on leadership development, engagement and recruitment and selection. These are identified as part of our Human Resources Plan 2014-2016 that spans all three DHBs. Included as part of this is further development of the leadership and management framework, review of leadership competencies at various levels to ensure they are meeting the needs of each DHB and aligned with the national work undertaken by the General Managers of Human Resources. We are looking to build leadership capability as one of the key things that we will need over the next three to five years. Effective recruitment and selection is key in building a strong resilient future workforce. To enable the resources and skills to meet this we will ensure policies, processes and training are appropriate to build the capability of those undertaking recruitment.

In addition to sub-regional and local workforce initiatives, the DHB works collaboratively with the Regional Director –Workforce and in conjunction with Health Workforce New Zealand (HWNZ) to support the development of the region's workforce and to achieve regionally-based solutions for the:

- Implementation of community-based attachments for prevocational trainees
- Increased participation of Māori and Pacific in the health workforce

- Development of vulnerable workforces
- Establishment of specialist roles, such as new palliative care specialist nurses and educators, nurse practitioners, clinical nurse specialists, nurses performing endoscopies, and medical physicists.

The DHB utilises both the National Leadership Domains and Workforce Intelligence and Planning Frameworks to ensure that local workforce activities fit with and complement those at a regional and national level.

Workforce

Regional Actions

Midwifery [linkage with Maternal and Child Health]

Provide midwifery professional support to ensure retention and quality of workforce:

- Continue model pilot evaluation (Q1)
- Develop and establish a regional professional support framework (Q2 on).

Medicine [linkage with End of Life]

Improve sustainability and resiliency of workforce:

- Continue to develop a regional orientation programme for Resident Medical Officers (RMOs) utilising nationally developed online programmes
- Identify potential funding streams for additional palliative medicine registrar training positions with DHB Chief Operating Officer, Chief Medical Officer, RMO Unit Manager and associated hospices for CCDHB and MCDHB (Q1)
- Scope current and identify future potential community-based attachments (Q1-Q2)
- Establish a minimum of one additional palliative medicine training position for the region for start end of 2016 year with plans in place for further training position for end of 2017 year (Q2)
- Develop a regional framework to ensure that current CBA initiatives are available for utilisation within region (Q3-Q4)
- Implement a regional RMO orientation programme (Q4 on).
- Stocktake of current palliative medicine training positions in the region.

Nursing [linkages with Screening & Diagnostics]

Support the development of the nursing workforce:

- Continue to develop a regional plan to align regional workforce initiatives with national bowel screening action plan (awaiting approval and delivery of national plan by the Government)
- Continue to develop and implement the regional plan with monitoring framework for utilising (top of scope) Clinical Nurse Specialist (CNS) and Nurse Practitioner (NP) positions in the region. Focus on supporting employment models to maximise outputs (standardisation of position profiles and KPIs) for requirement for CNS group to be positioned for nurse prescribing
- Benchmark current NP and CNS positions within region (Q4 on).

Allied Health, Scientific and Technical (AHST) [linkage with Allied Health, Scientific and Technical]

Support the development of the AHST workforce:

- Continued development and implementation of regional recruitment and retention initiatives and alignment of regional workforce policies and procedures for sonography, including the monitoring and evaluation of these initiatives.
- Commence and implement the process for AHST career pathways to be introduced at MidCentral and Whanganui DHBs
- Continue to implement the regional echocardiography workforce plan and monitoring framework
- Design a learning and development career framework for AHST (Q3).

Cultural Responsiveness [linkage with Māori Health & Pacific Health]

Support cultural development of workforce with reflection of recruitment aligned to population demographics:

- Quarterly benchmarking of Pacific and Māori workforce and review of agreed local and regional

recruitment targets (Q2-Q3)

- Continue to develop and implement strategic rollout plan for one regional Māori Capability Programme
    - Commence first phase of rollout of Māori Capability Programme to region as per plan for identified DHBs with identified percentages of staff in targeted high need areas (Q3 on).
- Phase one of implementation of Pacific cultural responsiveness plan (Q2 on - with further phased implementation and evaluation from 2017 onwards).

Kaiāwhina

Support national project through regional support framework:

- Scope current sector and Kaiāwhina workforce to align to Kaiāwhina 5 year action plan.
- Development of a regional framework for supporting workforce to include training initiatives and staff with formal qualifications for agreed profession groups (Q3).

Talent Management and Succession Planning

Appropriately enable regional workforce talent management and succession planning:

- Regionally share and understand the Hawkes Bay DHB Talent Management Programme (Q1-Q2)
- Regional agreement on principles for secondment opportunities and develop a secondment letter agreement template (Q2-Q3)
- Development of a secondment framework (Q3 on - with scheduled implementation in 2017).

Mental Health and Addiction [linkage with Mental Health and Addictions]

Implement 2015 Workforce Plans:

- Report quarterly to the Mental Health and Addictions Network and Te Pou with identified workforce requirements for new service delivery models
- Implement workforce development needs for the region aligned with the National Workforce Centres for Mental Health (Q3 on).

Advance Care Planning (ACP) [linkage with End of Life]

Improve regional ACP awareness and training in identified high-need priority areas.

- Continue increasing level one uptake of ACP training in Nursing, Allied Health, Scientific and Technical and RMO/SMO Workforces in high need service areas through publication of module and utilising DHB intranets
- Regional ACP Group to work in conjunction with DHB Learning and Development teams to enable phased regional transfer of ACP planning and support back into DHBs (Q3 on).

<u>Sub-regional and Local Actions</u>

Leadership [linkage with Quality]

- Develop a sustainable approach to leadership development with the development of a strategy which incorporates the priorities for the sub-region and includes:
    - Development and implementation of an introduction to leadership at our DHBs programme for existing managers that will also be used for induction for new managers
    - Introduction of programmes to build coaching skills for managers
    - Ongoing implementation of leadership modules for clinicians, including:
        - Clinical Leadership programme (commenced May 2016)
        - Frontline Leadership (incorporating quality improvement).
    - Implementation of Leading Change programmes and programmes designed to prevent bullying and harassment
    - Review and implementation of the leadership ethos and competencies into our people processes.

Engagement

- Finalise the engagement toolkit
- Development of engagement action plans for teams and DHBs.

Recruitment and selection

- Review of recruitment and selection policies, guidelines and templates
- Review and refine existing development options to ensure capable and consistent candidate assessment and selection by managers.

Other

• Introduction of Community-Based Attachments for Post Graduate Year 1 and Year 2 Resident Medical Officers.
Measures **Regional Service Plan Measures** (see Central Region Regional Service Plan 2016/17): • Quarterly report on progress against RSP milestones.

Information Technology – including National Health IT Board

Information Technology (IT) provides the platform to support improved information sharing and integrated health care. Well-designed IT solutions help us reduce costs and enable clinicians to work better together to enhance the patient and consumer journey improving their experience of giving them safer and faster care. However, greater utilisation of, and reliance on, technology requires effective management of IT assets. Sustained investment in IT will enable the health sector to manage increasing demand with limited resources.

National implementation of new IT initiatives continues in 2016/17 including the National Electronic Health Record and the development of a blueprint for a digital hospital. DHBs will have the maturity of its health ICT capabilities measured and benchmarked against an international framework - the Electronic Medical Record Adoption Model. The priority national initiatives that we support will be underpinned by national information platforms. Regionally and sub-regionally our health professionals and service providers are being supported to better co-ordinate and integrate care through information technology advances and better application and utilisation. Our approach relies on a strong primary care platform to support service transformation and provides us with opportunities to better manage demand and develop a more sustainable health system. DHBs are working with alliance leadership teams to strengthen this integration with primary care.

In addition to local Information Technology (IT) initiatives, there has been a focus in recent years on establishing regional information platforms. These include clinical workstation, clinical data repository and patient administration systems. Regions are now expected to build on these foundation platforms to create an integrated electronic medical record (EMR) that supports uniform, standards-based information capability across the sector, based on a nationally agreed blueprint for digital hospitals. The national *Health Information Technology (IT) Programme 2015-2020* requires DHBs to complete the critical priority regional investments as well as prioritising IT investments in four new areas:

- A single longitudinal Electronic Health Record (EHR) over the next five years
- 'hospital EMRs' based on a digital hospital blueprint
- A national health prevention IT platform to support screening and immunisation
- Data to support health and social investments.

These new areas will be commissioned over 2016 and the HIMSS Analytics EMR Adoption Model (EMRAM) will be used to benchmark DHB EMR solutions in 2016/17. The initiatives represented below are intentions only and are subject to change depending on available funding.

Information Technology (IT) <u>National actions</u> **eMedicines Reconciliation (eMR)**

Implementation of electronic reconciliation of medicines on admission and discharge from hospital is not currently prioritised. The initial focus is on accessing the NZePS data to support manual medicines reconciliation, in discussion with the National Health IT Board and the Health Quality and Safety Commission. Once the Central Region Information Strategic Plan has delivered the Clinical Portal then consideration will be given to eMR. This supports the sector's goals for Electronic Medicines Management.

National Maternity Information System Platform (MISP–NZ)

Implementation and transition to the National Maternity System for Obstetrics and Neonatal Services across the sub-region (CCDHB Q2, Hutt Valley DHB Q4 & Wairarapa DHB 2017/18, subject to the national system being ready by July 2016). This activity supports the National Health IT Board's goals for its National Maternity Information Systems Programme.

electronic Prescribing and Administration (ePA)

The DHB will work regionally to implement ePA. This supports the Sectors goals for Electronic Medicines Management. The DHB will develop a business case and implementation plan for electronic outpatient, discharge and mental health prescribing (Q3).

Integration with the national Electronic Health Record (EHR)

The DHB is committed to work regionally to ensure participation on EHR advisory groups and to undertaking an initial assessment as part of the national benchmarking exercise on the maturity of its electronic medical records.

Regional actions

The Central Region Information Strategic Plan (CRISP) is a regional strategy aimed at creating shared regional ICT systems and capabilities including a common clinical portal, shared clinical data repositories and a shared regional radiology system - all underpinned by a regional operating capability. The following initiatives are key focus areas for the sub-regional DHBs to achieve the vision of CRISP.

Clinical Portal (Clinical Workstation & Data Repository)

Development of a business case and implementation plan for a Clinical Workstation and Data Repository enabling greater integration of hospital services and patient care across the Central Region DHBs.

Radiology Information System (RIS) [linkage with Diagnostics]

Development of a business case and implementation plan for a Regional Radiology Information System enabling greater integration of radiology services and patient care across the Central Region DHBs. Note: this is subject to the regional solution being available by June 2016. If there is a delay interim steps will be taken as the current Radiology Information Systems (RIS) are unsupported.

Radiology Picture Archiving and Communication System (PACS) Upgrade [linkage with Diagnostics]

The current version of PACS needs to be upgraded to support a transition to the regional RIS.

Regional Service Management

Establishment of operational capability for regional applications, including Regional Service Desk and Ticketing Tool. This activity supports all of the other regional activities that establish shared ICT capability including the regional Clinical Portal and regional RIS.

Regional Access to Pharmacy Dispensing Data [linkage with Pharmacy]

As part of the National ePrescription Service, dispensing data from community pharmacies is being stored in a national repository. This initiative will work towards providing access to this data to aid in medicines reconciliation and general medication history checking ~~(Q3)~~.

Sub-regional actions

Windows and SQL Server Upgrade

Upgrade of the operating system (Windows Server) and database management system (SQL Server) to a supported version to mitigate the risk of failure and threats to IT security.

Information Security & Governance Programme

Implementation of best practices from the Health Information Security Framework and key recommendations from previous audits to mitigate the risk to information security and patient privacy. Recent internal and external audits have made a number of recommendations for ICT to implement to improve its information security and control environment.

- Reviewed and Revised ICT policies signed off and published

- Updated Audit strategy signed off and implemented
- Detailed implementation plan for key recommendations.

Integrated Laboratory Services ICT: Phase 2 – Transition to Wellington Southern Community Laboratories (WSCL) Laboratory Information System [linkage with Diagnostics]

The sub-regional outsourced laboratory service is currently supported by the DHB's Laboratory Information System (Delphic) as an interim measure. The service will need to fully transition to the outsourced provider WSCL's Ultra Laboratory System to enable greater efficiency and business continuity benefits through leverage of WSCL's full network of labs.

General Practice access to Hospital Information [linkage with Service Integration/Configuration]

General Practitioners (GPs) and external providers currently have limited access to the DHB's electronic health record. This initiative will implement secure and seamless integration between a GP's practice management system and the hospital's core clinical system (Concerto) enabling access to patient records.

Pharmacy Management System Replacement (ePharmacy) [linkage with Pharmacy]

The DHBs' hospitals Pharmacy Management Systems across the sub-region are out of support, unstable and will not support requirements, including medication management. This initiative will implement CSC's ePharmacy, the regionally agreed Pharmacy Management System, across each of the 3DHBs (Hutt Valley DHB Q3, Wairarapa & CCDHB Q4). This supports the CRISP strategy for convergence and consolidation of core applications.

National Collection Annual Maintenance Programme

Annual 2017 changes to the DHBs Patient Administration Systems to comply with new reporting requirements from the Ministry of Health.

National Patient Flow Stage 3

Implementation Plan for NPF Stage 3 for completion of the DHBs changes to systems including Patient Administration Systems, Radiology and Oncology. Note: Wairarapa DHB is unable to support NPF3 until it's PAS is replaced – currently expected in 2017.

Infrastructure as a Service (IaaS) Transition

Strategy and Roadmap for adoption of Infrastructure as a Service (IaaS) to guide architectural and investment decisions in 2017/18. IaaS (outsourced computing) offers the DHBs the opportunity to avoid lumpy capital investments cycles in hardware as well as the ability to refocus its ICT workforce more strategic activity.

Electronic Referral for Specialist Advice [linkage with Service Integration/Configuration]

Implementation of an electronic referral capability for virtual consultations. Virtual consults between hospital specialist clinicians and GPs have the potential to reduce demand for First Specialist Appointments and provide GPs with more timely access to specialist advice.

Electronic Nursing Observations

Implementation of a Nursing Observation solution for electronic documentation of nursing observations which has the potential of reducing the administration overhead and releasing time to care. This supports the sector's goal to improve the quality and completeness of the hospital Electronic Medical Record

Patient Administration System (PAS)

Upgrades to the current web-PAS at CCDHB and Wairarapa DHB. This supports the CRISP strategy for convergence and consolidation of core applications.

Integrated Clinical Portal (Transition) [linkage with Service Integration/Configuration]

The transition from unsupported Clinical Portals (Concerto) to a new Portal as a stepping stone to a Regional Clinical Portal. The new Portal will also enable greater sharing of clinical information across care settings including GPs, midwives and other DHBs. This supports the CRISP strategy for convergence and consolidation of core applications.

Patient Portals [linkage with Service Integration/Configuration]

Patients Portals are an on-line IT tool that will enable individuals to have access to their own health information. Eventually it will enable patients to communicate with their primary health practitioners and add information to their health record. General Practice Patient Management System (PMS) vendors are developing portals, and Orion Health is developing a portal in conjunction with Canterbury DHB's electronic Shared Care Record View (eSCRV) project.

Mobility [linkage with Service Integration/Configuration]

The DHBs will develop a strategy to enable mobility in the devices that are available and in its applications portfolio. This work supports the sector's goal of treating patients closer to their homes and in their communities:

- Implementation of a mobile security infrastructure and policies (Q1)
- Use of mobile security and integration infrastructure to support the CCDHB Health Care Homes initiative and Wairarapa's primary – community integration project (Q2)
- Development of a business case and implementation plan for a 3DHB mobility programme (Q3).

Local Actions

Anaesthesia Management [linkage with Quality]

Implementation of Safer Sleep application across theatres to manage the administration of anaesthetics during surgery resulting in improved safety.

Electronic Clinical Document Scanning

A significant portion of a patient's health record is still paper based which not quickly transferable between locations or easily shared with community providers. This document scanning solution will enable paper-based clinical documentation to be digitised and incorporated into the patient's electronic record resulting in efficiency gains as well as improvements in health outcomes. This supports the sector's goal to improve the quality and completeness of the hospital Electronic Medical Record.

Measures

National

- GP eReferrals into hospital services as a proportion of total referrals
- Compliance with NCAMP 2017
- Number of residual devices on unsupported Windows operating systems
- OS10: Improving the quality of identity data within the National Health Index and data submitted to National Collections (see DHB Performance Measures, Module 7).

Regional

- Quarterly report on progress against RSP milestones (see Central Region Regional Service Plan 2016/17)
- Transition plan to Regional Radiology Systems approved
- The Radiology Image Store (PACS) systems at Hutt Valley DHB and CCDHB are upgraded to the latest version that is compatible with the Regional Radiology Information System.

Sub-regional

- Percentage of General Practices having the ability to access Concerto from their Practice Management System
- Percentage of General Practices using the hospital health record
- Number of Primary care practices that have enabled the patient portal
- Percentage of patients able to access the patient portal
- Number of patients with a Shared Care Plan
- Number of GPs using Shared Care Plan tool
- Annual Privacy Maturity Framework Assessment
- Annual self-assessment against the Health Information Security Framework.

2B.2.7 Other Areas with a Regional Focus

Actions to Support Delivery of Regional Priorities

We are committed to working together with our region's DHBs to make the best use of available resources, strengthen clinical and financial sustainability and increase access to services, as detailed in the Central Region 2016/17 Regional Services Plan.

Actions to Support Delivery of Regional Priorities

Please refer to the following sections:

- Māori Health

- Mental Health and Addictions
- Cancer Services
- Stroke Services
- Cardiac Services
- Health of Older People
- Diagnostics
- Elective Services
- End of Life
- Quality
- Workforce
- Information Technology
- Hepatitis C
- Major Trauma.

Measures

DHB Performance Measures (see Module 7)

- SI2: Ensuring delivery of Regional Service Plans

Regional Service Plan Measures (see Central Region Regional Service Plan 2016/17):

- Quarterly report on progress against RSP milestones.

Hepatitis C

In January 2015, the Minister of Health considered advice on the future configuration of hepatitis C treatment services and approved the following recommendations:

- Resources in the next three to five years will be primarily directed towards targeted detection, management and treatment of hepatitis C in populations who are most at-risk.
- Primary and secondary care services will be extended to provide improved assessment and follow-up services for all people with hepatitis C.

A Hepatitis C pilot was delivered by the Hepatitis Foundation New Zealand in Capital and Coast, Hutt Valley and Wairarapa DHBs between 2012 and 2015. CCDHB was contracted in 2015 to support the planning, development and implementation of integrated Hepatitis C assessment and treatment services across primary and secondary care for the Central Region. The aims were to ensure continuity of care for patients in the pilot sites and to increase the identification, assessment and treatment of new patients with Hepatitis C. A project plan has been developed and Implementation of services is to start from 1 July 2016, provided sustainable funding is agreed.

Hepatitis C

The project plans to:

- Transition patients from the sub-regional pilot to primary care practitioners (subject to receipt of sufficiently detailed Pilot patient data from Hepatitis Foundation)
- Ensure all components of the clinical pathway are in place, including Fibroscan availability
- Promulgate and implement Hepatitis C Virus (HCV) clinical pathways in sub-regional and Central Region DHBs
- Raise General Practitioner (GP) awareness and education about the new HCV pathway and risk factors for infection
- Monitor volume of HCV diagnoses, Fibroscanning and treatment.

Actions to support implementation of integrated hepatitis C assessment and treatment services across community, primary and secondary care service in the region include:

- Raising community and GP awareness and education of HCV and the risk factors for infection
- Providing targeted testing of individuals at risk of HCV exposure
- Raising patient and GP awareness of long term consequences of HCV and the benefits of treatment, including lifestyle management and antiviral therapy

- Providing community-based access to HCV testing and care that will include Fibroscan services to all regions as a means for assessment of disease severity and as a triage tool for referral to secondary care and prioritisation for antiviral therapy
- Establishing systems to report on the delivery of Fibroscans in primary and secondary care settings
- Providing community-based on-going education and support (including referral to needle exchange services, community alcohol and drug services, GP primary care services or social service agencies)
- Providing long term monitoring (life-long in people with cirrhosis and until cured in people without cirrhosis)
- Providing good information sharing with relevant health professionals
- Working collaboratively with primary and secondary care to improve access to treatment.

Measures

Regional Service Plan Measures (see Central Region Regional Service Plan 2016/17):

- Quarterly report on progress against RSP milestones
- Number of people diagnosed with Hepatitis C per annum (by age)
- Number of HCV patients who have had a Fibroscan in the last year (by age and ethnicity), for
    - (a) new patients
    - (b) follow up
- Number of people receiving PHARMAC funded antiviral treatment per annum (by age and ethnicity).

Major Trauma

Trauma is a major health burden in New Zealand, with approximately 2,500 New Zealanders dying per year as a result of trauma and approximately 30,000 require hospital care for their injuries. 21 The Ministry of Health established a Major Trauma National Clinical Network (MTNCN) to improve patient outcomes from major trauma. The Regional Major Trauma network priorities to achieve this year are to:

- Continue to collect and refine the trauma data
- Commence monitoring and analysis of the data to assist with identifying areas for improvement for the network to focus on
- Complete the development of local and regional trauma systems, supported by appropriate trauma policies and guidelines
- Finalise the Central region component of the National Destination policy.

Major Trauma

Report the New Zealand Major Trauma National Minimum Dataset (NZMTNMDS) for major trauma patients to the National Major Trauma Registry:

- Major trauma data will be collected consistently across the region from July 2016.
- Data will be reported through the National Major Trauma registry via the regional arrangements with Midland Regional Trauma System and available from July 2016
- Analysis of the data will support the identification of key areas for improvement and will commence on the availability of the reports.

Develop and implement regionally consistent clinical guidelines for the management of major trauma patients:

- Clinical Guidelines will be developed consistently across the region and adapted to meet each DHBs specific requirement by December 2016
- Regional guidelines will be confirmed to support the timely and appropriate transfer of patients to the regional centre by December 2016.

Develop and implement Regional Destination Policies for major trauma patients (in collaboration with DHBs, patients, ambulance providers and National Major Trauma Clinical Network):

- Development of a regional destination policy for major trauma, in consultation across the Central Region DHBs and key partners, including patients
- Regional destination policy for major trauma signed off by regional clinical leads and regional CEOs
- Implementation of regional destination policy will be achieved consistently across the regional DHBs,

local trauma champions will work with local teams to ensure smooth implementation.
Measures **Regional Service Plan Measures** (see Central Region Regional Service Plan 2016/17): • Quarterly reporting of all mandatory fields for major trauma patients to the National Major Trauma Registry • Bi-annual report on progress against RSP milestones.

‘MODULE 3’ STATEMENT OF PERFORMANCE EXPECTATIONS

3.1 STATEMENT OF PERFORMANCE EXPECTATIONS

The following sections provide baselines, forecasts and targets for each Output Area.

Interpreting Our Baseline and Target Performance

Types of measures

Identifying appropriate measures for each output class requires us to do more than measure just the volumes of patients and consumers through our system. The number of services delivered or the number of people who receive a service is often less important than whether the right person or enough of the right people received the right service, and whether the service was delivered at the right time. Therefore, in addition to volume, we have added a mix of output measures to help us to evaluate different aspects of our performance. The outputs are categorised by type of measure, which shows whether the output is targeting coverage, quality, quantity (volume), or timeliness. In addition, some of our performance measures look at the health of the people who live in our district (DHB of domicile view), while other performance measures relate to the performance of the services we provide, regardless of where people live (DHB of service view). When possible and relevant, we have also broken our performance down by ethnicity.

Standardisation

Different populations have different characteristics, and these different population characteristics can lead to different rates between populations. One such characteristic is the age structure of a population. By standardising for age, we can see what the rates would have been if the two populations had the same proportion of people in each age group, and therefore draw comparisons. In the following outputs, if measures have been standardised (often by the Ministry of Health to allow comparison between DHBs), we have noted why and how.

Targets and estimates

Some of our performance measures are demand-based and are included to show a picture of the services that the DHB funds and provides. For these measures, there are no assumptions about whether an increase or decrease is desirable. For performance measures that are demand-based, we have provided an estimate of our 2016/17 performance (indicated with ‘Est.’), based on historical and population trends.

3.1.1 Output Class – Prevention

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising of services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction. Preventative services support health-promoting individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. On a continuum of care, many of these services are population-wide preventative services.

Prevention Measures

Output Area: **Public Health Protection and Regulatory Services**
Output Area Description: Health protection activity is enacted through a range of platforms, as described by the Ottawa Charter: public policy, reorienting the health system, environments, community action, and supporting individual personal skills. This is done to address the prerequisites of health, such as income, housing, food security, employment, and quality working conditions. While health has a significant role here, it requires a whole-of-sector approach; and our DHB and our Public Health Unit, Regional Public Health, work with other sectors (housing, justice, education) to enable this.
What we want to achieve: Protected healthy environments where environmental and disease hazards are minimised.
Linkage to Key Outcomes (Appendix 1): 3DHB Outcome 2: Environment and disease hazards are minimised.

Measure	Class / Type	Group	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
The number of disease notifications investigated	Prevention / Quantity	Total	505	505	Est. ≥505
		Māori	52	52	Est. ≥ 52
		Pacific	31	31	Est. ≥ 31
The number of environmental health investigations	Prevention / Quantity		206	206	Est. ≥206
The number of premises visited for alcohol controlled purchase operations	Prevention / Quantity		78	78	≥ 78

Output Area: **Health Promotion and Preventative Intervention Services**
Output Area Description: Health promotion service: inform people about health matters and health risks, and support people to be healthy. Success begins with awareness and engagement, reinforced by community health programmes that support people to maintain wellness or assist them to make healthier choices.
What we want to achieve: People are healthier and better supported to manage their own health. Children have a healthy start in life. Lifestyle factors that affect health are well-managed. Equitable health outcomes.
Linkage to Key Outcomes (Appendix 1): 3DHB Outcomes 1, 3 & 4: Reduced ethnic health disparities; Lifestyle factors that affect health are well-managed; Children have a healthy start in life.

Measure	Class / Type	Group	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region	Prevention / Quantity		29	25	Est. ≥ 29
The percentage of infants fully or exclusively breastfed at 3 months	Prevention / Coverage	Total	50%	50%	≥ 60%
		Māori	35.5%	37%	
		Pacific	43.5%	40%	
Number of new referrals to Public Health Nurses in primary/intermediate schools	Prevention / Quantity	Total	898	898	≥ 898
		Māori	466	466	≥ 466
		Pacific	40	40	≥ 40

Measure	Class / Type	Group	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
The number of adult referrals to the Green Prescription programme	Prevention / Quantity	Total	945	1,076	≥ 1,218

Output Area: **Immunisation Services**
Output Area Description: Immunisation services: work to prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations. The work spans primary and community care and allied health services to optimise provision of immunisations across all age groups, both routinely and in response to specific risk.
What we want to achieve: Fewer people experience vaccine preventable diseases. A high coverage rate. Equitable health outcomes.
Linkage to Key Outcomes (Appendix 1): Minister's Health Target for increased immunisation and 3DHB Outcomes 1, 2 & 4: Reduced ethnic health disparities; Environment and disease hazards are minimised; Children have a healthy start in life.

Measure	Class / Type	Group	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
The percentage of two year olds fully immunised	Prevention / Coverage	Total	95%	94%	≥ 95%
		Māori	95%	95%	
		Pacific	96%	95%	
The percentage of eight month olds fully vaccinated	Prevention / Coverage	Total	94%	94%	≥ 95%
		Māori	91%	91%	
		Pacific	96%	95%	
The percentage of Year 7 children provided Boostrix vaccination in schools in the DHB	Prevention / Coverage	Total	79%	79%	≥ 70%
		Māori	94%	94%	
		Pacific	96%	96%	
The percentage of Year 8 girls vaccinated against HPV (final dose) in schools in the DHB	Prevention / Coverage	Total	68%	68%	≥ 70%
		Māori	74%	74%	
		Pacific	88%	88%	

Output Area: **Smoking Cessation Services**
Output Area Description: Smoking cessation services: are provided by clinical staff to smokers to help smokers quit. Clinicians follow the ABC process : **A**sk all patients whether they smoke and document their response; if the patient smokes, provide **B**rief advice to quit smoking; and if patient agrees, provide **C**essation support (e.g., a prescription for nicotine gum or a referral to a provider like Quitline).
What we want to achieve: Fewer people take up smoking tobacco and quit attempts are made by more current smokers. Equitable health outcomes.
Linkage to Key Outcomes (Appendix 1): Minister's Health Target for better help for smokers to quit and 3DHB Outcomes 1 & 3: Reduced ethnic health disparities; Lifestyle factors that affect health are well-managed.

Measure	Class / Type	Group	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
Health Target: The percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	Prevention / Coverage	Total	79%	79%	≥ 90%
		Māori	n/a	79%	
		Pacific	n/a	75%	
The percentage of hospitalised smokers receiving advice and help to quit	Prevention / Coverage	Total	95%	95%	≥ 95%
		Māori	96%	96%	
		Pacific	95%	93%	
Health Target: The percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer being offered brief advice and support to quit smoking	Prevention / Coverage	Total	92%	90%	≥ 90%

Output Area: **Screening Services**
Output Area Description: These services help to identify people at risk of ill-health and to pick up conditions earlier.
What we want to achieve: More eligible people participate in screening programmes. Children entering school are ready

to learn. Equitable health outcomes.
Linkage to Key Outcomes (Appendix 1): Minister's Health Target for childhood obesity and 3DHB Outcomes 1 & 4: Reduced ethnic health disparities; Children have a healthy start in life.

Measure	Class/Type	Group	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
The percentage of eligible children receiving a B4 School Check	Prevention / Coverage	Total	90%	96%	≥ 90%
		High Need	90%	100%	
The percentage of eligible women (25-69 years old) having cervical screening in the last 3 years	Early Detection & Management / Coverage	Total	77%	78%	≥ 80%
		Māori	68%	70%	
		Pacific	70%	71%	
The percentage of eligible women (50-69 years old) having breast screening in the last 2 years	Early Detection & Management / Coverage	Total	72%	72%	≥ 70%
		Māori	66%	67%	
		Pacific	66%	65%	

3.1.2 Output Class – Early Detection and Management

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Early Detection and Management Measures

Output Area: **Primary Care Services**
Output Area Description: Primary care services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners, and other primary health care professionals; aimed at improving, maintaining, or restoring health. These services keep people well by: intervening early to detect, manage, and treat health conditions (e.g., health checks); providing education and advice so people can manage their own health; and, reaching those at risk of developing long-term or acute conditions.
What we want to achieve: Accessible, affordable and connected primary care services. Long-term conditions are well-managed. Increased availability of urgent and acute primary health care services. Fewer people are admitted to hospital for avoidable conditions. Equitable health outcomes.
Linkage to Key Outcomes (Appendix 1): 3DHB Outcomes 1 & 5: Reduced ethnic health disparities; Long-term conditions are well-managed.

Measure	Class / Type	Group	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
The percentage of the DHB-domiciled population that is enrolled in a PHO	Early Detection & Management / Coverage	Total	98%	98%	≥ 98%
The percentage of practices with a current Diabetes Practice Population Plan (or a current LTC plan which includes diabetes)	Early Detection & Management / Quality	PHO practices	n/a	17%	≥ 90%
The percentage of the eligible population assessed for CVD risk in the last five years	Early Detection & Management / Coverage	Total	89%	86%	≥ 90%
		Māori	84%	85%	
		Pacific	86%	87%	
The number of new and localised HealthPathways in the sub-region	Early Detection & Management / Quality		114	200	≥ 250
The number of visits to the HealthPathways website in the last month of the financial year	Early Detection & Management / Quantity		2,888	4,500	≥ 5,750

Output Area: **Oral Health Services**
Output Area Description: Dental services are provided to children (pre-schooler, primary school & intermediate school children) and adolescents (year 8 up to their 18th birthday) by registered oral health professionals to assist people in maintaining healthy teeth and gums.
What we want to achieve: Sustained level of utilisation of dental services by children and adolescents. Better teeth and gum health in children with reduced numbers of caries, decayed, missing and filled teeth. Equitable health outcomes. A reduction in the number of young children requiring invasive complex oral health treatment (under general anaesthetic) is also indicative of the quality of early intervention and of public health education and messages regarding the importance of good oral health.
Linkage to Key Outcomes (Appendix 1): 3DHB Outcomes 1 & 4: Reduced ethnic health disparities; Children have a healthy start in life.

Measure	Class / Type	Group	Baseline 2014	Forecast 2015	Target/Est. 16/17-18/19
The percentage of children under 5 years enrolled in DHB-funded dental services	Early Detection & Management / Coverage	Total	55%	94%	≥ 95%
		Māori	44%	84%	
		Pacific	51%	88%	
The percentage of adolescents accessing DHB-funded dental services	Early Detection & Management / Coverage	Total	73%	73%	≥ 85%

Output Area: **Pharmacy**
Output Area Description: The provision and dispensing of medicines and are demand-driven. Community pharmacies provide medicine management services to people living in the community. Medication management is particularly important for people on multiple medications to reduce potential negative interactive effects.
What we want to achieve: People are on the right medications to manage their conditions.
Linkage to Key Outcomes (Appendix 1): 3DHB Outcomes 5: Long-term conditions are well-managed.

Measure	Class / Type	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
The number of initial prescription items dispensed	Early Detection & Management / Quantity	1,527,802	1,534,784	Est. ≥ 1,543,994
The percentage of the DHB-domiciled population that were dispensed at least one prescription item	Early Detection & Management / Coverage	80%	80%	Est. ≥ 80%
The percentage of people registered with a Long Term Conditions programme in a pharmacy	Early Detection & Management / Coverage	8.0%	6.9%	≥ 6.9%[4]
The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy	Early Detection & Management / Quantity	191	205	220

3.1.3 Output Class – Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together. On a continuum of care these services are at the complex end of treatment services and focussed on individuals. They include:

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

4 The local rate is expected to reduce further but remain higher than the national rate, which for Q1 2015/16 was 4.7%.

- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.

Intensive Assessment and Treatment Measures

Output Area: **Medical and Surgical Services**
Output Area Description: Unplanned hospital services (Acute services) are for illnesses that have an abrupt onset and are often of short duration and rapidly progressive, creating an urgent need of care. Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Planned Services (Elective surgery) are services for people who do not need immediate hospital treatment and are 'booked' services. This also includes non-medical interventions (coronary angioplasty) and specialist assessments (first assessments, follow-ups, or preadmission assessments).
What we want to achieve: Reduced acute/unplanned hospital admissions. People have shorter waits for specialist assessment and treatment. Patients have a positive experience of care. Services provided are safe and effective. Equitable health outcomes.
Linkage to Key Outcomes (Appendix 1): Minister's Health Targets for shorter stays in Emergency department & increased access to elective surgery and 3DHB Outcomes 1 & 6: Reduced ethnic health disparities; People receive high quality hospital and specialist health services when they need them.

Measure	Class / Type	Group	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
Health Target: The percentage of patients admitted, discharged or transferred from Emergency Department within six hours	Intensive Assessment & Treatment / Timeliness		91%	91%	≥ 95%
Health Target: The number of surgical elective discharges	Intensive Assessment & Treatment / Quantity		n/a*	5,832	≥ 6,007
The standardised inpatient average length of stay (ALOS) in days, Acute	Intensive Assessment & Treatment / Timeliness		n/a*	2.51	≤ 2.35
The standardised inpatient average length of stay (ALOS) in days, Elective	Intensive Assessment & Treatment / Timeliness		n/a*	1.66	≤ 1.55
The rate of inpatient falls causing harm, per 1,000 bed days	Intensive Assessment & Treatment / Quality		2.1	2.1	≤ 2.0
The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days	Intensive Assessment & Treatment / Quality		0.4	0.3	≤ 0.5
The rate of identified medication errors causing harm, per 1,000 bed days	Intensive Assessment & Treatment / Quality		3.4	3.1	≤ 3.1
The weighted average score in the Patient Experience Survey by domain	Intensive Assessment & Treatment / Quality	Communication	8.5	8.3	≥ 8.3
		Coordination	8.5	8.4	
		Partnership	8.4	8.5	
		Physical & Emotional Needs	8.6	8.6	
The percentage of "DNA" (did not attend) appointments for outpatient specialist appointments (first appointments)	Intensive Assessment & Treatment / Quality	Total	7%	7%	≤ 7%
		Māori	14%	16%	
		Pacific	13%	14%	
The percentage of "DNA" (did not attend) appointments for outpatient specialist appointments (follow-up appointments)	Intensive Assessment & Treatment / Quality	Total	8%	8%	≤ 8%
		Māori	15%	17%	
		Pacific	14%	15%	

* Revised Ministry of Health methodology was introduced for this measure

Output Area: **Cancer Services**
Output Area Description: Cancer services include diagnosis and treatment services. Cancer treatment in the sub-region is delivered by the Wellington Blood and Cancer Centre.
What we want to achieve: People have shorter waits for specialist assessment and treatment. Patients have a positive experience of care. Services provided are safe and effective. Equitable health outcomes.
Linkage to Key Outcomes (Appendix 1): Minister's Health Target for faster cancer treatment and 3DHB Outcomes 1 & 6: Reduced ethnic health disparities; People receive high quality hospital and specialist health services when they need them.

Measure	Class / Type	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
The percentage of patients, ready for treatment, who waited less than four weeks for radiotherapy or chemotherapy	Intensive Assessment & Treatment / Timeliness	100%	100%	100%
The percentage of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred	Intensive Assessment & Treatment / Timeliness	56%	71%	≥ 95%

Output Area: **Mental Health and Addictions Services**
Output Area Description: Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population.
What we want to achieve: People have shorter waits for specialist assessment and treatment. Patients have a positive experience of care. Services provided are safe and effective. Equitable health outcomes.
Linkage to Key Outcomes (Appendix 1): 3DHB Outcomes 1 & 7: Reduced ethnic health disparities; People receive high quality mental health services when they need them.

Measure	Class / Type	Group	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
The number of people accessing secondary mental health services	Intensive Assessment & Treatment / Quantity	Total	6,023	6,165	Est. 6,033
		Māori	1,638	1,711	Est. 1,683
		Pacific	373	380	Est. 376
The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks	Intensive Assessment & Treatment / Timeliness	Total	86%	85%	≥ 95%
The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks	Intensive Assessment & Treatment / Timeliness	Total	96%	89%	≥ 95%
The percentage of people admitted to an acute mental health inpatient service that were seen by mental health community team in the 7 days prior to the day of admission	Intensive Assessment & Treatment / Quality	Total	45%	47%	≥ 75%
The percentage of people discharged from an acute mental health inpatient service that were seen by mental health community team in the 7 days following the day of discharge	Intensive Assessment & Treatment / Quality	Total	49%	48%	≥ 90%

3.1.4 Output Class – Rehabilitation and Support

Rehabilitation and support services are delivered following a 'needs assessment' process and co-ordination input by NASC Services for a range of services including palliative care, home-based

support and residential care services. On a continuum of care these services will provide support for individuals.

Rehabilitation and Support Measures

Output Area: **Disability Services**
Output Area Description: Many disability services are accessed through a Needs Assessment and Service Co-ordination (NASC) service. NASCs are organisations contracted to the DSS, which work with disabled people to help identify their needs and to outline what disability support services are available. They allocate Ministry-funded support services and assist with accessing other supports.
What we want to achieve: Responsive health services for people with disabilities. Enhanced quality of file for people with disabilities.
Linkage to Key Outcomes (Appendix 1): 3DHB Outcome 8: Responsive health services for people with disabilities.

Measure	Class / Type	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
The number of sub-regional and HVDHB Disability Forums	Rehabilitation and Support / Quantity	1	1	≥ 1
The number of sub-regional Disability Newsletters	Rehabilitation and Support / Quantity	3	2	≥ 2
The total number of hospital staff that have completed the Disability Responsiveness eLearning Module	Rehabilitation and Support / Quality	n/a	40	≥ 80
The total number of Disability Alert registrations	Rehabilitation and Support / Quality	4,466	5,346	≥ 6,220

Output Area: **Health of Older People Services**
Output Area Description: These are services provided to enable people to live as independently as possible and to restore functional ability. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups.
What we want to achieve: Improve the health, well-being, and independence of our older people. Reduced acute/unplanned hospital admissions. Older people with complex health needs are supported to live in the community. Services provided are safe and effective.
Linkage to Key Outcomes (Appendix 1): 3DHB Outcome 9: Improve the health, well-being and independence of our older people.

Measure	Class / Type	Baseline 2014/15	Forecast 2015/16	Target/Est. 16/17-18/19
The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan	Rehabilitation and Support / Coverage	100%	100%	100%
The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home	Rehabilitation and Support / Coverage	65%	65%	≥ 65%
The percentage of the population aged 75+ who are in Aged Residential Care (including private payers)	Rehabilitation and Support / Coverage	11.0%	11.0%	≤ 11.0%
The percentage of residential care providers meeting three or more year certification standards	Rehabilitation and Support / Quality	94%	93%	≥ 93%

3.1.5 Output Class Financials

Intensive Assessment & Treatment Forecast Statement of Financial Performance For the Year Ended 30 June $000s	2014\15 Audited	2015\16 Forecast	2016\17 Plan	2017\18 Plan	2018\19 Plan	2019\20 Plan
Income						
Operating Income	259,523	268,786	270,213	273,687	278,251	282,890
Interest Income	1,124	638	632	652	663	674
Total Income	**260,647**	**269,424**	**270,846**	**274,339**	**278,913**	**283,564**
Expenditure						
Personnel Costs	143,548	144,608	142,807	145,663	148,576	152,291
Depreciation	11,343	12,082	12,380	12,430	12,492	12,567
Outsourced Services	11,737	16,435	10,302	10,452	10,626	10,832
Clinical Supplies	23,196	22,969	23,507	23,626	23,744	23,981
Infrastructure and Non Clinical Expenses	12,239	11,639	10,495	10,535	10,588	10,645
Other District Health Boards	67,879	70,182	64,076	65,165	66,273	67,400
Non Health Board Providers	3,878	3,980	5,329	5,420	5,512	5,605
Capital Charge	5,987	6,220	5,949	6,008	6,068	6,129
Interest Expense	3,865	3,719	3,536	3,572	3,609	3,646
Other	2,639	2,559	4,131	4,149	4,170	4,198
Internal Allocations	(5,389)	(6,079)	(8,667)	(8,667)	(8,667)	(8,667)
Total Expenditure	**280,921**	**288,313**	**273,845**	**278,352**	**282,990**	**288,627**
Net Surplus / (Deficit)	**(20,274)**	**(18,889)**	**(3,000)**	**(4,013)**	**(4,076)**	**(5,063)**

Prevention Forecast Statement of Financial Performance For the Year Ended 30 June $000s	2014\15 Audited	2015\16 Forecast	2016\17 Plan	2017\18 Plan	2018\19 Plan	2019\20 Plan
Income						
Operating Income	21,942	21,883	21,179	21,507	21,840	22,178
Interest Income	62	35	40	36	36	37
Total Income	**22,004**	**21,918**	**21,219**	**21,543**	**21,876**	**22,215**
Expenditure						
Personnel Costs	13,026	12,812	12,156	12,400	12,648	12,964
Depreciation	262	298	364	365	367	369
Outsourced Services	1,351	1,380	1,049	1,064	1,079	1,099
Clinical Supplies	669	586	545	548	551	556
Infrastructure and Non Clinical Expenses	816	658	519	521	524	527
Other District Health Boards	62	56	416	423	430	438
Non Health Board Providers	1,226	1,242	1,507	1,533	1,559	1,585
Capital Charge	328	341	326	330	333	336
Interest Expense	62	62	62	62	62	62
Other	1,052	1,076	1,075	1,080	1,085	1,095
Internal Allocations	3,208	3,643	3,559	3,559	3,559	3,559
Total Expenditure	**22,063**	**22,155**	**21,579**	**21,884**	**22,196**	**22,590**
Net Surplus / (Deficit)	**(59)**	**(237)**	**(360)**	**(341)**	**(320)**	**(374)**

Early Detection & Management
Forecast Statement of Financial Performance
For the Year Ended 30 June

$000s	2014\15 Audited	2015\16 Forecast	2016\17 Plan	2017\18 Plan	2018\19 Plan	2019\20 Plan
Income						
Operating Income	117,868	152,281	164,610	167,992	170,397	172,838
Interest Income	40	23	26	23	24	24
Total Income	**117,908**	**152,304**	**164,636**	**168,015**	**170,421**	**172,862**
Expenditure						
Personnel Costs	4,673	4,748	10,420	10,629	10,841	11,112
Depreciation	712	760	790	793	797	802
Outsourced Services	1,081	1,091	1,273	1,288	1,303	1,320
Clinical Supplies	498	481	511	514	517	522
Infrastructure and Non Clinical Expenses	579	610	914	917	922	928
Other District Health Boards	11,894	15,424	15,836	15,542	15,239	14,924
Non Health Board Providers	86,235	115,108	129,370	130,558	131,756	132,964
Capital Charge	962	1,050	1,040	1,051	1,061	1,072
Interest Expense	41	41	41	41	41	41
Other	102	122	530	532	535	538
Internal Allocations	1,567	1,768	3,102	3,102	3,102	3,102
Total Expenditure	**108,343**	**141,203**	**163,826**	**164,967**	**166,113**	**167,324**
Net Surplus / (Deficit)	**9,565**	**11,101**	**810**	**3,049**	**4,307**	**5,538**

Rehabilitation & Support
Forecast Statement of Financial Performance
For the Year Ended 30 June

$000s	2014\15 Audited	2015\16 Forecast	2016\17 Plan	2017\18 Plan	2018\19 Plan	2019\20 Plan
Income						
Operating Income	61,785	55,848	71,366	72,440	73,530	74,638
Interest Income	2	1	1	1	1	1
Total Income	**61,786**	**55,849**	**71,367**	**72,441**	**73,532**	**74,639**
Expenditure						
Personnel Costs	3,512	3,611	3,567	3,639	3,711	3,804
Depreciation	16	19	16	16	16	16
Outsourced Services	428	427	429	433	438	442
Clinical Supplies	1,279	1,235	1,166	1,172	1,177	1,189
Infrastructure and Non Clinical Expenses	67	65	70	70	71	71
Other District Health Boards	3,619	3,487	3,979	4,019	4,059	4,100
Non Health Board Providers	48,976	45,216	60,064	60,722	61,388	62,062
Capital Charge	11	12	11	11	12	12
Interest Expense	2	2	2	2	2	2
Other	36	43	49	49	49	50
Internal Allocations	613	669	2,007	2,007	2,007	2,007
Total Expenditure	**58,558**	**54,785**	**71,360**	**72,141**	**72,931**	**73,755**
Net Surplus / (Deficit)	**3,229**	**1,064**	**7**	**300**	**601**	**884**

'MODULE 4'
FINANCIAL PERFORMANCE

4.1 FINANCIAL PERFORMANCE

4.1.1 Forecast Financial Statements

Financial Performance

DHB Provider Forecast Statement of Comprehensive Income For the Year Ended 30 June						
$000s	2014/15 Audited	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Income						
Operating Income	224,796	229,991	240,191	242,821	245,482	248,173
Interest	1,228	697	700	712	724	736
Total Income	**226,024**	**230,688**	**240,891**	**243,533**	**246,206**	**248,909**
Expenditure						
Personnel Costs	164,699	165,706	168,894	172,272	175,718	180,111
Depreciation	12,333	13,155	13,550	13,604	13,672	13,754
Outsourced Services	12,546	17,292	11,003	11,167	11,355	11,581
Clinical Supplies	25,640	25,270	25,730	25,859	25,988	26,248
Infrastructure & Non-Clinical Expenses	28,340	27,856	28,224	28,402	28,600	28,816
Internal Allocations	(617)	(459)	(621)	(621)	(621)	(621)
Total Expenditure	**242,941**	**248,820**	**246,779**	**250,683**	**254,711**	**259,889**
Net Surplus/(Deficit)	**(16,917)**	**(18,132)**	**(5,888)**	**(7,150)**	**(8,505)**	**(10,980)**
Other Comprehensive Income						
Revaluation of Land and Buildings	11,534	(0)	(0)	(0)	(0)	(0)
Total Comprehensive Income	**(5,383)**	**(18,132)**	**(5,888)**	**(7,150)**	**(8,505)**	**(10,980)**

Governance and Administration Forecast Statement of Comprehensive Income For the Year Ended 30 June						
$000s	2014/15 Audited	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Income						
Operating Income	3,271	3,276	3,270	3,304	3,338	3,372
Interest	-	-	-	-	-	-
Total Income	**3,271**	**3,276**	**3,270**	**3,304**	**3,338**	**3,372**
Expenditure						
Personnel Costs	60	69	56	57	59	60
Depreciation	1	-	1	1	1	1
Outsourced Services	2,051	2,047	2,050	2,070	2,091	2,112
Clinical Supplies	2	1	0	0	0	0
Infrastructure & Non-Clinical Expenses	447	371	527	529	531	535
Internal Allocations	617	459	621	621	621	621
Total Expenditure	**3,178**	**2,947**	**3,255**	**3,278**	**3,303**	**3,328**
Total Comprehensive Income	**93**	**329**	**16**	**25**	**35**	**44**

DHB Funder Forecast Statement of Comprehensive Income For the Year Ended 30 June						
$000s	2014/15 Audited	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Income						
Operating Income	425,847	461,816	491,271	498,939	506,731	514,648
Total Income	**425,847**	**461,816**	**491,271**	**498,939**	**506,731**	**514,648**
Expenditure						
Hutt Provider Arm and Governance	192,794	196,280	207,364	209,438	211,532	213,648
Other District Health Boards	83,454	89,142	84,307	85,150	86,002	86,862
Non Health Board Providers	140,315	165,554	196,270	198,232	200,215	202,217
Total Expenditure	**416,563**	**450,976**	**487,941**	**492,820**	**497,749**	**502,726**
Total Comprehensive Income	**9,284**	**10,840**	**3,330**	**6,119**	**8,982**	**11,922**
Expenditure Breakdown						
Personal Health	337,356	356,980	379,447	383,242	387,074	390,945
Mental Health	38,347	39,145	40,383	40,786	41,194	41,606
DSS	51,761	54,197	62,271	62,894	63,523	64,158
Public Health	1,455	1,778	1,488	1,503	1,518	1,533
Maori Health	1,237	1,251	1,201	1,213	1,225	1,237
Hutt Governance	3,152	3,156	3,151	3,182	3,214	3,246
Total Expenditure	**433,308**	**456,507**	**487,941**	**492,820**	**497,749**	**502,726**

Hutt Valley District Health Board Forecast Statement of Comprehensive Income For the Year Ended 30 June						
$000s	2014/15 Audited	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Income						
Operating Income	461,120	498,803	527,368	535,627	544,018	552,545
Interest	1,228	697	700	712	724	736
Total Income	**462,348**	**499,500**	**528,068**	**536,338**	**544,742**	**553,281**
Expenditure						
Personnel Costs	164,759	165,775	168,951	172,330	175,776	180,171
Depreciation	12,334	13,155	13,550	13,605	13,673	13,755
Outsourced Services	14,597	19,339	13,052	13,237	13,445	13,693
Clinical Supplies	25,642	25,271	25,730	25,859	25,988	26,248
Infrastructure & Non-Clinical Expenses	28,787	28,227	28,750	28,931	29,131	29,351
Other District Health Boards	83,454	89,142	84,307	85,150	86,002	86,862
Non Health Board Providers	140,315	165,554	196,270	198,232	200,215	202,217
Total Expenditure	**469,888**	**506,463**	**530,611**	**537,344**	**544,230**	**552,296**
Net Surplus/(Deficit)	**(7,540)**	**(6,963)**	**(2,542)**	**(1,005)**	**512**	**986**
Other Comprehensive Income						
Revaluation of Land and Buildings	11,535	(0)	(0)	(0)	(0)	(0)
Total Comprehensive Income	**3,995**	**(6,963)**	**(2,542)**	**(1,005)**	**512**	**986**

Movements in Equity

Hutt Valley District Health Board Forecast Statement of Changes in Equity For the Year Ended 30 June						
$000s	2014/15 Audited	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Equity as at 1 July	**93,613**	**97,401**	**91,454**	**88,705**	**87,492**	**87,797**
Revaluation Reserve	11,535	-	-	-	-	-
Capital Contributions from the Crown	-	1,220	-	-	-	-
Repayment of Equity to the Crown	(207)	(207)	(207)	(207)	(207)	(207)
Total Comprehensive Income for the Year	(7,540)	(6,963)	(2,542)	(1,005)	512	985
Equity as at 30 June	**97,401**	**91,451**	**88,705**	**87,493**	**87,797**	**88,575**

Financial Position

Hutt Valley District Health Board
Forecast Statement of Financial Position
For the Year Ended 30 June

$000s	2014/15 Audited	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Assets						
Current Assets						
Cash and Cash Equivalents	14,400	10,544	8,499	9,742	13,989	17,618
Debtors and Other Receivables	15,127	15,527	12,785	14,365	13,445	14,425
Inventories	1,391	1,481	1,481	1,481	1,481	1,481
Total Current Assets	**30,918**	**27,552**	**22,765**	**25,587**	**28,915**	**33,523**
Non Current Assets						
Property, Plant and Equipment	208,143	200,622	195,961	191,038	187,307	183,507
Intangible Assets	5,803	10,573	14,747	16,336	16,444	16,540
Investment in Joint Ventures	1,908	2,308	2,558	2,858	3,158	3,158
Trust and Bequest Funds	288	1,419	1,419	1,419	1,419	1,419
Total Non Current Assets	**216,142**	**214,922**	**214,686**	**211,651**	**208,328**	**204,624**
Total Assets	**247,060**	**242,474**	**237,451**	**237,238**	**237,243**	**238,147**
Liabilities						
Current Liabilities						
Creditors and Other Payables	27,227	28,194	29,661	30,661	30,361	30,486
Employee Entitlements and Provisions	29,166	28,066	27,466	27,466	27,466	27,466
Borrowings	15,402	9,622	9,223	9,223	9,223	9,223
Total Current Liabilities	**71,795**	**65,882**	**66,350**	**67,350**	**67,050**	**67,175**
Non Current Liabilities						
Employee Entitlements and Provisions	6,516	6,816	6,816	6,816	6,816	6,816
Borrowings	65,588	70,415	70,173	70,173	70,173	70,173
Trust and Bequest Funds	5,760	7,907	5,407	5,407	5,407	5,407
Total Non Current Liabilities	**77,864**	**85,138**	**82,396**	**82,396**	**82,396**	**82,396**
Total Liabilities	**149,659**	**151,020**	**148,746**	**149,746**	**149,446**	**149,571**
Equity						
Crown Equity	44,727	45,745	45,538	45,331	45,124	44,917
Revaluation Reserves	91,341	91,341	91,341	91,341	91,341	91,341
Retained Earnings	(38,667)	(45,632)	(48,174)	(49,179)	(48,668)	(47,682)
Total Equity	**97,401**	**91,454**	**88,705**	**87,493**	**87,797**	**88,576**
Total Equity and Liabilities	**247,060**	**242,474**	**237,451**	**237,238**	**237,243**	**238,146**

Cash Flow

Hutt Valley District Health Board
Forecast Statement of Cash Flow
For the Year Ended 30 June

$000s	2014/15 Audited	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Cash Flows from Operating Activities						
Cash Receipts	477,338	498,648	529,819	534,147	545,038	551,565
Payments to Providers	(223,851)	(254,696)	(280,577)	(283,382)	(286,216)	(289,078)
Payments to Suppliers and Employees	(240,587)	(227,763)	(224,350)	(228,372)	(233,545)	(238,030)
Goods and Services Tax (Net)	(5,368)	522	-	-	-	-
Capital Charge Paid	(3,691)	(7,623)	(7,327)	(7,400)	(7,474)	(7,549)
Net Cash Flows from Operating Activity	**3,841**	**9,088**	**17,566**	**14,993**	**17,803**	**16,908**
Cash Flows from Investing Activities						
Interest Received	1,229	697	700	712	724	736
Proceeds from Sale of Property, Plant and Equipmen	-	(4)	(7)	(7)	(7)	(8)
Purchase of Sale of Property, Plant and Equipment	(5,699)	(10,456)	(13,064)	(10,270)	(10,050)	(10,050)
Investments	(3,698)	616	(2,750)	(300)	(300)	-
Net Cash Flows from Investing Activity	**(8,168)**	**(9,147)**	**(15,121)**	**(9,866)**	**(9,633)**	**(9,321)**
Cash Flows from Financing Activities						
Equity Contribution	-	1,220	-	-	-	-
Loans Raised	(926)	(953)	(641)	-	-	-
Interest Paid	(3,970)	(3,860)	(3,642)	(3,678)	(3,715)	(3,752)
Payment of Finance Leases	-	-	-	-	-	-
Repayment of Equity	-	(204)	(207)	(207)	(207)	(207)
Net Cash Flows from Financing Activity	**(4,896)**	**(3,797)**	**(4,489)**	**(3,885)**	**(3,922)**	**(3,959)**
Net Increase / (Decrease) in Cash Held	(9,223)	(3,856)	(2,045)	1,242	4,248	3,628
Cash and Cash Equivalents at Beginning of Year	23,623	14,400	10,544	8,499	9,741	13,989
Cash and Cash Equivalents at End of Year	**14,400**	**10,544**	**8,499**	**9,741**	**13,989**	**17,617**

Capital Expenditure

Hutt Valley District Health Board
Capital Expenditure
For the Year Ended 30 June

$000s	2014/15 Audited	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Baseline Expenditure						
Property and Plant	2,051	1,686	2,927	2,500	3,000	3,000
Clinical Equipment	529	2,581	1,814	2,000	2,000	2,000
Computer Equipment	(1,219)	1,242	2,625	1,850	1,850	1,850
Other Equipment	112	228	-	100	100	100
Motor Vehicles	224	-	-	-	-	-
Total Baseline	**1,697**	**5,737**	**7,366**	**6,450**	**6,950**	**6,950**
Strategic Expenditure						
Property and Plant	305	2,393	605	400	-	-
Clinical Equipment	4	939	320	800	1,950	2,000
Computer Equipment	3,827	2,050	4,773	2,620	1,150	1,100
Other Equipment	(134)	-	-	-	-	-
Motor Vehicles	-	-	-	-	-	1,100
Total Strategic	**4,002**	**5,382**	**5,698**	**3,820**	**3,100**	**4,200**
Total Capital Expenditure	**5,699**	**11,119**	**13,064**	**10,270**	**10,050**	**11,150**
Financed By						
Internally Sourced Funding	(7,540)	(6,963)	(2,542)	(1,005)	512	986
Depreciation	12,332	13,155	13,550	13,550	13,605	13,673
Sale of Fixed Assets	-	(4)	(7)	-	-	-
Equity Injections for Capital Expenditure	-	1,220	-	-	-	-
Private Debt	(926)	(953)	(641)	-	-	-
CHFA Debt	-	-	-	-	-	-
Other (Includes Cash Reserves)	17,723	15,891	11,226	8,522	10,797	14,864
Total Finance	**21,589**	**22,345**	**21,586**	**21,067**	**24,914**	**29,522**

Full Time Equivalents

DHB Provider
FTEs by Class
For the Year Ended 30 June

	2014/15 Audited	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Medical	246	255	259	259	259	259
Nursing	755	758	747	747	747	747
Allied Health	440	398	395	395	395	395
Non-Allied Health	139	132	138	138	138	138
Management/Clerical	302	305	325	325	325	325
Total FTEs	**1,882**	**1,848**	**1,863**	**1,863**	**1,863**	**1,863**

DHB Governance & Administration
FTEs by Class
For The Year Ended 30 June

	2014/15 Audited	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Medical	-	-	-	-	-	-
Nursing	-	-	-	-	-	-
Allied Health	-	-	-	-	-	-
Non-Allied Health	-	-	-	-	-	-
Management/Clerical	1	0	1	1	1	1
Total FTEs	**1**	**0**	**1**	**1**	**1**	**1**

Hutt Valley District Health Board FTEs by Class For the Year Ended 30 June	2014/15 Audited	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Medical	246	255	259	259	259	259
Nursing	755	758	747	747	747	747
Allied Health	440	398	395	395	395	395
Non-Allied Health	139	132	138	138	138	138
Management/Clerical	303	305	326	326	326	326
Total FTEs	**1,883**	**1,849**	**1,864**	**1,864**	**1,864**	**1,864**

Key Financial Information

Hutt Valley District Health Board Key Financial Information For the Year Ended 30 June $000s	2014/15 Audited	2015/16 Forecast	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
Revenue	462,348	499,500	528,068	536,338	544,742	553,281
Expenditure	(469,888)	(506,463)	(530,611)	(537,344)	(544,230)	(552,296)
Revaluation of Land and Buildings	11,535	(0)	(0)	(0)	(0)	(0)
Total Comprehensive Income	**3,995**	**(6,963)**	**(2,542)**	**(1,005)**	**512**	**986**
Total Property, Plant & Equipment	208,143	200,622	195,961	191,038	187,307	183,507
Total Equity	97,401	91,454	88,705	87,493	87,797	88,576
Term Borrowings	65,588	70,415	70,173	70,173	70,173	70,173

Expenditure Category

Expenditure Category	2014/15 Audited $m	2015/16 Forecast $m	2016/17 Plan $m	2017/18 Plan $m	2018/19 Plan $m	2019/20 Plan $m
DHB Provider Arm	242.9	248.8	246.8	250.7	254.7	259.9
Funder Arm	140.3	165.6	196.3	198.2	200.2	202.2
Services Purchased from Other DHBs (IDF Outflows)	83.5	89.1	84.3	85.2	86.0	86.9
Governance Arm	3.2	2.9	3.3	3.3	3.3	3.3
Total Allocated	**469.9**	**506.5**	**530.6**	**537.3**	**544.2**	**552.3**
Funding (excluding IDF inflows below)	422.9	421.8	430.4	437.7	445.1	452.7
Services provided for Other DHBs (IDF Inflows)	51.0	77.7	97.7	98.6	99.6	100.6
Total Funding	**473.9**	**499.5**	**528.1**	**536.3**	**544.7**	**553.3**
Surplus / (Deficit)	**4.0**	**(7.0)**	**(2.5)**	**(1.0)**	**0.5**	**1.0**

4.1.2 Financial Assumptions

The assumptions are the best estimates of future factors which affect the predicted financial results. As such there is necessarily a degree of uncertainty about the accuracy of the predicted result, which is unable to be quantified. Factors which may cause a material difference between these prospective financial statements and the actual financial results would be a change in the type and volume of services provided, significant movement in staff levels and remuneration, plus unexpected changes in the cost of goods and services required to provide the planned services.

Revenue

- PBFF Increase of $6.2M as per Funding Envelope plus an additional 1.8M contribution towards Demographic and cost pressures and $1.2M towards pharmaceutical investment funding
- IDF levels based on Funding Envelope or agreed changes within the sub-region.

Expenditure

- Personnel expenditure increase in line with agreed financial assumptions of 2%
- Supplies and expenses based on current contract prices where applicable
- Provider Arm 2015/16 achieved baseline savings targets are included in 2016/17 where these are on-going
- Depreciation to include base, plus work in progress, plus new purchases
- Capital Charge at 8% payable half yearly
- Debt renewals based on DMO quoted future rate projections
- Total Capital Expenditure of up to $13.1 million p.a. is planned from 2016/17.

Capital Plan

The operational capital funding requirements for the Provider Arm will be met from cash flow from depreciation expense and prioritised with the clinical leaders both within the Directorates and across the Provider Arm. Only items of a legal & safety nature, or essential to support the District Annual and Strategic Plans have been included in the CAPEX budget. The baseline CAPEX for 2016/17 of $7.37 million and $5.69 million for strategic capex is required to be funded internally.

Debt & Equity

Equity Drawing

No additional deficit support is required for the 2016/17 financial year.

Core Debt

The net interest cost on the Core CHFA debt of $79 million is currently between 2.21% and 6.54%, and there are two loans due for renewal in the 2016/17 year.

Working Capital

The Board has a working capital facility with the Westpac bank, which is part of the national DHB collective banking arrangement negotiated by HBL. This facility is limited to one month's provider's revenue, to manage fluctuating cash flow needs for the DHB.

Gearing and Financial Covenants

No gearing or financial covenants are in place.

Asset Revaluation

Current policy is for land and buildings to be revalued every 3 – 5 years. A full revaluation was last completed in the year ended 30 June 2015 with desktop valuations planned for each yearend for the next 4 years.

Strategy for disposing of assets

The DHB regularly reviews its fixed asset register, and undertakes fixed asset audits in order to dispose of assets which are surplus to requirements. This ensures that the DHB reduces its level of capital to the minimum consistent with the supply of contracted outputs.

Disposal of Land

All land that has legally been declared to be surplus to requirements will be disposed of following the statutory disposal process defined in the Public Works Act 1991, the Health Sectors Act 1993, the New Zealand Public Health and Disabilities Act 2000, the Reserves Act 1977 and the Māori Protection Mechanism Regulations set up to fulfil the Crown's obligations under the Treaty of Waitangi. No land has been identified as surplus to requirements within this plan.

‘MODULE 5’ STEWARDSHIP

5.1 MANAGING OUR BUSINESS

Each DHB is governed by a board of up to 11 members. DHB boards set the overall strategic direction for the DHB and monitor its performance. The Minister of Health appoints up to four members to each board, and the board’s chair and deputy chair. Seven members are publicly elected every three years at the time of local government elections. The Minister can also appoint Crown monitors to boards.

Key to the efficient running of the DHB is that there is a clear division between the roles of the Board and management. The Board concentrates on setting policy, approving strategy and monitoring progress toward meeting objectives. Management is concerned with implementing policy and strategy. The Board delegates to the CEO, on such terms and conditions as are appropriate, the power to make decisions on operational and management matters within the framework of the Board’s agreed strategic direction as set out in the Annual Plan. It endorses the CEO, assigning defined levels of authority to other specified levels of management within the organisational structure.

The Board holds regular at least bi-monthly meetings to monitor progress toward its strategic objectives and to ensure that the affairs of the DHB and its subsidiaries are being conducted in accordance with the DHB’s policies. While many of the Board’s functions have been delegated, the overall responsibility for maintaining effective systems of internal control ultimately rests with the Board.

Over the past few years, the three sub-regional Boards of Capital & Coast, Hutt Valley and Wairarapa DHB’s have taken a ‘whole-of-health system’ approach, including integrating clinical and support services where this provides benefits across the system. Each Board continues to provide governance of local services and all three Boards provide collective governance over services that are shared or integrated, ensuring local accountability. Integrated service approaches are intended to deliver:

- Preventative health and empowered self-care
- Provision of relevant services close to home; and
- Quality hospital care, including highly complex care, for those who need it.

This requires a strong focus on relationships with primary and community care and working closely with staff and communities as we progress service design. The Boards believe this gives us the best opportunity to address the challenges of balancing quality, cost and access.

The Board acknowledges that it is ultimately responsible for the management of risks to the DHB. The Board has charged the Chief Executive through its risk management policy with establishing and

operating a risk management programme in accordance with the Joint Australian/New Zealand Standard guideline requirements on risk management. The Board acknowledges its responsibility to ensure the organisation complies with all relevant legislation.

Our DHB plans, purchases and monitors services sub-regionally through our Service Integration and Development Unit (SIDU)[5], with each of the three Boards maintaining oversight of its business in respect to services for their own communities. Sub-regionally we also share a joint Community and Public Health Advisory Committee (CPHAC) and Disability Services Advisory Committee (DSAC) to monitor the progress across DHB integration and population health and disability initiatives. Each sub-regional Board operates its own Finance, Risk and Audit Committee (FRAC) and Hospital Advisory Committee (HAC). In each DHB there is also a local Alliance Leadership Team (ALT) that supports primary/secondary integration work, for the Hutt Valley this is the Hutt Integrated Network of Care (Hutt INC).

A key mechanism for monitoring our performance is the 'non-financial monitoring framework' tool used by the Ministry of Health to provide assurance that DHBs deliver in terms of the legislative requirements, and in terms of Government priorities. A summary of the monitoring framework, including our targets (where appropriate) are included in Module 7 (Performance Measures) of this Annual Plan.

In the role of sub-regional funder of health services, SIDU holds over 700 contracts and service agreements with the organisations and individuals who provide the health services required to meet the needs of our population. The delivery and quality of outputs against these agreements are monitored through regular performance reports and data analysis, and reporting of adverse incidents, routine quality audits, service reviews and issues-based audits.

SIDU coordinates a Routine Audit Programme to monitor provider performance against agreements held by the DHB. Additional Special Audits can be requested if there are particular concerns or 'red flags' with a provider's performance. The Central Region Technical Advisory Service (Central TAS) completes these audits on the DHB behalf, and coordinates national and regional audits. Central TAS is also able to provide SIDU with a Provider Risk Assessment rating to ensure the DHB is alert to 'at risk' providers.

The National Health Board provides an Audit & Compliance (A&C) service by requesting and getting permission from the DHB to conduct claims audits, which are also coordinated through SIDU, who monitor progress of any issues identified. Two other bodies also provide comprehensive audit processes to SIDU - Medicines Control (Ministry) – who audits pharmacies against licence requirements, and HealthCERT (Ministry) – a provider monitoring website for Aged Residential Care (ARC) facilities. The DHB Provider Arm services are also actively involved in regular programmed internal audits, as well as the annual statutory audit to ensure the accuracy and integrity of the DHBs

[5] Towards the end of 2015/16 the sub-regional DHBs began consulting on proposals to strengthen the local executive management and support structures within each of the 3 DHBs. This included a proposal for a blended operating model for planning and funding (SIDU) functions, with some functions proposed to be returned to being locally-based while other functions to remain shared, based out of CCDHB, and provided to Wairarapa and Hutt Valley DHBs as part of service level agreements.

financial results. All these monitoring systems of internal control and the quality and reliability of financial and non-financial information are reported to FRAC and the Board.

For SIDU, the Government Rules of Sourcing (GROS) are an effective tool to support good practice procurement, including monitoring provider performance. Engagement and continued dialogue with providers are essential to the results that are achieved, and strengthen the DHBs accountability for how we spend taxpayer's money. Strong processes mean that providers are chosen who demonstrate they fully understand and have the capability to deliver on the service specifications, and meet all other contractual conditions.

On the basis of this Annual Plan, the DHB can enter into, or amend, service agreements or arrangements with the organisations or individuals who can provide the health and disability services required to meet the needs of our population and to achieve the objectives of the DHB.

5.2 BUILDING CAPABILITY

We want a thriving organisation. The key features of this are:

- Clear and consistent direction and decision-making
- Clear and consistent communication
- Strengthened clinical engagement
- Valuing and developing our people (including developing and supporting our clinical and non-clinical leaders)
- Strong improvement and innovation culture
- Strong focus on quality and safety (including clinical governance).

Key enablers to building our organisational capability are quality assurance and improvement, workforce development and information communications technology. More detail on each of these areas can be found in the Quality, Workforce and Information Technology sections of Module 2B.2.6.

Other key contributions to building capability relate to our Triple Aim Quality Framework, System Integration, Clinical Leadership, Health System Planning and Consumer Engagement developments. More detail on each of these can be found in Module 1.3.2.

5.3 WORKFORCE

The Vulnerable Children Act 2014 (VCA) contains workforce requirements relating to child protection policies and worker safety checks. We have a VCA working group chaired by a sub-regional Quality Team to ensure adherence to VCA requirements across the sub-region.

5.3.1 Managing our workforce within fiscal restraints

The sub-regional DHBs meet the Government's 'Expectations for Pay and Employment Conditions in the State Sector' both within the bargaining strategies and parameters agreed with DHB Shared Services, and within our own strategies. We will continue to collect appropriate workforce metrics and data on MECA interpretation, implementation for areas aligned with areas of focussed growth for the DHB and make such information available to DHB Shared Services on request to inform the

process of collective bargaining. We endeavour to progressively practice pro-active national and international recruitment strategy implementation to support in areas of higher recruitment and retention needs.

In order to deliver on shorter patient journeys as a goal the focus will remain on applying the workforce in areas of high impact to support a cost effective but high quality 24/7 hospital services. Innovative adjustments to pay structures for those not on collective agreements to promote internal relativity and equity will be investigated to facilitate and promote employee engagement and improved staff retention.

The3DHB Human Resources (HR) Plan 2014-2016 has been developed for the sub-region to ensure staff management policies and processes align with organisational goals. The HR Plan provides a platform from which to implement a range of initiatives to enhance staff management practices. At a strategic level, the HR Plan contains a number of objectives around enhancing leadership capability across our three DHBs and developing a framework to improve employee engagement, with the aim of contributing to the enhancement of patient outcomes. At a more operational level, the HR Plan contains initiatives to support managers in effectively leading their staff and delivering services to patients and to ensure consistent HR policies and procedures across the sub-region.

Identifying more efficient and effective ways to deliver services at a regional, sub-regional and local level, controlling the growth of hospital labour costs, maintaining and where possible improving hospital productivity, and achieving better integration of local primary and secondary services all require support, active involvement and leadership by clinicians. More detail can be found in the Clinical Leadership sub-sections of Module 1.3.2.

5.3.2 Strengthening our workforce

A skilled, supported and responsive workforce is essential for sustainable service delivery. The DHB needs the right mix of trained and qualified people in sufficient supply and working in partnership with each other. Trusting, valuing and fully engaging health professionals improves patient care and job satisfaction and will assist in recruitment and retention. Focusing on improving clinical workforce retention and fostering clinical leadership continues to be a key priority for the DHB.

To ensure a consistent approach to leadership and workforce planning we work collaboratively with the national DHB General Managers Human Resources group, DHB Shared Services (through the Regional Director – Workforce) and Health Workforce New Zealand in using national frames works (i.e. the National Leadership Domains and Workforce Intelligence and Planning) and to achieve agreed regionally-based workforce solutions. More detail can be found in the Workforce section of Module 2B.2.6.

5.4 ORGANISATIONAL HEALTH

The DHB focuses on the needs of each employee through individual performance planning and development. This ensures all staff have performance objectives that align to the DHB's strategy, goals and values.

The DHB takes its obligations to be a good employer very seriously. We apply appropriate processes to meet the seven key elements of 'the Good Employer' as prescribed by the Equal Employment Opportunities Commissioner. We also have plans to further build practice in these elements.

As a good employer the DHB values professionalism through leadership and unacceptable employee behaviour is not tolerated. In 2015/16 we updated our suite of Human Resource policies and guidelines related to discipline, performance, code of conduct, bullying, harassment, victimisation and discrimination prevention.

Most of our employees are covered by Collective Employment Agreements (CEA). All the CEAs have remuneration, recognition and conditions clauses. We also take a similar approach for those employees on individual employment agreements to ensure fairness and equity in remuneration, recognition and conditions across the organisation.

The Protected Disclosure Act 2000 and the Board's related policy, protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation or the mechanisms covered by the Employment Relations Act 2000. Employees also have 'no questions asked' access to the employee assistance programme.

The Health and Safety at Work Act 2015 places a positive duty on directors to exercise due diligence to ensure that organisation complies with its health and safety duties and obligations. As a good employer the DHB has policies and procedures in place to meet these obligations and health and safety is actively monitored by the Executive Team (monthly) and the Board (bimonthly).

‘MODULE 6’
SERVICE CONFIGURATION

6.1 SERVICE COVERAGE

The Service Coverage Schedule between the DHB and the Ministry of Health specifies the required minimum level and standard of service to be made available to eligible people. We seek to identify service coverage gaps through analysis of performance indicators, risk reporting, audits and complaint mechanisms. We will manage and resolve any service coverage issues identified.

We are not seeking any formal exemptions to the Service Coverage Schedule for 2016/17.

6.1.1 Service Issues

No other service issues for Hutt Valley DHB have been identified.

6.2 SERVICE CHANGE

Potential Services Changes for 2016/17

- **Needs Assessment and Service Coordination**: Carry out a review of the Hutt Valley and Capital & Coast DHB’s Health of Older People (HOP) Needs Assessment and Service Coordination (NASC) service. A new integrated NASC model for HOP NASC service will be developed and in place for the 17/18 year. The implementation may involve a contestable procurement process.
- **Home and Community Support Services**: a service review and procurement process for the Hutt Valley and Capital & Coast DHB Health of Older People Home and Community Support Services was carried out in 2015/16. As a result of this process a bulk funded, restorative service model was developed and approved by both DHB’s Boards. An RPF process has been completed and, following final Board approval, the service is planned to start in September 2016.
- **Sub-regional Child Health Project:** Work with our neighbouring DHBs to review and further develop Child Development and Child Protection services.
- **Gastroenterology Service Integration**: Options for developing a single Gastroenterology service across the sub-region have been identified, including the key components of service design required. The end goal of a single service may take a number of years to fully implement.
- **Review of sub-regional approach for inpatient rehabilitation services for the under 65 with rehabilitation needs**.
- **Sub-regional approach to Radiology**:
    - Implementation of the same Community Referred Radiology Access Criteria across the sub-region
    - Locally expanding access to community radiology in the Hutt Valley to include Decile 5.
- **Mental Health Model of Care**: Develop more flexible options for community care and support the development of partnerships between primary, community and specialist services:
    - **Review of Opioid Substitution Treatment Model of Care.**
    - **Mental Health Acute Alternatives to Hospitalisation**: Implement the new model, which may include a contestable procurement process.
    - **Review Mental Health Community-Based Options** for people with high and/or complex needs.

  - **Mental Health Employment Support Service**: Review and implementation of a sub-regionally consistent model.
  - **Primary Mental Health for Mild to Moderate Illness:** Review of the model of delivery to ensure the service is focused on highest needs groups and strengthen integration with other MHA services funded by the DHB, e.g. NGOs and the provider arm.
- **Central Region Alcohol and Other Drug (AOD) Residential Service**: Implementation of a consistent Adult AOD Model of Care across the region for more efficient and effective use of resources and supporting the provision of services under the proposed Substance Addiction (Compulsory Assessment and Treatment) Bill.
- **Central Region Child and Youth Alcohol and Other Drug Residential**: Service review in 2016/17.
- **Regional Public Health services**: Due to increasing costs and changes to revenue, Regional Public Health is considering changes to service delivery, while ensuring the DHBs are delivering on the services contracted for through the core public health funding and Crown Funding Agreement variations. This will include looking for efficiencies in service delivery from health promotion, preventive interventions and support services, across the three DHB (sub-regional) environment.
- **Respiratory services**: Review of current services across community and hospital services.
- **Emergency Department (ED)**: A recent ED service external review highlighted the need to look at ED processes and systems, staffing and models and care and culture within our ED. This includes reviewing workforce development, leadership and patient flow and a whole of system approach to achieving the Shorter Stay in ED target. A number of workstreams and recommendations will fall out of the review and this will be worked throughand implemented in 2016/17.
- **Older Persons Rehabilitation Service (OPRS)**: In 2015/16 OPRS has refined its models of care within the hospital setting, strengthening its leadership and role and patient flow. Whilst the rehab team have always had a community-based approach to delivering care, they recognise the need to increase their effort if they are to deliver a more patient-centric service and using intra-agency and inter-professional approach to their care.
- **Theatre Efficiency Project**: To ensure that our operating theatres are as productive and efficient as possible, an initiative is being developed to examine all aspects of theatre planning, resourcing, utilisation and flow and to subsequently make appropriate improvements.
- **Intensive Care Unit/High Dependency Unit/Coronary Care Unit:** Service Improvement project that may lead to a different configuration of these services to support more integrated acute care.
- **Travel policy changes:** Review current practices to align with the National Travel Assistance policy.
- **Primary Care**: Developing a Health care Home like model, integration of Community Health services, further rolling out Primary Options for Acute Care, and a Child Health Network Asthma Quality Improvement Programme to improve management of asthma in primary care.
- **Reprioritisation of Services to Improve Access (SIA) and related funding**: Te Awakairangi has signalled changes in subsidies: Youth Sexual Health Services (so this will no longer be a free visit in primary care from 2016/17, with free visits still being available through VIBE and Family Planning); Cardiovascular Disease risk assessment (to now target high needs groups who have not received a first assessment); Transport service (to now target trips to primary care and Hutt Hospital not out of the areas); Cervical screening (to now target high needs groups to lift coverage in those groups).
- **NGO and Community Providers**: Work with providers to provide more efficient services, review discretionary investment areas, and enable funding to be reprioritised.
- **Bowel Screening**: In conjunction with Wairarapa and Waitemata DHBs, prepare for commencement of Bowel Screening in the Hutt Valley in July 2017.

The DHB recognises its obligations under the Operational Policy Framework to notify the Minister of Health of any plans for significant service change.

‘MODULE 7’ PERFORMANCE MEASURES

7.1 MONITORING FRAMEWORK PERFORMANCE MEASURES

7.1.1 Dimensions of DHB Performance Measures (non-financial)

The DHB monitoring framework aims to provide a rounded view of performance using a range of performance measures. These are reported on a quarterly basis to the Ministry of Health. Different dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services, which cover:

- Achieving Government’s priority goals/objectives and targets or ‘Policy Priorities’ (code PP)
- Meeting service coverage requirements and supporting sector inter-connectedness or ‘System Integration’ (code SI)
- Providing quality services efficiently or ‘Ownership’ (code OS)
- Purchasing the right mix and level of services within acceptable financial performance or ‘Outputs’ (code OP)
- Establishment of baselines for new measures or ‘Developmental’ (code DV).

7.1.2 2016/17 Performance Measures

The following table specifies the range of DHB performance measures for 2016/17, including current baseline information for quantitative measures (where available) and targets for the 2016/17 year (where applicable). System Level Measures (SLMs) are indicated.

Performance Measure	Performance Expectation	Target Groups		2015 (*2014*)	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	HV Target	NZ Target	Reporting Freq	Key Module 2B Section Reference
PP6: Improving the health status of people with severe mental illness through improved access	% of the population accessing specialist mental health service	Age 0-19	Māori	4.95%				5.33%		4.25%		Six-monthly	Mental Health and Addictions
			Other	3.99%				4.00%					
			Total	4.25%				4.36%					
		Age 20-64	Māori	8.84%				8.56%		4.82%			
			Other	4.09%				4.17%					
			Total	4.82%				4.84%					
		Age 65+	Māori	2.54%				2.31%		2.03%			
			Other	1.99%				2.06%					
			Total	2.02%				2.07%					
PP7: Improving mental health services using transition (discharge) planning	% of clients discharged with a transition (discharge) plan)	Age 0-19	Total					n/a		≥95%	≥95%	Quarterly	Mental Health and Addictions
		Long term clients	Total					n/a					
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	% of people seen by Mental Health Provider Arm within 3 weeks		Age 0-19					43.7%		≥80%	≥80%	Quarterly	Mental Health and Addictions
	% of people seen by Mental Health Provider Arm within 8 weeks		Age 0-19					84.5%		≥95%	≥95%		
	% of people seen by Addictions Services (Provider Arm and NGO) within 3 weeks		Age 0-19					81.2%		≥80%	≥80%		
	% of people seen by Addictions Services (Provider Arm and NGO) within 8 weeks		Age 0-19					91.3%		≥95%	≥95%		
PP10: Oral health: Mean Decayed/Missing/Filled Teeth score at year 8	Mean DMFT for children examined in the Year 8 group	Age 12/13	Māori	*1.03*						2016: ≤0.72 2017: ≤0.70		Quarter 3	Dental/Oral Health
			Pacific	*0.98*									
			Other	*0.61*									
			Total	*0.74*									
PP11: Children caries-free at 5 years of age	% caries-free in the children examined at 5 years old	Age 5	Māori	*44%*						2016: ≥70% 2017: ≥70%		Quarter 3	Dental/Oral Health
			Pacific	*36%*									
			Other	*75%*									
			Total	*63%*									
PP12: Utilisation of DHB-funded dental services by adolescents from School	% access to DHB-funded adolescent dental services	Year 9 up to age 17 years	Māori	*n/a*						2016: ≥85% 2017:	≥85%	Quarter 4	Dental/Oral Health
			Pacific	*n/a*									

Performance Measure	Performance Expectation	Target Groups		2015 (*2014*)	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	HV Target	NZ Target	Reporting Freq	Key Module 2B Section Reference
Year 9 up to and including 17 years			Other	*n/a*						≥85%			
			Total	*72.6%*									
PP13: Improving the number of children enrolled in DHB funded dental services	% of pre-school children enrolled in DHB-funded dental services	Age 0-4	Māori	*44.2%*						2016: ≥95% 2017: ≥95%	≥95%	Quarter 3	Dental/Oral Health
			Pacific	*51.4%*									
			Other	*60.7%*									
			Total	*55.1%*									
	Percentage of enrolled pre-school and primary school children overdue for their scheduled examinations	Age 0-12	Māori	*11%*						2016: ≤10% 2017: ≤10%			
			Pacific	*11%*									
			Other	*12%*									
			Total	*12%*									
PP20: Improved management for long term conditions	Focus Area 1: Long Term Conditions: narrative report											Quarterly	Long Term Conditions
PP20: Diabetes Services	Focus Area 2: Diabetes Services: narrative report												Diabetes
	Focus Area 2a: % of people enrolled in a PHO with diabetes with managed HbA1c levels (≤ 64 mmol/mol)	Age 15-74	Māori					65%		≥70%			
			Pacific					64%					
			Indian					83%					
			Other					73%					
			Total					71%					
	Focus Area 2b: % with HbA1C levels ≤ 80 mmol/mol	Age 15-74	Total					n/a		≥90%			
	Focus Area 2c: % with HbA1C levels ≤ 100 mmol/mol	Age 15-74	Total					n/a		≥98%			
	Focus Area 2d: % with HbA1C levels > 100 mmol/mol	Age 15-74	Total					n/a		≤2%			
PP20: Cardiovascular Disease	Focus Area 3: Cardiovascular health narrative report												Cardiovascular Disease
	Focus Area 3a: % of the eligible population who have had their	Māori men age 35-44						n/a		≥90%	≥90%		
		Māori						85%					
		Pacific						87%					
		Other						91%					

Performance Measure	Performance Expectation	Target Groups		2015 (*2014*)	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	HV Target	NZ Target	Reporting Freq	Key Module 2B Section Reference
	cardiovascular risk assessed in the last five years	Total						89%					
PP20: Acute Heart Service	Focus Area 4: Acute Heart Services narrative report												Cardiac Services
	Focus Area 4a: % of high-risk patients receiving an angiogram within 3 days of admission		Māori				n/a			≥70%	≥70%		
			Pacific				n/a						
			Other				n/a						
			Total				80.4%						
	Focus Area 4b1: % of ACS patients undergoing coronary angiography having registry data completion within 30 days						100%			≥95%	≥95%		
	Focus Area 4b2: % of cardiac surgery patients having registry data completion within 30 days									≥95%	≥95%		
PP20: Stroke Service	Focus Area 5: Stroke Services: Narrative report												Stroke Services
	Focus Area 5a: % of potentially eligible stroke patients thrombolysed							9%		≥6%	≥6%		
	Focus Area 5b: % of stroke patients admitted to a stroke unit/service							80%		≥80%	≥80%		
	Focus Area 5c: % of patients admitted with acute stroke transferred to inpatient rehabilitation services							n/a					
	Focus Area 5d: % of patients admitted with acute stroke transferred to inpatient rehabilitation services within 7 days							n/a		≥80%	≥80%		
PP21: Immunisation coverage	Focus Area 1a: % of children fully immunised at age 24 months	At 2 years	Māori					91.6%		≥95%	≥95%	Quarterly	Immunisation
			Pacific					90.2%					
			Total					92.2%					
	Focus Area 1b: % of children fully immunised at age 5	At 5 years	Māori					88.8%		≥95%	≥95%		
			Pacific					95.4%					
			Total					91.7%					
	Focus Area 2: % of eligible girls fully immunised against HPV	Eligible girls	Māori					78.8%		≥70%	≥70%	Quarter 3	
			Pacific					89.2%					
			Total					71.6%					
PP22: Improving system integration (SLM)	Report on delivery of actions and milestones to improve system integration and introduction of System Level Measures. Jointly agreed Alliance/DHB Improvement Plan to be provided at the end of Q1 to support achievement of this.											Quarterly	System Integration / Configuration

Performance Measure	Performance Expectation	Target Groups	2015 (*2014*)	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	HV Target	NZ Target	Reporting Freq	Key Module 2B Section Reference
PP23: Improving Wrap Around Services – Health of Older people	Report on delivery of actions and milestones to improve Wrap Around Services for Older People										Quarterly	Health of Older People
PP23: System integration for older people	DHBs to provide evidence that integrated systems and processes are in place to support information flow and improve outcomes											Health of Older People
PP23: Home and Community support services for older people	Pending outcomes resultant of the In-Between Travel Director General's Reference Group report											Health of Older People
PP23: InterRAI: Comprehensive Clinical Assessment in residential care and in home and community support settings	InterRAI(a): % of older people who received long term support services for home and community supports in the last 3 months who have had a Comprehensive Clinical Assessment and completed care plan						99.9%		100%			Health of Older People
	InterRAI(b): % of people in aged residential care who have a subsequent interRAI Long Term Care Facility (LTCF) assessment completed within 230 days of the previous assessment, by facility						62%		≥75%			
	InterRAI(c): % of LTCF clients admitted to an aged residential care facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first LTCF assessment						n/a		≥95%			
	InterRAI(d): Report on time taken from any referral from any source to complete (not triage) an interRAI assessment (ie, Contact, MDS-HC, LTFC assessment).											
	InterRAI(e): Report on InterRAI measures to progress and compare performance with other DHBs.											
PP23: Dementia Care Pathways	Report on improvements to support and services available following a dementia diagnosis											Health of Older People
PP23: Cross Agency: Minimisation of Harm from Falls and Fracture	Report on how older people are being assessed for their risk of falls											Health of Older People
	# of older people referred into fracture liaison services	Primary Referral					n/a					
		Secondary Referral					n/a					
	# of older people after fracture service assessment referred to a strength and balance retaining service who are seen	Primary Referral					n/a					
		Secondary Referral					n/a					

Performance Measure	Performance Expectation	Target Groups	2015 (*2014*)	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	HV Target	NZ Target	Reporting Freq	Key Module 2B Section Reference
	# of older people after fracture service assessment referred to osteoporosis management programmes	Primary Referral					n/a					
		Secondary Referral					n/a					
PP25: Prime Minister's youth mental health project	Reports on progress and delivery of the Prime Minister's youth mental health initiatives 1, 3 & 5:										Quarterly	Youth Health
	Initiative 1: School Based Health Services											
	Initiative 3: Youth Primary Mental Health											
	Initiative 5: Improving the responsiveness of primary care to youth											
PP26: Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Focus Area 1: Primary Mental Health: Template and narrative report on services delivered										Quarterly	Mental Health and Addictions
	Focus Area 2: District Suicide Prevention and Postvention: Report on highlights, exceptions, who and # trained											
	Focus Area 3: Improving Crisis response services: Report on actions undertaken to reduce the rate of known clients being referred to by police to crisis teams, and outcomes											
	Focus Area 4: Improve outcomes for children: Exceptions report where actions identified in the Annual Plan for improving outcomes for children are not on track											
	Focus Area 5: Improving employment and physical health needs of people with low prevalence conditions: Exceptions report where actions identified in the Annual Plan are not on track											
PP27: Supporting Vulnerable Children	Checklist report and progress update against actions and milestones agreed in the Annual Plan										Quarterly	Supporting Vulnerable Children
PP28: Reducing Rheumatic Fever	Focus Area 1a: Reducing the Incidence of First Episode Rheumatic Fever: Initial hospitalisation rate per 100,000 total population	Māori	*n/a*						≤1.6	≤1.4	Quarterly	Rheumatic Fever
		Pacific	*n/a*									
		Total	*2.8*									
	Focus Area 1b: Reducing the Incidence of First Episode Rheumatic Fever: Progress report on the rheumatic fever prevention plan											
	Focus Area 1b: Reducing the Incidence of First Episode Rheumatic Fever: Template report on the lessons learned and actions taken following reviews each quarter											
	Focus Area 2: Facilitating the Effective Follow-up of Identified Rheumatic Fever Cases: Provide confirmation and exception reports on progress in following up known risk factors and system failure points in cases of first episode and recurrent acute rheumatic fever											
PP29: Improving waiting times for diagnostic services	Elective Coronary Angiography: % of accepted referrals receiving angiography within 90 days						n/a		≥95%	≥95%	Monthly	Diagnostics
	Computed Tomography : % of accepted referrals receiving scan within 42 days						86%		≥95%	≥95%		
	Magnetic Resonance Imaging: % of accepted referrals receiving scan within 42 days						82%		≥85%	≥85%		

Performance Measure	Performance Expectation	Target Groups		2015 (*2014*)	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	HV Target	NZ Target	Reporting Freq	Key Module 2B Section Reference
	Urgent Diagnostic Colonoscopy: % of accepted referrals receiving procedure within 14 days							86%		≥85%	≥85%		
	Urgent Diagnostic Colonoscopy: % of accepted referrals receiving procedure within 30 days							n/a		100%	100%		
	Non-Urgent Diagnostic Colonoscopy: % of accepted referrals receiving procedure within 42 days							55%		≥70%	≥70%		
	Non-Urgent Diagnostic Colonoscopy: % of accepted referrals receiving procedure within 90 days							n/a		100%	100%		
	Surveillance Colonoscopy: % of people receiving procedure within 84 days							67%		≥70%	≥70%		
	Surveillance Colonoscopy: % of people receiving procedure within 120 days							n/a		100%	100%		
PP30: Faster Cancer Treatment	Part A: 31 Day Indicator: % of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat							75.5%		≥85%	≥85%	Quarterly	Cancer Services
	Part B: Radiotherapy: % of patients ready for treatment waiting less than four weeks from date of decision-to-treat							95%		100%	100%		
	Part B: Chemotherapy: % of patients ready for treatment waiting less than four weeks from date of decision-to-treat							93%		100%	100%		
PP31: Better help for smokers to quit in public hospitals	% of adults admitted to hospital as inpatients who identify as a current smoker receiving brief advice and support to quit smoking							95.1%		≥95%	≥95%	Quarterly	Tobacco
SI1: Ambulatory Sensitive Hospitalisations (ASH, a SLM) Note: 0-4 target tbc as part of jointly agreed (by district alliances) System Level Measure Improvement Plan in Q1 PP22 reporting	Non-standardised ASH rate per 100,000 population. Note: methodology changed for latest quarter, calculated and standardised differently.	Age 0-4	Other						7174	tbc	<6789	Six Monthly	Service Integration / Configuration
			Māori					10480	10176				
			Pacific					15707	15238				
			Total					9269	8908				
		Age 45-64	Other						3445	<4061	<3717		
			Māori					8210	6603				
			Pacific					9422	7181				
			Total					4388	4061				
SI2: Delivery of Regional Service Plans (RSP)	Part 1: Progress report on implementation of RSP priorities											Quarterly	Actions to Support Delivery of Regional Priorities

Performance Measure	Performance Expectation	Target Groups	2015 (*2014*)	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	HV Target	NZ Target	Reporting Freq	Key Module 2B Section Reference
SI2: Implementation of integrated hepatitis C assessment and treatment services	Part 2a: Number of people diagnosed with hepatitis C, by age										Quarter 2 & Quarter 4	Hepatitis C
	Part 2b: Number of HCV patients who have had a Fibroscan in the last year		New patients, by age and ethnicity									
			Follow-up patients, by age and ethnicity									
	Part 2c: Number of people receiving PHARMAC funded antiviral treatment per annum, by age and ethnicity											
SI3: Ensuring Delivery of Service Coverage	Report on progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage identified										Six Monthly	Living Within Our Means
SI4: Standardised Intervention Rates (SIRs)	Major Joint Replacement procedures SIR per 10,000				20.35				21.0	21.0	Quarter 1	Elective Services
	Cataract procedures SIR per 10,000				43.62				27.0	27.0		
	Cardiac Surgery SIR per 10,000						5.25		6.5	6.5	Quarterly	
	Percutaneous Revascularisation SIR per 10,000						11.41		12.5	12.5		
	Coronary Angiography SIR per 10,000						26.74		34.7	34.7		
SI5: Delivery of Whānau Ora	Mental Health area: Report on progress of Whānau Ora in the district										Annual	Whānau Ora
	Asthma area: Report on progress of Whānau Ora in the district											
	Oral Health area: Report on progress of Whānau Ora in the district											
	Obesity area: Report on progress of Whānau Ora in the district											
	Tobacco area: Report on progress of Whānau Ora in the district											
	Commissioning Agencies: Report on engagement and collaboration with Whānau Ora Commissioning Agencies											
SI7: Total Acute Hospital Bed Days per capita (SLM)	Total acute hospital bed days per capita is being introduced as a System Level Measure in 2016/17										tbc	System Integration / Configuration
SI8: Patient Experience of Care (SLM)	Focus Area 1: National inpatient survey - Patient experience survey data supplied according to HQSC requirements										Quarterly	System Integration / Configuration and Quality
	Report on delivery of actions and milestones to improve patient experiences											
	Focus Area 2: Primary care survey is being introduced as a System Level Measure in 2016/17											
SI9: Amenable Mortality Rate (SLM)	Amenable mortality is being introduced as a System Level Measure in 2016/17										tbc	System Integration / Configuration
OS3: Inpatient Average Length of Stay (ALOS), standardised	Part 1: Elective Surgical Inpatient standardised ALOS (ratio of actual to predicted, multiplied by the nationwide inpatient ALOS)					1.68		1.66	≤1.55 days	≤1.55 days	Quarterly	Elective Services
	Part 2: Acute Inpatient standardised ALOS (ratio of actual to predicted, multiplied by the nationwide inpatient ALOS)					2.47		2.51	≤2.35 days	≤2.35 days		Acute Demand
OS8: Reducing Acute Readmissions to Hospital	Acute readmission rates to hospital within 28 days (model tbc)	Total									Quarterly	Acute Demand
		Age 75+										
OS10: Improving the quality of identity data	% of new NHI registrations in error (causing duplication)						1.57%		≤3%	≤3%	Quarterly	Information Technology

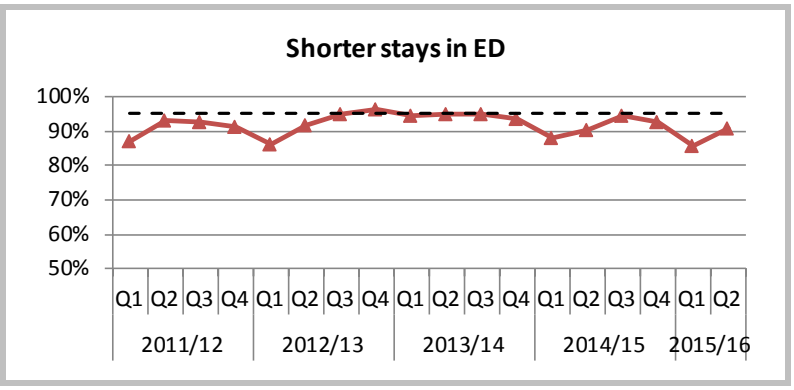
Performance Measure	Performance Expectation	Target Groups	2015 (*2014*)	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	HV Target	NZ Target	Reporting Freq	Key Module 2B Section Reference
within the National Health Index (NHI) and data submitted to National Collections	% of non-specific ethnicity in new NHI registrations						0.81%		≤2%	≤2%		
	% of updates to ethnicity in existing NHI records with a non-specific value						2.59%		≤2%	≤2%		
	% of validated addresses						n/a		>76%	>76%		
	% of NBRS records that link to NNPAC and NMDS						97.84		≥97%	≥97%		
	% of National Collection records (PRIMHD, NMDS, NNPAC, NBRS) successfully loaded					NBRS NMDS NNPAC PRIMHD	97.94% 98.34% 71.39% 98.62%		≥98%	≥98%		
	% of diagnosis code descriptors submitted to the NMDS edited from standard descriptions						74.8%		≥75%	≥75%		
	% of NNPAC events loaded more than 20 days post month of discharge						93.49 %		≥95%	≥95%		
Output 1: Mental Health Output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: A) five percent variance (+/-) of planned volumes for services measured by FTE, B) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and C) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.						A 3% B 1% C 24%		+/- 5% of plan	+/- 5% of plan	Quarterly	Living Within Our Means
DV6: Youth access to and utilisation of youth appropriate health services (SLM developmental measure, detail not yet available)												System Integration / Configuration
DV7: Number of babies who live in a smoke-free household at six weeks post-natal (SLM developmental measure, detail not yet available)												

APPENDICES

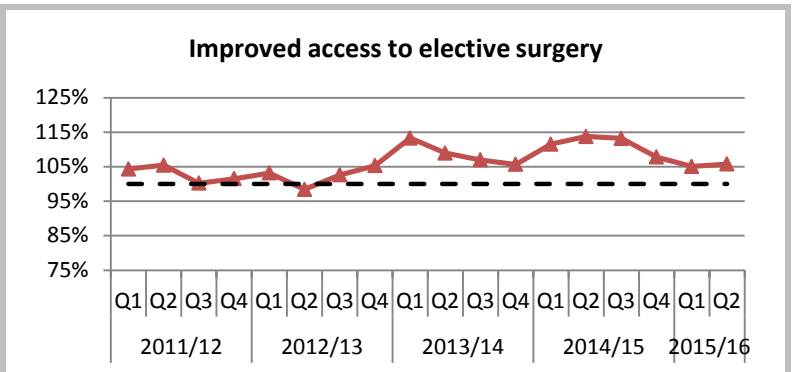
APPENDIX 1 PROGRESS ON DHB OUTCOME MEASURES

The Minister's Health targets are a set of national performance measures specifically designed to improve the performance of health services that reflect significant public and government priorities and to provide a focus for action.

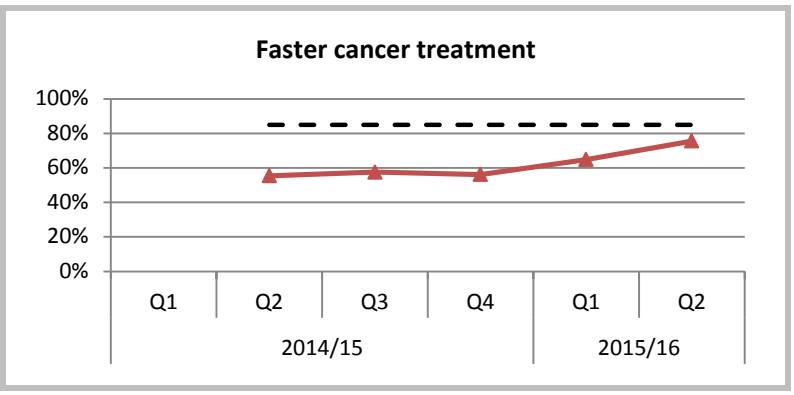
Minister's Health Target: Shorter stays in emergency departments

95 percent of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours.	

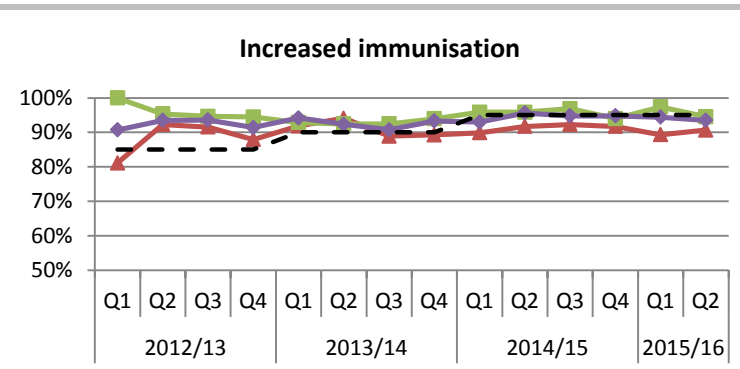
Minister's Health Target: Improved access to elective surgery

More New Zealanders have access to elective surgical services with at least 4,000 additional discharges nationally every year.	

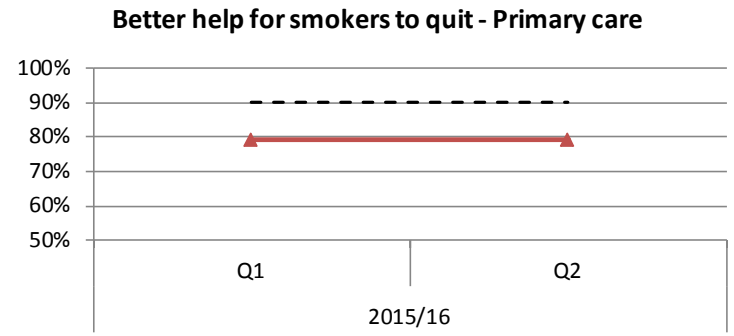
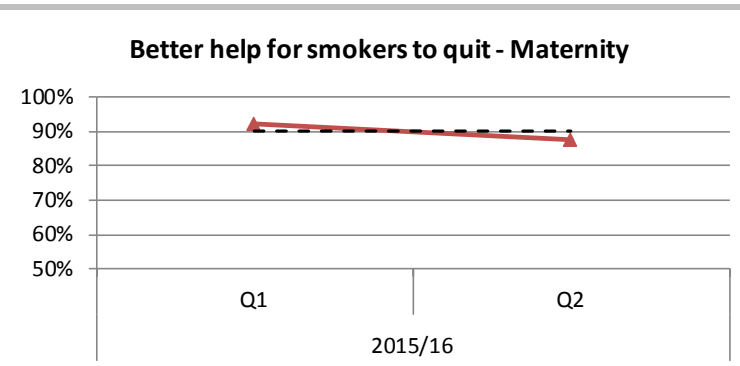
Minister's Health Target: Faster cancer treatment

85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	

Minister's Health Target: Increased immunisation

95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time. Māori Pacific Total Target	

Minister's Health Target: Better help for smokers to quit

Primary care 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. Note: The Ministry of Health revised methodology for this measure from 2015/16 Q1.	
Maternity 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking. Note: New measure from 2015/16 Q1.	

Minister's Health Target: Childhood Obesity

By December 2017, 95% of obese children (BMI > 98th percentile) identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	New measure for 2016/17

3DHB Outcome 1: Reduced ethnic health disparities

There are recognised health disparities for several population groups due to accessibility, social determinants of health, cultural responsiveness, and current models of care. Patients can find it hard to access services or to know how to manage their health if services are not culturally competent. We acknowledge our responsibility to design and deliver services that are accessible and responsive to our population's needs.

Impact Measures:

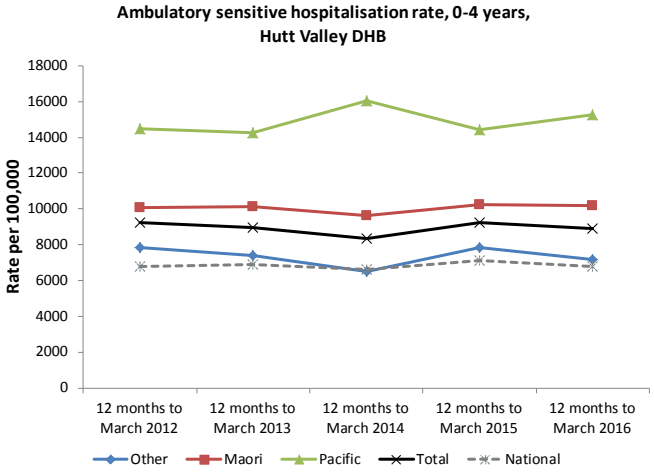
- A reduction in Ambulatory Sensitive Hospital (ASH) ethnic disparity rates
- A reduction in amenable mortality ethnic disparity rates.

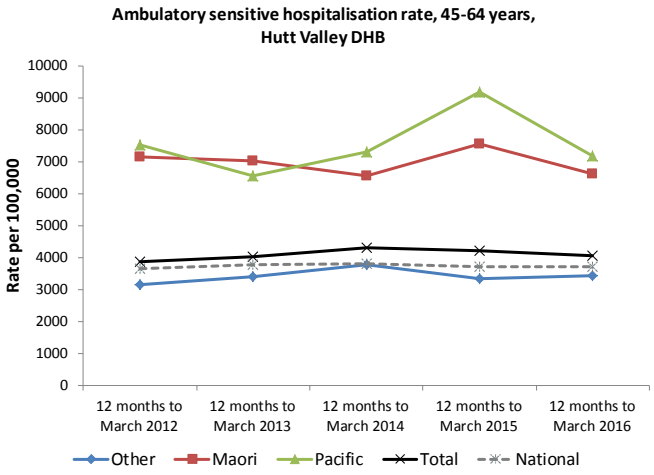
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. These conditions include skin infections, dental conditions, asthma, pneumonia, cardiovascular disease, and diabetes.

ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

Note: This measure was revised by the Ministry of Health in 2015/16 and ASH rates for 0-74 years, as previously published, are no longer available. ASH rates are now reported for the 0-4 and 45-64 years age groups only.



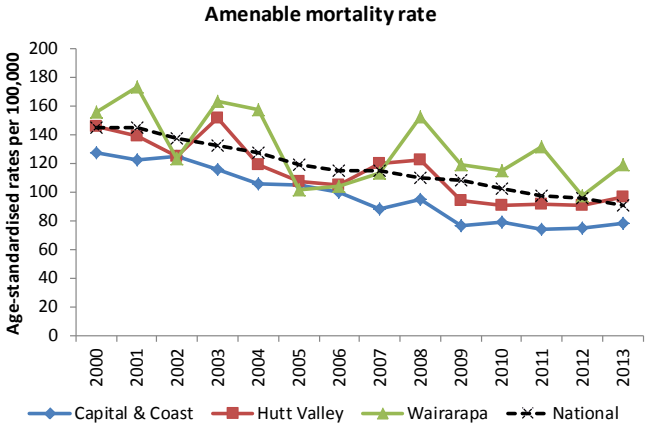


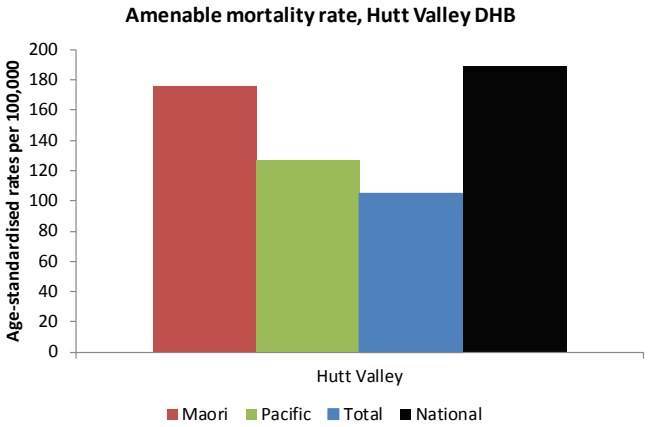
Source: Ministry of Health

Impact measure: A reduction in amenable mortality rates

'Amenable mortality' is defined as premature deaths from conditions that were potentially avoidable through health care.

Differences in amenable mortality rates for different population groups reflect variation in the coverage and quality of health care received by them.





Source: Health Needs Assessment

3DHB Outcome 2: Environment and disease hazards are minimised

Through effective public health disease surveillance, investigation and control, the impacts of communicable, waterborne and foodborne diseases can be minimised. Public health actions are aimed at reducing the levels of harm from alcohol and drug use in the greater Wellington region. To achieve this Regional Public Health works with Police, councils, and community agencies to understand and address the issues driving the harmful consumption of alcohol and drug use.

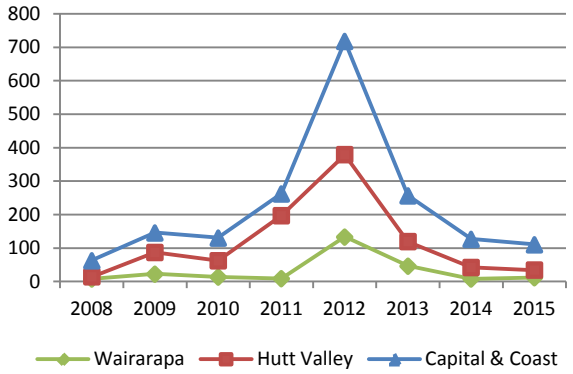
Impact Measures:

- A decrease in vaccine-preventable disease notification
- An increase in the percentage of premises visited that are compliant with the Supply of Liquor Act 2012, for sales to minors (in the sub-region)

Impact measure: A decrease in vaccine-preventable disease notifications[6]

In addition to protecting an individual from disease, immunisation can also provide population-wide protection by reducing the incidence of infectious diseases and preventing the spread of these diseases to vulnerable people. The peak in 2012 was due to Pertussis (whooping cough) outbreaks in the region, which caused an increase in vaccine preventable disease notifications. The number of notifications returned to previous levels in 2014. In the longer term, with increased immunisation, we expect that the number of vaccine-preventable disease notifications will decrease.

Number of vaccine-preventable disease notifications in the sub-region



Source: Institute of Environmental Science and Research

[6] Includes the following notifiable diseases: Haemophilus influenzae type B, Hepatitis B, Invasive pneumoccocal disease, Measles, Mumps, Pertussis, and Rubella.

Impact measure: An increase in the percentage of premises visited that are compliant with Supply of Liquor Act 2012, for sales to minors (in the sub-region)

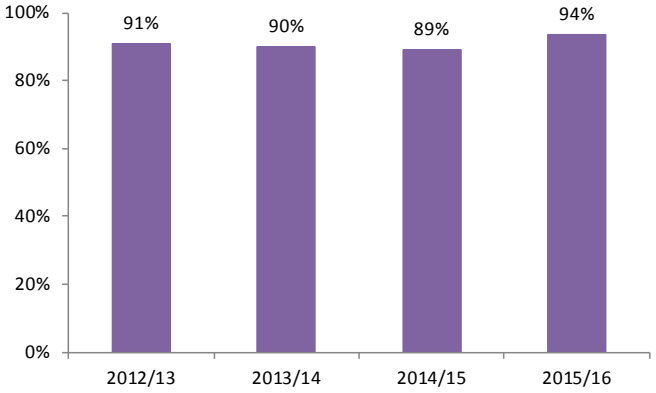
Alcohol is a significant contributor to disease and injury for New Zealanders. Alcohol is causally related to more than 60 health conditions and is a significant contributor to injury, road trauma, alcohol poisoning and crime.

In 2007 alcohol consumption was attributed to 5.4% of all deaths for those under 80 years old. In 2004 alcohol accounted for 28,403 years of life lost (disability-adjusted life years – DALYs) representing 6.5% of all DALYs for those under 80 years[7]. Young people, Māori, Pacific peoples and those living in areas of higher socioeconomic deprivation are at greater risk of experiencing harms from alcohol.

Harm reduction strategies include changing both physical and social environments. Effective interventions include regulating the availability of alcohol through minimum legal age of purchase, hours and days of sale restrictions and restriction on the density of outlets.

Controlled purchase operations (CPOs) have been an effective compliance tool over the last ten years, with the national incidence of premises selling to minors declining during this time. Regional Public Health works with Police, volunteers aged 15-17 and the District Licensing Committee to carry out CPOs.

Proportion of visited premises in th e sub-region that were compliant with the Supply of Liquor Act 2012 for sales to minors



Source: Regional Public Health

3DHB Outcome 3: Lifestyle factors that affect health are well-managed

Lifestyle factors have a significant impact on overall health and well-being and are key contributors to cancer, obesity, cardiovascular disease and diabetes, which are major causes of death and poor health in our population. The Ministry of Health has estimated the burden of disease across New

[7] Ministry of Health (2013). *Health loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016.* Wellington: Ministry of Health.

Zealand using 'disability-adjusted life years' (DALYs) that include both burden from early death and from lives led with disability. There are four key lifestyle factors that drive health loss: smoking (9.1% of health loss), obesity (7.9%), physical inactivity (4.2%) and poor diet (3.3%). Reducing the incidence of these negative lifestyle factors will improve the health of our population.

Impact Measures:

- A decrease in the obesity prevalence in adults (15+) and children (0-14)
- A decrease in the proportion of the PHO-enrolled population that is recorded as a 'current smoker'
- An increase in the proportion of mothers who are smoke-free two weeks post-natal.

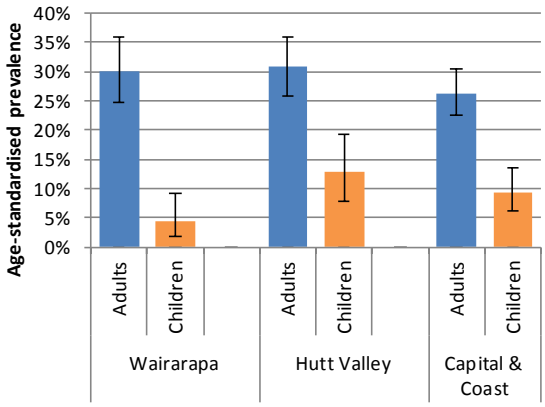
Impact measures: A decrease in the obesity prevalence in adults and children (adults 15+ years and children 0-14 years)

Obesity is one of the most important modifiable risk factors for a number of major diseases, including type 2 diabetes, ischaemic heart disease, ischaemic stroke, and several common cancers. In the last two decades, the prevalence of overweight and obesity in developed countries has increased so quickly that is has been described as an epidemic[8].

The most recent NZ Health Survey shows that there is no significant difference in obesity rates between the three DHBs. Adults have a much higher obesity rate than children in all three.

By providing education and support for people to live healthily, we expect that the prevalence of obesity will decrease.

Obesity prevalence in adults and children, NZHS 2011-13



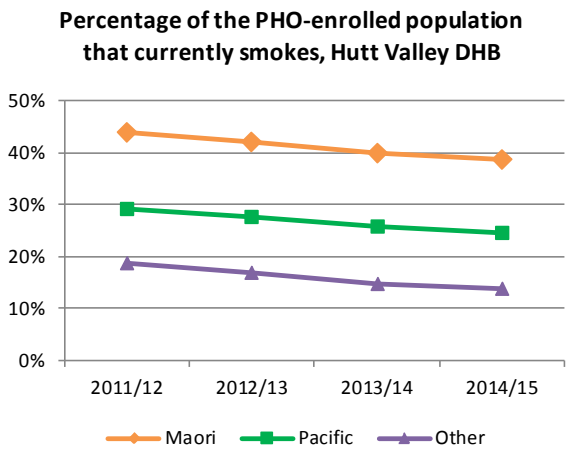
Source: New Zealand Health Survey, 2011-13.
Error bars represent 95% confidence interval.

[8] Ministry of Health. 2004. *Tracking the Obesity Epidemic: New Zealand 1977–2003.* Wellington: Ministry of Health.

Impact measure: A decrease in the proportion of the PHO-enrolled population that is recorded as a 'current smoker'

Cigarette smoking has serious consequences for health. It is estimated that smoking kills 5,000 New Zealanders a year. Ministry of Health has set a goal that New Zealand will be smokefree by 2025. Our DHB is working towards this goal by providing smoking advice and cessation support to patients when they visit their general practice or visit the hospital. Despite a drop in the smoking rate across all ethnicities in the last two years, Māori and Pacific continue to have higher smoking rates than other ethnicities.

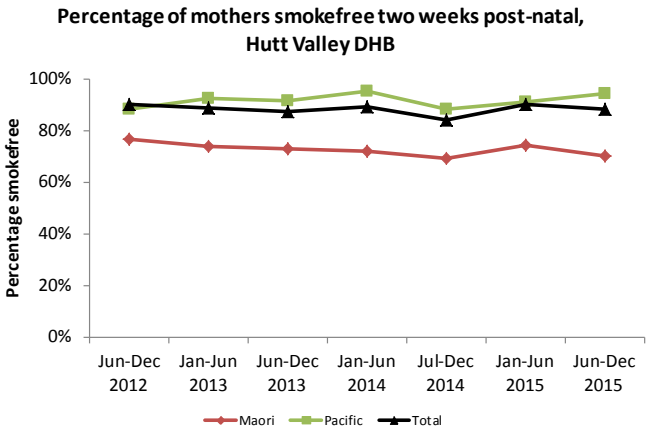
By continuing to provide smoking cessation advice and support, we expect that the percentage of people who smoke will decrease.



Impact measure: An increase in the proportion of mothers who are smokefree two weeks post-natal

Maternal smoking, both during and after pregnancy, can negatively impact a child's health. Infants are more at risk of sudden infant death syndrome, respiratory conditions, and tooth decay if they are exposed to cigarette smoke.

Mothers are given smoking cessation advice in hospital, and lead maternity carers provide information about the risks associated with smoking and referrals to smoking cessation providers. By continuing to provide cessation advice and support, we expect that the percentage of mothers who are smokefree two weeks post-natal will increase.



Source: WCTO Quality Indicators, Ministry of Health via Trendly

3DHB Outcome 4: Children have a healthy start in life

A child's circumstances and health can have a lasting effect on their life. People who have poor health in childhood are more likely to have poor self-rated health and develop chronic conditions in adulthood. For this reason, it is important that the DHB provides children and their whānau with high-quality, equitable, and accessible services.

Impact Measures:

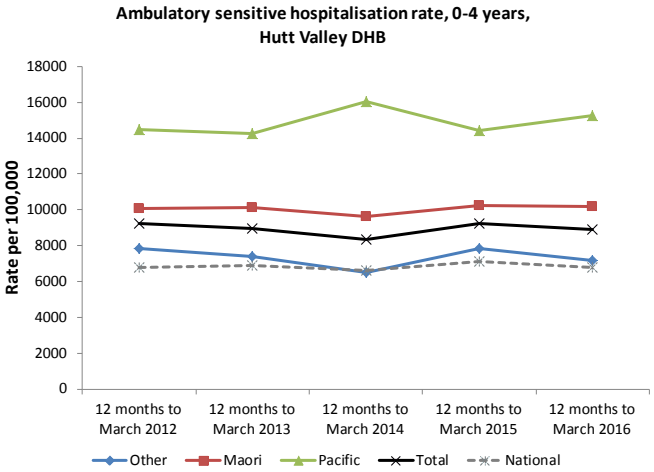
- Ambulatory Sensitive Hospitalisation rate, 0-4 years
- An increase the proportion of children caries-free at 5 years
- A decrease in the burden of tooth decay at Year 8.

Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year olds

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. For children, these conditions include skin infections, dental conditions, asthma, respiratory infections, and gastroenteritis.

ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

Note that Ministry of Health revised the methodology for this measure in 2015/16.



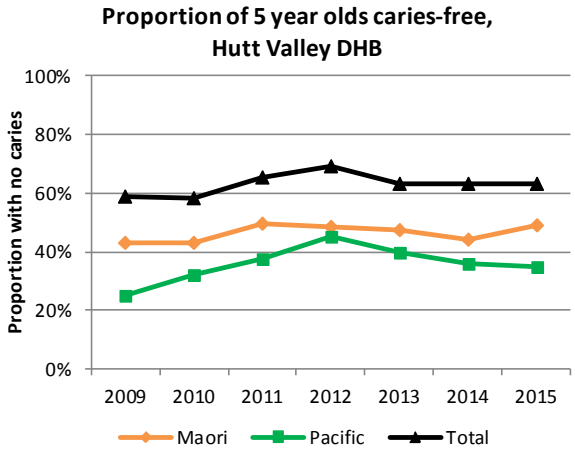
Source: Ministry of Health

Impact measure: An increase in the proportion of children caries-free at 5 years

Regular dental care has lifelong benefits for health. Improved oral health is also an indicator of the equity of access to services and the effectiveness of mainstream services at targeting those most in need. Māori and Pacific children have worse oral health outcomes than other ethnicities.

The DHB is undertaking a number of activities to improve oral health outcomes for children. A new sub-regional enrolment system has recently been established, and its aim is to enrol every infant with community oral health services. In addition, Before School Checks include a 'Lift the Lip' oral health examination, through which children with poor oral health are referred to community oral health services.

By ensuring that every child has access to and is receiving oral health services, we expect that the proportion of five year olds with no caries will increase.

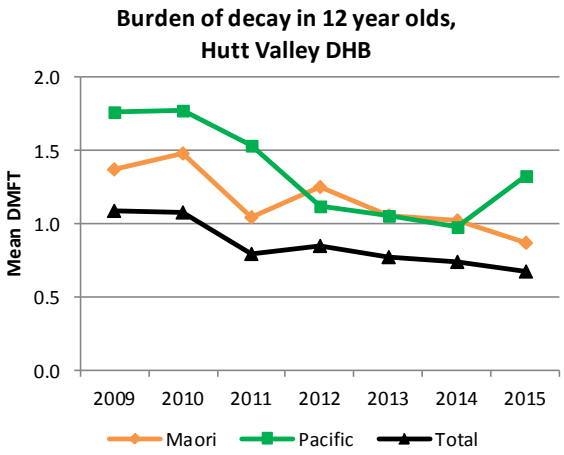


Source: Bee Healthy Dental Service

Impact measure: A decrease in the burden of tooth decay at Year 8

The burden of tooth decay is measured by the mean number of decayed, missing or filled teeth (DMFT) in twelve year old children. Māori and Pacific children have a higher burden of decay than other ethnicities.

By ensuring that every child has access to and is receiving oral health services, we expect that the burden of decay in twelve year olds will decrease.



Source: Bee Healthy Dental Service

3DHB Outcome 5: Long-term conditions are well-managed

The New Zealand Burden of Disease Study suggest that over the next decade people will be living longer with more long-term conditions and consequent disability. In response, our health and

disability system needs to increasingly focus on the prevention and on-going management of long-term conditions, and enhance wellbeing in the presence of illness.

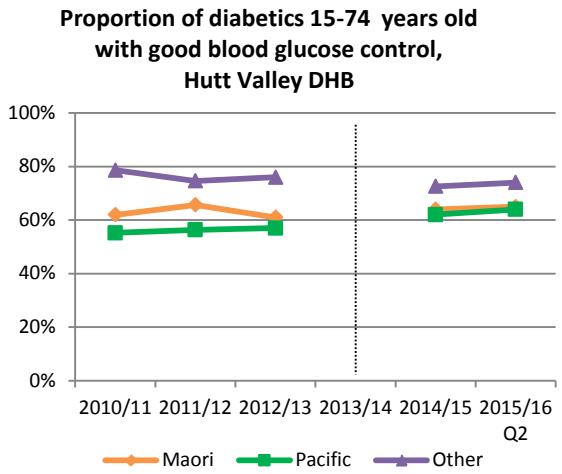
Impact Measures:

- An increase in the proportion of people with diabetes with satisfactory blood glucose control (HbA1c less than 64 mmol/mol)
- A decrease in the hospitalisation rate for cardiovascular disease
- A decrease in the hospitalisation rate for chronic pulmonary disease
- An increase in the proportion of dispensed asthma medications that were preventers rather than relievers.

Impact measure: An increase in the proportion of diabetics with satisfactory blood glucose control (HbA1c less than 64 mmol/mol)

Diabetes is a long-term condition that is caused by the body not being able to control its blood sugar levels properly. Diabetes is associated with kidney failure, eyesight problems, foot ulcers, and cardiovascular disease. However, with good diet and exercise, diabetes can be controlled and the risks associated with diabetes minimised. A lower level of HbA1c in the blood indicates that a person's diabetes is being well-managed.

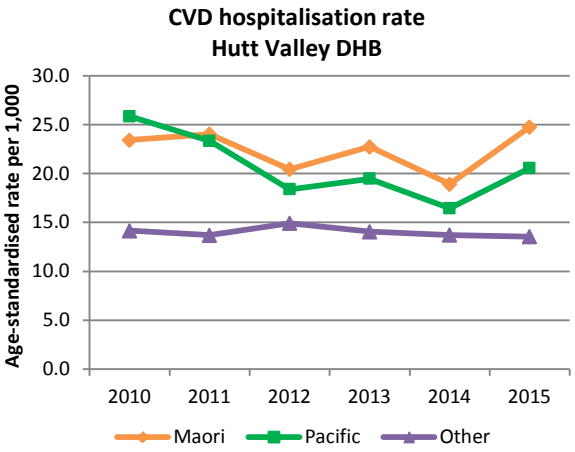
General Practices in our sub-region are required to have a 'Practice Population Plan' that outlines the services and support that they will provide to diabetics. By improving the quality of care and empowering people with diabetes to look after their health, we expect to see an increase in the proportion of diabetics with good blood glucose control.



Impact measure: A decrease in the hospitalisation rate for cardiovascular disease

Cardiovascular diseases (CVD) are diseases that affect the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease. Cardiovascular disease is the leading cause of death in the sub-region. Overall, around 70% of the burden of cardiovascular disease is attributed to modifiable risk factors. CVD is preventable through adopting a healthy lifestyle, and can be managed with lifestyle change, early intervention and effective management.

By identifying those at risk of CVD early, we can help them to change their lifestyle to improve their health, and reduce the chance that they develop a serious health condition. We expect that this intervention will lead to a decrease in the rate of CVD-related hospitalisations for our population.

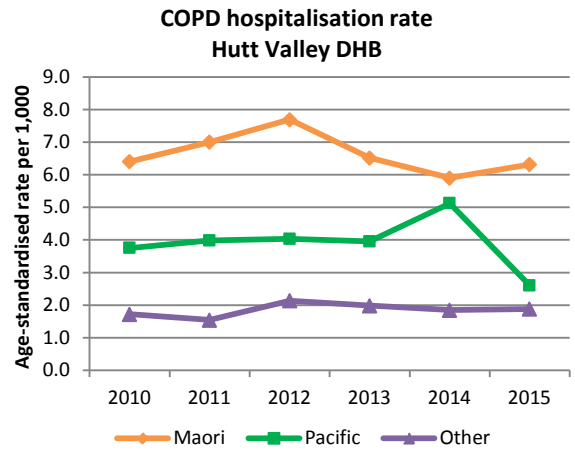


Source: National Minimum Dataset, ICD codes I00-I99, 15+ year olds

Impact measure: A decrease in the hospitalisation rate for chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is the result of damage to the lungs. COPD is most commonly associated with smoking, and although lung damage is permanent, quitting smoking can help to improve COPD symptoms and prevent further damage.

By providing cessation support for people who smoke, improving access to primary care, and helping people to take their medication regularly, we expect that the rate of COPD hospitalisations for our population will decrease.

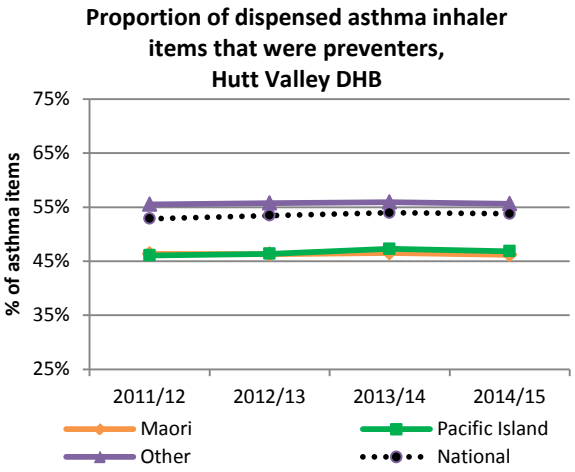


Source: National Minimum Dataset, ICD codes J40-J44, 15+ year olds

Impact measure: An increase in the proportion of dispensed asthma medications that were preventers rather than relievers[9]

Asthma occurs when a person's airways tighten and produce more mucous, making it difficult to breathe. It is often caused by pollen, cold air, or respiratory infections. People with on-going asthma generally use a preventer, which reduces the chance that their asthma will be triggered. They can also use a reliever, which they take to reduce their symptoms if they have trouble breathing.

If a person's asthma is well-managed, they should be using their preventer more frequently than their reliever.
A higher percentage of preventers dispensed indicates that asthma is being well-managed. By improving access to primary care, and supporting people to take their long term medications, we expect that people will use more preventers and less relievers.



Source: Pharmacy Data Warehouse.

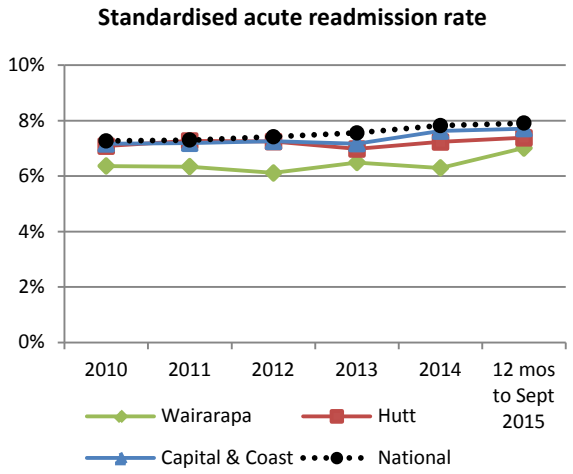
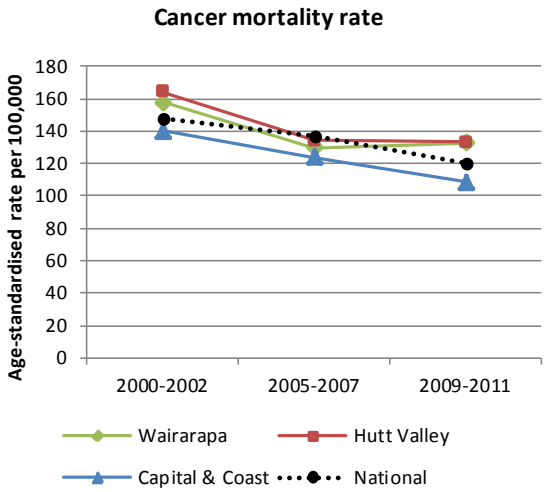
3DHB Outcome 6: People receive high quality hospital and specialist health services when they need them

Equitable and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention, or through corrective action (i.e. major joint replacements to relieve pain and improve activity). Improving our service delivery, systems, and processes will improve patient safety, reduce the number of hospital events causing harm, and improve outcomes for people using our services.

Impact Measures:

- A reduction in the standardised rate of acute readmissions to hospital within 28 days
- Maintain or reduce the age-standardised cancer mortality rate.

[9] Note that this measure has changed from the HQSC measure in the 2015/16 Annual Plan – the 2016/17 measure counts the number of asthma items dispensed, rather than the number of individuals who were dispensed at least one asthma item in the financial year.

Impact measure: A reduction in the standardised[10] rate of acute readmissions to hospital within 28 days A decrease in the rate of acute readmissions shows that people are receiving high-quality care in hospital, that they are being appropriately discharged (i.e., not leaving hospital too early or too late), and that they are being well-supported by primary and community care once they are out of hospital. Note that the methodology for this measure was revised by Ministry of Health in 2015/16.	 Source: Ministry of Health
Impact measure: Maintain or reduce the age-standardised[11] cancer mortality rate More people are developing cancer, mainly because the population is growing and getting older. Many cancers can be cured if they're found and treated in time. It is estimated that in New Zealand, about one person in every three who gets cancer is cured. By screening women for breast and cervical cancer, and providing timely cancer treatment, we expect that the cancer mortality rate will decrease.	 Source: Ministry of Health Mortality dataset

3DHB Outcome 7: People receive high quality mental health services when they need them

Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act.

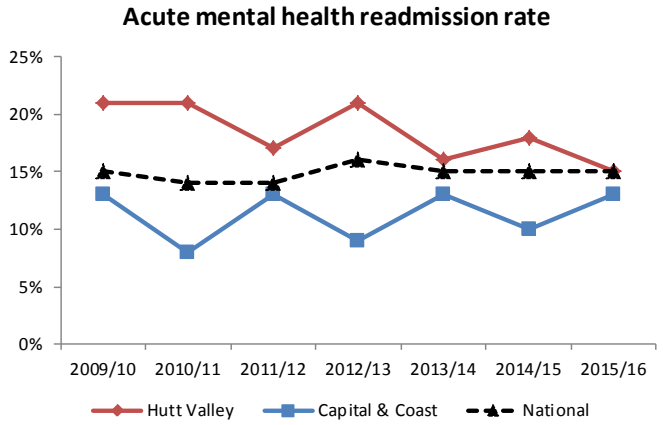
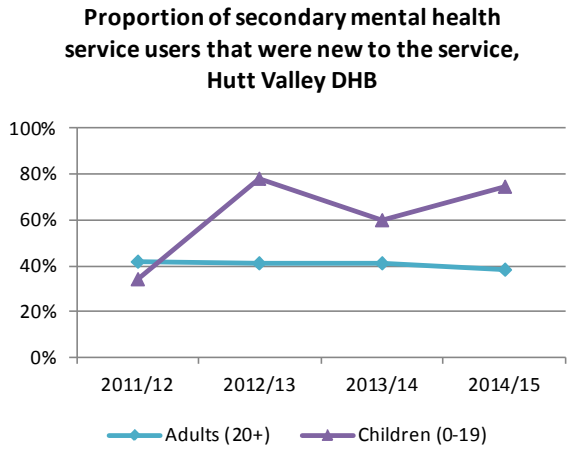
Impact Measures:

- A reduction in the rate of acute readmissions to inpatient mental health services within 28 days

[10] The standardised acute readmission rate accounts for casemix and population differences between DHBs, in order to improve the comparability of the measure across the sector. Refer to the Ministry of Health website (www.moh.govt.nz) for more information on how this measure is calculated.

[11] Age-standardisation accounts for differences in the age structure between populations and changes in the age structure over time. The age-standardised rate estimates what the rate would be if the age structures were the same. See also Section 3.2.2.

- An increase in the percentage of new service users accessing secondary mental health services (of all people accessing secondary mental health services. New service users are those who have not used mental health services in the last five years).

Impact measure: A reduction in the rate of acute readmissions to inpatient mental health services within 28 days Inpatient mental health services aim to provide treatment that enables individuals to return to the community as soon as possible. Unplanned readmissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to support the person out of hospital. A decrease in the rate of acute mental health readmissions reflects good continuity of care across the health system.	 Source: Ministry of Health
Impact measure: An increase in the percentage of new service users accessing secondary mental health services (of all people accessing secondary mental health services. New service users are those who have not used mental health services in the last five years) This measure indicates the responsiveness of secondary mental health services to people who require secondary mental health care for the first time. By ensuring that existing users of secondary mental health services only receive these services for as long as they need them, we can increase our capacity and remove access barriers for new service users. As a result, we expect that the proportion of service users that are new will increase.	 Source: Ministry of Health

3DHB Outcome 8: Responsive health services for people with disabilities

Disability is defined as long-term limitation (resulting from impairment) in a person's ability to carry out daily activities. In 2013, an estimated 24% of people living in New Zealand were identified as

disabled. National estimates by age and gender applied to the sub-region indicate a disabled population of approximately 109,000 people: 11,000 in Wairarapa (27%), 33,000 in Hutt Valley (24%) and 65,000 in CCDHB (23%). The DHB has a responsibility to provide responsive and appropriate health services to people with disabilities.

Impact Measures:

- An increase in the proportion of patients and clinicians that found the Health Passport useful (as a percentage of patients and clinicians that responded to an evaluation survey and reported using the Health Passport).
-

Impact measure: An increase in the proportion of patients and clinicians that found the Health Passport useful (as a percentage of patients and clinicians that responded to an evaluation survey and reported using the Health Passport) The Health Passport is a document that a person takes with them when they use medical services. The Health Passport contains information about the person that they would like hospital staff to know. For example, a Health Passport includes how a person would like to be communicated with, their medical conditions, what medications they are allergic to, and their religious/spiritual preferences. An increase in the proportion of people that find the Health Passport useful will indicate that the Health Passport is achieving its aims and improving the quality of care of patients when they are in hospital.	Measure being developed

3DHB Outcome 9: Improve the health, well-being and independence of our older people

Our ageing population will increase pressure on the health and disability system. National estimates suggest that the increase in health expectancy over the period 2006–2016 will be less than the corresponding increase in life expectancy. In other words, people will live longer, and they will live longer in good health, but they will also live longer in poor health, with multiple comorbidities, functional impairments and frailty. The DHB has a responsibility to provide appropriate services to improve the health, wellbeing, and independence of our older population.

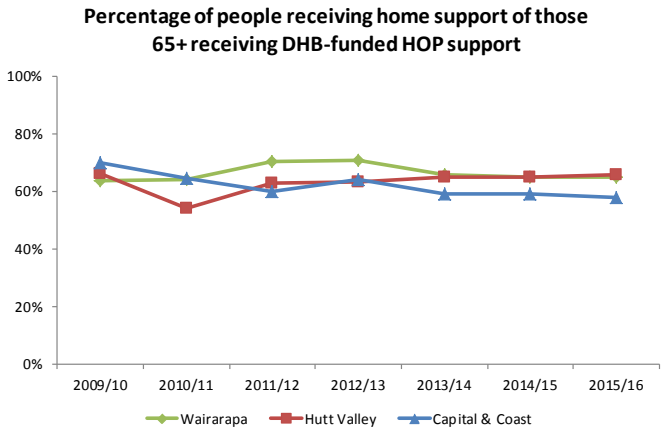
Impact Measures:

- Maintain or increase the proportion of patients receiving home-based support services (of those 65+ who receive DHB home-based support services or aged residential care services)
- Maintain or increase the average age of entry into residential care.

Impact measure: Maintain or increase the proportion of patients receiving home based support services (of those 65+ who receive DHB funded home based support or aged residential care services)

With an ageing population, it is important that services are effective and efficient for people who wish to remain in their own homes. A 2008 study[12] found that "…home support plays an important and effective role in enhancing quality of life and the experience of ageing in place for older people in New Zealand, earning the retention of its place on the continuum of care, and should be acknowledged and valued as a critical ageing in place strategy." This shows the importance of helping older people to maintain their independence.

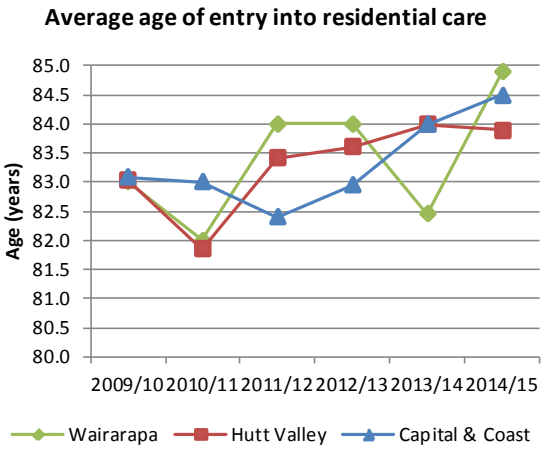
By providing comprehensive and high-quality home-support services, we expect that there will be an increase in the proportion of people receiving home support rather than in residential care.



Source: Health of Older People regional benchmarking

Impact measure: Maintain or increase the average age of entry into residential care

An increase in the average age of entry into residential care would indicate that older people are remaining independent and staying at home for longer. By providing quality home support services to those who need them, and high-quality and timely health services for older people to help them maintain their health, we expect that the average age of entry into residential care will increase.



Source: Health of Older People regional benchmarking

[12] Hambleton, P., Keeling, S., & McKenzie, M. (2008). Quality of life is ... : The views of older recipients of low-level home support. *Social Policy Journal of New Zealand, 33*, 146-162.

Annual Plan 2016/17 & Statement of Intent 2016/17-2019/20

Persuant to Section 38 of the New Zealand Public Health and Disability Act 2000 and Sections 139 and 149C of the Crown Entities Act 2004 as amended by the Crown Entities Amendment Act 2013

Hutt Valley District Health Board, Private Bag 31907, Lower Hutt 5010

Note: This document should be read in conjunction with the Hutt Valley DHB Māori Health Plan 2016/17, Central Region Regional Services Plan 2016/17 and Regional Public Health Business Plan 2016/17. These plans are available on our website: http://www.huttvalleydhb.org.nz
This document incorporates content from the above plans and also content from the Ministry of Health's website: http://www.health.govt.nz/