Hutt Valley District Health Board Annual Plan 2018/19

Issued under Section 38 of the New Zealand Public Health and Disability Act 2000

December 2018

Annual Plan (Final) dated December 2018
(Issued under Section 38 of the New Zealand Public Health and Disability Act 2000)

Photo on cover page by Frank Mackasy.

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

17 DEC 2018

Mr Andrew Blair
Chair
Hutt Valley District Health Board
andrew@blairconsulting.co.nz

Dear Andrew

Hutt Valley District Health Board 2018/19 Annual Plan

This letter is to advise you I have approved and signed Hutt Valley District Health Board's (DHB's) 2018/19 Annual Plan for one year.

I understand your DHB has planned deficits for 2018/19 and the out years. I encourage your Board to consider appropriate activities to ensure that you reduce the projected deficits in the coming years. This will require a concerted effort and I trust that you will continue to work with the Ministry to evaluate and improve your financial performance.

Production Plan is still to be confirmed, and you will work with the Ministry to resolve this.

I am aware you are planning a number of service reviews in the 2018/19 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. 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 2018/19 Annual Plan. I look forward to seeing your achievements.

Please ensure that a copy of this letter is attached to all copies of the Annual Plan made available to the public.

Yours sincerely

Hon Dr David Clark
Minister of Health

cc: Ms Dale Oliff, Acting Chief Executive, Hutt Valley District Health Board, dale.oliff@huttvalleydhb.org.nz

+64 4 817 8709 Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand d.clark@ministers.govt.nz beehive.govt.nz

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SECTION ONE: Overview of Strategic Priorities

1.1 Message from the Chair

On behalf of the members of the Hutt Valley District Health Board, I am pleased to present the Annual Plan for the 2018/19 financial year. This plan has been developed to meet the Minister's expectations for a population health approach, with improved access to health and disability services, to achieve better equity and health and wellbeing outcomes for all New Zealanders. The Annual Plan also aligns with the New Zealand Health Strategy, as well as our own local strategy, *Our Vision For Change – How We Will Transform The Health System 2017-2027.* Throughout 2017, the focus of the Board was on understanding current and future needs, and developing a set of comprehensive strategic plans to provide guidance to the board on the future configuration of our clinical services, as well as provide clarity as to how to best improve local population health.

We developed our local strategy, *Our Vision For Change*, in 2017 through engagement hui with whānau, patients, health professionals and service providers from our community. In 2018/19 the Board will oversee the implementation of *Our Vision For Change.* The strategy identifies three key strategic directions for this Board: Support Living Well; Services Closer to Home; and Shorter, Safer, Smoother Care. These will be progressed through three key strategic enablers: Adaptive Workforce, Smart Infrastructure, and Effective Commissioning.

The guiding plans that support implementation of the key strategic directions are our Clinical Services Plan, our Wellbeing Strategy, our Māori Health Strategy and our Pacific Health Plan – all of which guide a transformational change in the way we fund, provide and deliver health services to successfully address both the increasing burden on the health system and the necessary health improvements required for our population in a clinically and financially sustainable manner.

This 2018/19 Annual Plan addresses key strategic imperatives for our organisation to improve health equity across all populations in the Hutt Valley district. This plan has a strong focus on the whole system of care and working together across clinicians, consumers, and NGOs to be more responsive and preventative in our approach. The plan also includes an ongoing reduction in our budget deficit and a commitment to improve our financial position so we can make investments in new services in the years ahead.

1.2 Message from the Chief Executive

The Hutt Valley DHB's Annual Plan for 2018/19 reflects the cooperative approach we have taken to planning and delivery of consistent services and care for the sub-region. We continue to be committed to working collaboratively across the sub-region and this is evidenced in a number of the work-streams outlined in this Annual Plan. Equally, we have strengthened partnership and collaboration in our local district through the work programmes of the Alliance Leadership Team and the Integrated Care Clinical Networks. We will actively support the continuation of this work in 2018/19 to develop integrated services and improve preventative health.

In line with the Minister's expectations, our emphasis in this plan is to reduce the cost of access to primary care, reduce the growing pressure on emergency services, and improve health equity for our populations. We have incorporated specific actions to improve health outcomes for Māori and Pacific peoples into every aspect of our planning and service delivery processes.

Strong clinical leadership and a flexible, capable workforce are essential foundations for us to become a thriving organisation that demonstrates innovation and continued improvement. Our plan includes an ongoing focus on the development of our workforce and strengthened leadership so that we continue to deliver high value, high quality care and improve the health of all groups in our population.

1.3 Signature Page

Agreement for the Hutt Valley DHB 2018/19 Annual Plan

between

Hon Dr David Clark
Minister of Health
Date: 17/12/18

Andrew Blair
Chair
Hutt Valley DHB
Date:

Dale Oliff
Acting Chief Executive
Hutt Valley DHB
Date:

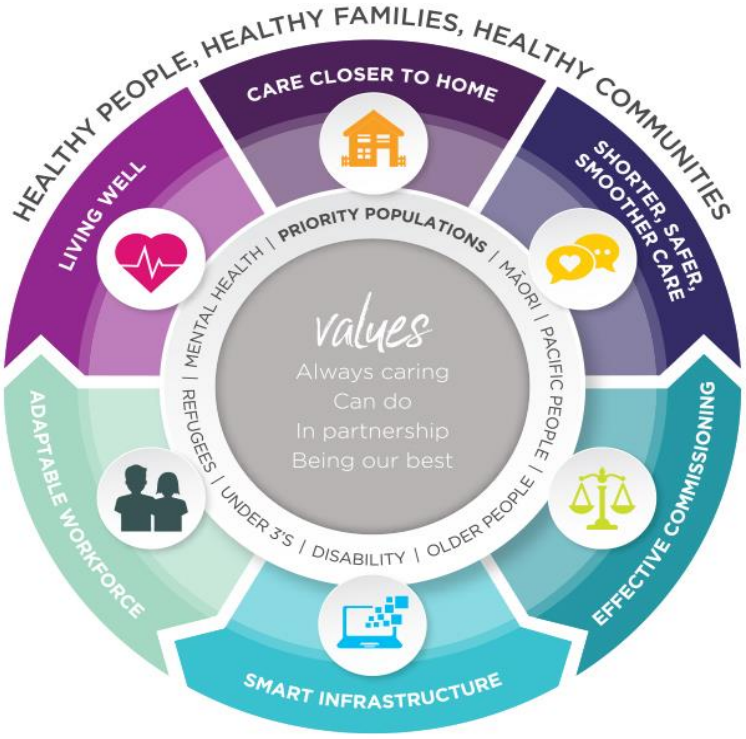
1.4 Strategic Intentions/Priorities

This Annual Plan articulates Hutt Valley DHB's commitment to meeting Ministerial expectations, and our continued commitment to our Board's vision:

Whānau Ora ki te Awakairangi
Healthy People, Healthy Families, Healthy Communities

The Hutt Valley DHB's Annual Plan is aligned with the refreshed New Zealand Health Strategy by fully integrating the five strategic themes of the government's strategy into our DHB's strategic goals and priority action plans.

Our Annual Plan is also heavily influenced by *Our Vision For Change – How We Will Transform The Health System 2017-2027* – as defined in the picture below.



Our *Vision For Change* provides the framework for our thinking as a DHB, focusing on the key directions and enablers to achieve healthy people, healthy families, and healthy communities.

Our three key strategic directions are:

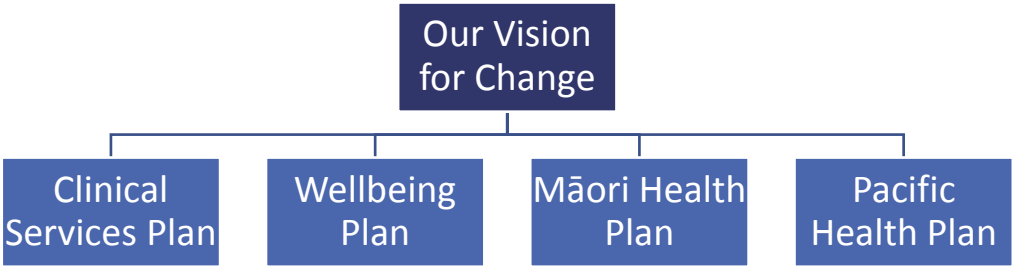
- Support living well
- Shift care closer to home
- Deliver shorter, safer, smoother care.

Our three key strategic enablers are:

- Adaptable workforce
- Smart infrastructure
- Effective Commissioning.

We have been developing a number of plans to support us to meet the bold vision set out in *Our Vision For Change*. Together these plans reflect our Hutt Valley DHB's strategic framework (see below).

Hutt Valley DHB's Strategic Framework



Our Clinical Services Plan provides an outline of how we will need to reconfigure our clinical services over the next 5-10 years to address growing health demands. The Wellbeing Plan focusses on prevention, strengthening whānau and communities, and addressing the wider determinants and environmental factors that impact our physical and mental wellbeing. Our Māori Health Strategy details our commitment to improving the health of Māori in our district and accelerate Māori health equity. Our Pacific Health Plan aims to improve Pacific health and reduce health inequities through four priorities focus areas: child health, health literacy, access to care, and workforce capacity.

Our Annual Plan is also guided by the Treaty of Waitangi and the principles of:

- **Partnership** – working together with iwi, hapū, whānau and Māori communities to develop strategies and services to improve Māori health and wellbeing
- **Participation** – involving Māori at all levels of decision-making, planning, development and service delivery
- **Protection** – working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

Māori as the indigenous peoples of Aotearoa have unique rights under the Treaty. We pay particular attention to the health needs and aspirations of our Māori population. There are well-documented inequalities in the determinants of health between Māori and non-Māori, and these flow through to inequalities in health outcomes. Our intention is that the health care provided, and the partnerships we develop with the wider social sector, supports equitable opportunities for Māori to attain good health and wellbeing.

This plan has been developed in cooperation with our local partners and stakeholders in keeping with the collaborative and cooperative approach for planning, supporting and delivering services in our district and across the sub-region and more widely in the Central Region.[1]

Our Annual Plan is further guided by key national strategies and international conventions. Our commitment to working and acting in accord with their principles, and in support of their implementation is articulated here:

The Treaty of Waitangi	In collaboration with our health partners we prioritise actions to measurably improve health equity and improve outcomes for Māori. We work with Māori at DHB governance and operational levels. We establish and support mechanisms to enable Māori to contribute to decision-making about health services and participate in the delivery of health and disability services.
The New Zealand Health Strategy	Hutt Valley DHB's strategic framework and Annual Plan are aligned with the *New Zealand Health Strategy: Future Directions*.

[1] Central Region comprises six DHBs (Capital & Coast Health, Hawkes' Bay, Hutt Valley, MidCentral, Wairarapa and Whanganui).

He Korowai Oranga	Hutt Valley DHB's strategic framework is aligned with He Korowai Oranga, the national Māori Health Strategy, which aims to achieve Pae Ora (healthy futures for Māori), Wai Ora (healthy environments), Whānau Ora (healthy families), and Mauri Ora (healthy individuals).
The Healthy Aging Strategy	We prioritise work to support healthy aging and respectful end-of-life care that recognises physical, cultural and spiritual needs. We prioritise planning, support and delivery of services to help people live well with long term conditions and to enable high quality acute and restorative care.
UN Convention on the Rights of Persons with Disabilities	We prioritise work to give voice, visibility and legitimacy to disabled people across our wider health services. We prioritise service and skill development to ensure respect for, and protection of, the dignity of people with disabilities.
'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-18	We prioritise work to improve health equity for our Pacific population. We prioritise work to design, support and develop services that best meet the needs of our Pacific population, including services delivered locally in primary care.

1.6 Population Performance

The Ministry of Health is exploring life course approaches as a way of understanding DHB population performance challenges. Actions that Hutt Valley DHB expects to deliver in 2018/19 across the life course are provided in the table below.

Life course group	One significant action that is to be delivered in 2018/19
Pregnancy	The maternity and birthing areas within Hutt Valley Hospital will be upgraded and refurnished. This includes an upgrade of the hospital's eight delivery rooms, the postnatal rooms and bathrooms, and the family/whānau room. The upgrade is expected to support improved workflow and maternity care, and provide a modern, comfortable, and supportive environment for women and their families/whānau. There are also plans to create a specific primary birthing room – informed by consultation with consumers – to encourage and support primary birthing for women with low clinical risk and reduce elective caesarean operations.
Early years and childhood	Complete a stocktake of services provided in the first 1000 days of life to whānau with complex health and social outcomes to identity any gaps in pathways of care or services. Co-design solutions with health and social service community providers to address service gaps and improve outcomes for tamariki and whānau with complex health and social outcomes.
Adolescence and young adulthood	Work to improve screening and data collection on alcohol-related presentations in Hutt Hospital Emergency Department. This will enable us to gauge the extent of alcohol-related presentations and identify options to reduce alcohol-related harm.
Adulthood	Progress implementation of the Health Care Home (HCH) patient-centred model of care across the Hutt Valley. The HCH is a team-based health care delivery model, led by primary health clinicians, providing comprehensive and continuing health care with the goal of reducing disparities, improving access to timely care for patients, and supporting individuals and their whānau to obtain the best possible health outcomes.
Older people	Reconfigure DHB services (older persons, community nursing, allied health and assistant workforce) and establish neighbourhood teams (localities) to implement

	integrated working with general practice teams and improve access to same day acute input in the community.

SECTION TWO: Delivering on Priorities

2.1 Government Planning Priorities

The 2018/19 Planning Priorities are:

- Mental Health
- Primary Care Access
- Public Delivery of Health Services
- Child Health
- School-Based Health Services
- Healthy Ageing
- Disability Support Services
- Pharmacy Action Plan
- Improving Quality
- Access to Elective Services
- Climate Change
- Waste Disposal
- Fiscal Responsibility
- Health Targets
- Delivering the Regional Services Plan.

The key activities Hutt Valley DHB is planning in each priority area are outlined in the table below.

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
Mental Health (both Māori and Pacific focussed equity actions are expected in this priority area)	**Population Mental Health**	Outline actions to improve population mental health and addictions, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness and addiction, further integrating mental and addiction and physical health care, and co-ordinating mental health care with wider social services.	**One team**	1. Establish a sub-regional secondary-care service for young people with alcohol and other drug problems and co-existing problems. This service will include specialist support to primary and NGO providers. 2. Co-design and establish a dedicated Housing Co-ordination service to assist people with mental health or addiction needs overcome housing issues and sustain secure housing. 3. Implement an Occupational Service to assist people with mental health or addiction needs to find and retain employment. 4. Collaborate with local council to implement training for key stakeholders around suicide prevention and supporting first symptoms of mental health. This training will help better equip a diverse range of people within community settings to engage with people experiencing mental health difficulties. 5. Provide community-based support to children of parents with mental illness and addiction problems through family group-based and individual programmes.	Q2 Q1 Q1 Q1-4 Q1-4	PP43 Population mental health
		Outline how the DHB will ensure your staff and members of your community will be encouraged to participate in the Government Inquiry into Mental Health and Addiction.		1. Collaborate with our regional DHB partners (CCDHB and Wairarapa DHB) to support the Inquiry. 2. Arrange for the Inquiry team to meet with relevant clinical and management DHB staff, mental health and addiction service providers, and community groups across the three DHBs. 3. Promote Inquiry public meetings through our DHB provider networks and our website.	Q1 Q1 Q1	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	Mental Health and Addictions Improvement Activities	Outline your commitment to the HQSC mental health and addictions improvement activities with a focus on minimising restrictive care (including the aspirational goal of eliminating seclusion by 2020) and improving transitions. *Please note the percentage and quality of transition plans forms part of the PP7 performance measure. The other three programmes that will be led by the HQSC over the life of the programme are; learning from serious adverse events and consumer experience, maximising physical health and improving medication management and prescribing issues. This programme will support standardised, evidence-based processes and practices for prescribing and management.*	**One team**	1. Develop a seclusion dashboard and continue to monitor and reduce the use of seclusion through the Restraint and Seclusion Elimination Monitoring and Advisory Group. 2. Reconfigure Te Whare Ahuru Acute Inpatient Unit to deliver best practice and culturally safe models of care in a modern environment that is safe, restful, and supports recovery and greater wellbeing. 3. Establish a Youth Mental Health Respite Service with a focus on meeting the needs of young Māori Tangata whai ora and Pacific people. (EOA) [2] 4. Implement a Regional Alcohol and Other Drugs Intensive Residential Treatment Service, including: - the development of a regional pathway of care to move service users and their family/whānau seamlessly through the alcohol and other drug continuum (including intensive residential, respite services, and options for step-down care and support) - service that is responsive to Māori, Pacific, and at-risk populations (EOA). 5. MHAIDS[3] will focus on improving the transition processes between the Crisis Resolution Service and the Adult Community Mental Health Teams with support from the Health, Quality and Safety Commission.	Q1-4 Q1-4 Q1 Q2 Q1-4	PP7 Improving mental health services using wellness and transition (discharge) planning

[2] Equity Outcomes Action.

[3] The Mental Health, Addictions and Intellectual Disability Service.

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	Mental health and addictions	For those DHBs that are not currently meeting the PP8 addiction related waiting times targets (for total population or all population groups), please identify actions to improve performance. *Note: DHBs should take into account both DHB provided services and those that are DHB funded but provided by NGOs.*	**Value and high performance**	1. Continue to reduce wait times through improvements to the Infant, Child, Adolescent and Family Service (ICAFS), including: - embedding the Choice and Partnership Approach (CAPA)[4] throughout the service with training and resources for all staff - standardising evidence-informed approaches to common presenting problems - strengthening links with Iwi and Māori service providers - ongoing management of referrals from Te Haika (secondary adult service) to ICAFS. 2. Explore and scope other potential service improvements to the ICAFS, including: - technology to enhance efficiency and effectiveness - new systems for sharing information and collecting and reporting useful data - survey tools to collect real-time feedback from service users - mechanisms for consumer participation in service changes - enabling electronic appointment booking across the service - outreach services at various locations.	Q1-4 Q1-4	PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds

[4] CAPA introduces ways of working that increase the efficiency and quality of services by implementing systems to utilise resources effectively while keeping the service user at the heart of the process. This includes making sure that children, young people and their family/whānau are met in a timely fashion, listened to and respected, offered all options available, given opportunity to voice their views and are supported with their decisions.

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
Primary Health Care (both Māori and Pacific focussed equity actions are expected in this priority area)	**Access**	As per Budget 2018 announcements, commit to the implementation of new primary care initiatives to reduce the cost of access to primary care services. This includes extending zero fees for under-13s to zero fees for under-14s and reducing fees for community service card holders. Describe actions that will ensure at least 95% of eligible children aged under 14 have zero fee access to afterhours care within 60 minutes travel time. This includes general practice services and prescriptions.	**Closer to home**	1. As per Budget 2018 announcements, HVDHB will work with PHOs and primary care providers to implement new primary care initiatives to reduce the cost of access to primary care services. This include the extension of zero fee access to general practice and prescriptions during regular hours and after-hours for all eligible children under 14 year olds from December 2018. HVDHB is predominantly an urban district with general practices and afterhours accessible within 60 minutes driving time. 2. Progress implementation of the Health Care Home (HCH) model of care across the Hutt Valley, which includes the provision of primary care services over extended hours (beyond normal 8am-5pm business hours) in a way that ensures access to care is increased to reflect the needs of the practices enrolled population. (EOA) 3. Work with the PHO's practices and after hours service providers to explore ways of reducing the burden of high utilisation of after-hours services by this population group. 4. Improve the responsiveness of the adult primary mental health service to ensure access is enhanced.	Q3 Q1-4 Q4 Q4	PHO enrolment, by ethnicity GP and practice nurse consultations, by ethnicity

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	Integration	DHBs are expected to continue to work with their district alliances on integration including (but not limited to): - strengthening their alliance *(eg, appointing an independent chair, establishing an alliance programme office, expanding the funding currently considered by the alliance)* - broadening the membership of their alliance *(eg, pharmacy, maternity, public health, WCTO providers, mental health providers, ambulance)* - developing services, based on robust analytics, that reconfigure current services. In addition: -please identify actions you are undertaking in the 2018/19 year to assist in the utilisation of other workforces in primary health care settings. …… -identify actions to demonstrate how you will work proactively with your PHOs and other providers to improve newborn enrolment with general practice in 2018/19.	**Closer to home**	1. Provide standardised direct acute access to specialist advice and assessment across general medicine, cardiology, respiratory and mental health. 2. Implement the specialist support for primary care (case collaboration model of care) in: cardiology, respiratory services, mental health, and geriatrics. 3. Continue to implement 3DHB Health Pathways and Information Management programmes including: - additional local Health Pathways (online best practice information for general practice) to improve consistency in care - adopt the 2017/18 evaluation findings to enhance adoption of Health Pathways - pilot an electronic shared care planning tool across general practice and DHB services in the Hutt Valley. 4. Continue to integrate the clinical and cultural support services provided by Pacific health services at Naenae Medical Centre. (EOA) 5. Establish an Adult Mental Health Network reporting to the Alliance Leadership Team to identify and drive service integration activity and new initiatives. 6. Develop an ambulance work programme to support acute triage, assessment and management in the home setting. 7. Improve newborn enrolment rates for Māori and Pacific in general practice by working with PHOS, general practices, Well Child/Tamariki Ora providers and Lead Maternity Carers. 8. Develop a community hub model for integrating DHB community services with primary care services, to establish proactive health care teams in different locations by 30 June 2019. (Also a Healthy Ageing activity). 9. Progress the 'Red2Green Initiative' in Hutt Valley Hospital to avoid unnecessary delays for in-patients, and improve patient flow and patient experience of care.[5] (Also an Improving Quality activity).	Q1-4 Q4 Q2 Q2 Q2-4 Q1-4 Q2 Q4 Q4 Q4 Q1-4	SI18: Improving newborn enrolment in General Practice SI1: Ambulatory sensitive hospitalisations

[5] Under the Red2Green Initiative, delays in patient care are monitored using a simple measure, where a 'red' bed day is a wasted day for hospital patients and a 'green' bed day is a productive one.

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	System Level Measures	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix. System Level Measures Guidance is available on the Nationwide Service Framework Library.	**Value and high performance**	Implement the local System Level Measure Improvement Plan developed by our Alliance Leadership Team as outlined in the Appendix.	Q1-4	SI7: SLM total acute hospital bed days per capita SI8: SLM patient experience of care SI9: SLM amenable mortality SI12: SLM youth access to and utilisation of youth appropriate health services SI13: SLM number of babies who live in a smoke-free household at six weeks post-natal

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	CVD and diabetes risk assessment	Commit to maintaining a rate of 90% in undertaking CVD and Diabetes Risk Assessments for their eligible population. Those DHBs whose current performance is below 90% are expected to work closely with their alliance partners to achieve 90%. These DHBs must describe specific actions their alliance will take to reach this target. These actions could be part of the actions committed to in the System Level Measures Improvement Plan (specifically in achieving the Acute Bed Days or Amenable Mortality SLMs), in which case this should be cross-referenced, if that is appropriate. If specific risk assessment activity is not part of the SLM Improvement Plan, actions to improve the level of risk assessments provided must be included in this section along with two quarterly milestones. In addition each DHB should identify three priority areas they will be undertaking for quality improvement in diabetes care and services with key actions and milestones. These areas may be informed by their self-assessment against the Quality Standards for Diabetes Care 2014.	**One team**	1. Achieve and maintain the 90% target for CVD risk assessments in primary care for all population groups as outlined in the local System Level Measure Improvement Plan. This includes: - working with PHOs to complete and distribute practice variation analysis by ethnicity for CVD risk assessments - providing cardiology and diabetes specialist support for primary care, targeted to practices with the highest proportion of Māori and Pacific enrolled patients. (EOA) 2. Improve the management of CVD in primary care by working with PHOs to complete and distribute practice variation analysis by ethnicity for people with established cardiovascular disease. (Also an activity in the local System Level Measure Improvement Plan). 3. Embed a new model of care (identified in our review of community podiatry services in 2017/18) for people with diabetes who have moderate foot risk and can be safely managed in the community. 4. Evaluate the 12 month pilot of the digital health self-management programme for diabetes management (due for completion in December 2018) to inform future provision and investment. 5. Work with PHOs to improve the management of diabetes amongst Māori and Pacific, with the aim of achieving 72% of Māori and Pacific patients with well managed diabetes.[6] 6. Work with the PHOs to increase the number of Māori age 15-74 with diabetes having an annual review, with the aim of achieving 69% having had an annual review.[7]	Q4 Q4 Q1-2 Q4 Q4 Q2	PP20 Focus Area 2: Diabetes services PP20 Focus Area 3: Cardiovascular health

[6] Well managed diabetes is HbA1c < 64mmol/mol. The aim is to increase the rate by approximately 6% per quarter for both Māori and Pacific.

[7] The aim is to increase the rate by approximately 2% per quarter.

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	Pharmacy Action Plan	Continue to engage with the agreed national process to develop and implement a new contract to deliver integrated pharmacist services in the community. Continue to support the vision of the Pharmacy Action Plan by working with pharmacists, consumers and the wider health sector (eg, primary health care) to develop integrated local services that make the best use of the pharmacist workforce.	**One team**	1. Continue to engage with the agreed national process to develop and implement a new contract to deliver the Integrated Community Pharmacy Services Agreement. 2. Continue to support the vision of the Pharmacy Action Plan by working with pharmacists, consumers and the wider health sector (eg, primary health care) to develop integrated local services that make the best use of the pharmacist workforce. 3. Implement a pharmacy services strategy for the Hutt Valley that aligns with the Pharmacy Action Plan and aims to improve medication access and outcomes for our population. 4. Implement a pharmaceutical co-payment support service for people with financial barriers to medication collection. (EOA)	Q1-4 Q1-4 Q3 Q3	PP38 Delivery of response actions and milestones agreed in the annual plan for each Government planning priority
	Support to quit smoking	Please identify activities that continue to support delivery of smoking ABC in primary care		1. Additional funding to TeAHN (PHO) to continue to support delivery of smoking ABC[8] in primary care. TeAHN will provide ABC smokefree training and support to practices and assist in improving referral systems from primary care to specialist cessation services for priority groups (Māori, Pacific, and pregnant women). 2. Develop a Hutt Valley Health System Tobacco Control Plan with key partners across council, primary and secondary care, community providers and Regional Public Health. (EOA)	Q1 Q4	

[8] Ask, provide Brief advice, refer to smoking Cessation.

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
Child Health (both Māori and Pacific focussed equity actions are expected in this priority area)	**Child Wellbeing**	Please identify the most important focus areas to improve child wellbeing and that realises a measurable improvement in equity for your DHB. Identify key actions that demonstrate how the DHB is building its understanding of population needs, including those of high-needs populations, and making connections with and between local service providers of maternal health, child health and youth focused services.	**Value and high performance**	1. Complete a stocktake of services provided in the first 1000 days of life to whānau with complex health and social outcomes, to identity any gaps in pathways of care or services. 2. Evaluate our marae-based primary maternity clinic to improve early registration of pregnant Māori women with Lead Maternity Carers, leading to better outcomes for mother and baby. (EOA) 3. Implement Sudden Unexpected Death in Infancy prevention initiatives targeting Māori, including the provision of safe sleep devices, smoking cessation, breastfeeding support, coordination support to providers, and safe sleep education and awareness raising. (EOA) 4. Complete the review of youth health services in HVDHB and progress work on the resulting recommendations. 5. Increase preventative oral health initiatives, including: - health promotion and resources targeting Māori and Pacific[9] - increasing examinations for pre-schoolers in target populations - increasing preventative treatments to target populations[10] - active follow-up of children who miss appointments. (EOA) 6. Provide extended care in general practice (especially for childhood ASH conditions) by expanding Primary Options for Acute Care (POAC) to improve the management of acute conditions in the community. (EOA) 7. Reconfigure our Whānau Ora services to improve responsiveness to whānau with complex health and social needs. (EOA)	Q4 Q3 Q1-4 Q1-4 Q1-4 Q3 Q1	PP10 Oral Health- Mean DMFT score at Year 8 SI1: Ambulatory sensitive hospitalisations - Age 0- 4

[9] This includes actions that change behaviour at home and at school, such as campaigns to encourage twice daily tooth brushing and reducing access to sugary drinks (eg the Water Only toolkit for schools).
[10] This includes tooth brush and paste distribution, and supervised brushing programmes in Kohanga, and additional treatments such as Fluoride varnish.

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	Maternal Mental Health Services	Commit to have completed a stock-take by the end of quarter two, of community-based maternal mental health services currently funded by your DHB, both antenatal and postpartum. Please include funding provided to PHOs specifically to address primary mental health needs for pregnant women and women and men following the birth of their baby. Commit to identify, and report in quarter four on the number of women accessing primary maternal mental health services both through PHO contracts that the DHB holds and, through any other DHB funded primary mental health service.	**Closer to home**	1. Complete a stock-take of community-based maternal mental health services currently funded by HVDHB. 2. Identify and report on the number of women accessing primary maternal mental health services in the Hutt Valley. 3. Scope options to improve screening of maternal mental health in primary care. 4. Improve access to maternal mental health interventions, particularly for Māori, Pacific, and low income women. (EOA)	Q1 Q1 Q2 Q4	PP44 Maternal mental health
	Supporting Health in Schools	Identify actions currently under way to support health in schools by the end of quarter two, an example can be found on the FAQ sheet on the NSFL (in addition to School-Based Health Services – see guidance below). This requirement is asks DHBs to provide a list of DHB health initiatives that are delivered in schools (such as initiatives supporting nutrition, mental health, public health messaging etc) by end of quarter two.	**Closer to home**	1. Identify actions currently under way to support health in schools.	Q2	PP39 Supporting Health in Schools

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	School-Based Health Services (SBHS)	Commit to have completed a stocktake of health services in public secondary schools in the DHB catchment (MoH to provide list of schools) by the end of quarter 2. Commit to have developed an implementation plan including timeframes for how SBHS would be expanded to all public secondary schools in the DHB catchment (MoH to provide template) by the end of Q4. *Note that the implementation plan should include an equity focus.*	**Closer to home**	1. Complete a stocktake of health services in public secondary schools in the HVDHB catchment. 2. Develop an implementation plan including timeframes for how SBHS would be expanded to all public secondary schools in the HVDHB catchment.	Q2 Q4	PP25: Youth mental health initiatives
	Immunisation	Work as one team across all immunisation providers within your region, and in collaboration with other child services, to improve immunisation rates and equity for the key milestone ages in early childhood. This includes delivery of the primary series of vaccines under one year of age, and completion of immunisations due at two and five years of age, with a particular focus on increasing immunisation rates for Māori infants.	**One team**	1. Implement a process to identify the immunisation status of children presenting at hospital (including ED) and refer them for immunisation if not up to date by March 2019. This action is expected to increase Maori infant immunisation coverage because a disproportionate number of Māori infants who present to hospital and are unimmunised compared with other ethnic groups. 2. Work with GP practices (focussing on those that have the highest referrals to outreach immunisation services) to review their processes for active follow-up with families and whānau who are	Q3 By 21 December 2018	PP21: Immunisation coverage

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
		Please provide three specific actions that will increase Māori infant immunisation coverage levels and sustain high levels during 2018/19. These actions must be accompanied by a date for implementation of the action, an expected outcome, and a date by which the outcome will be achieved.	Value and high performance	due for their immunisations.[11] This action is expected to increase Maori infant immunisation coverage because a disproportionate number of Māori infants are referred for outreach immunisation services because immunisations are late compared with other ethnic groups. 3. Consider options to increase the capacity of the Outreach Immunisation Service during school holiday periods with the provision of Regional Public Health school-based nurses by December 2018. This action is expected to increase Maori infant immunisation coverage because a disproportionate number of Māori infants are referred for outreach immunisation services and are unimmunised compared with other ethnic groups. 4. Incentivise general practices to improve immunisation rates through implementation of the Health Care Home patient-centred model of care across the Hutt Valley. The expected outcomes are improved follow-up for child immunisations, strengthened outreach services over school holiday periods, and increased Māori infant immunisation coverage.	By 21 December 2018 By 28 June 2019	

[11] This activity will focus on GP practices that have the highest referrals to the Outreach Immunisation Service.

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	Responding to childhood obesity	Please identify activities that continue to respond to children identified as obese at their B4 school check.	**Value and high performance**	1. Evaluate a pilot 'healthy eating and exercise programme' that incentivises whānau with obese children identified through the B4 School Check to enrol in and complete the programme. (EOA) 2. Work with Sport Wellington to increase the numbers of families accepting the offer of support and graduating from the preschool active families programme. 3. Launch and progress implementation of a Wellbeing Plan. This plan is focussed on prevention, strengthening whānau and communities, and the health sector's role in addressing the wider determinants and environmental factors that impact wellbeing in the Hutt Valley. The key focus areas of the plan are: housing, healthy lifestyles and physical activity, alcohol and other drugs, tobacco, wellbeing at work, and tamariki and whanau with complex social needs impacting their wellbeing. Initiatives will be targeted to Māori and Pacific, as populations disproportionately represented in wellness statistics (EOA) (Also a Strengthen Public Delivery of Health Services activity).	Q4 Q2-4 Q1-4	PP27 Supporting child wellbeing

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
System Settings (both Māori and Pacific focussed equity actions are expected in this priority area)	**Strengthen Public Delivery of Health Services**	Identify any activity planned for delivery in 2018/19 to strengthen access to public health services.	**Value and high performance**	1. Launch and progress implementation of a Wellbeing Plan. This plan is focussed on prevention, strengthening whānau and communities, and the health sector's role in addressing the wider determinants and environmental factors that impact wellbeing in the Hutt Valley. The key focus areas of the plan are: housing, healthy lifestyles and physical activity, alcohol and other drugs, tobacco, wellbeing at work, and tamariki and whanau with complex social needs impacting their wellbeing. Initiatives will be targeted to Māori and Pacific, as populations disproportionately represented in wellness statistics (EOA) (Also a Responding to Childhood Obesity activity). 2. Increase Violence Intervention Programme (VIP)[12] awareness and risk assessment across the district, and increase VIP training uptake focusing on priority areas including emergency department, child health and maternity services.	Q1-4 Q1-4	PP38 Delivery of response actions and milestones agreed in the annual plan for each Government planning priority
	Shorter stays in emergency department	Please identify activities that continue to improve patient flows through hospital.		1. Improving patient flow through the Emergency Department by: - staff undertaking the 'Plan-Do-Study-Act' (problem-solving model) to improve triage accuracy - information/training to medical registrars on timeliness and pathway development regarding abdominal pain and falls - work to reduce steps in the patient flow process and simply the process for requesting beds. 2. Reduce the length of time acute medical patients spend in ED by testing (Quarter 1) and refining (Quarter 4) a process that encourages the on-call general medical team[13] to proactively find and assess people waiting in ED (including the waiting room). 3. Progress the 'Red2Green Initiative' in Hutt Valley Hospital to avoid unnecessary delays for in-patients, and improve patient flow and patient experience of care.[14] (Also an Integration activity)	Q1-4 Q1 and 4 Q1-4	HT1: Time patient is in ED (discharged or transferred with 6 hours) OS3: Inpatient Average Length of Stay (ALOS)

[12] The Violence Intervention Programme (VIP) seeks to reduce and prevent the health impacts of violence by early identification, assessment and referrals of victims presenting to designated services (Maternity, Child health, Emergency, and Mental Health, Addictions and Intellectual Disability Services).

[13] Approximately 40 percent of admissions to Hutt Hospital are referred to medicine.

[14] Under the Red2Green Initiative, delays in patient care are monitored using a simple measure, where a 'red' bed day is a wasted day for hospital patients and a 'green' bed day is a productive one.

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	Access to Elective Services	Please provide three specific actions that will support your delivery of the agreed number of Elective discharges, in a way that meets timeliness and prioritisation requirements and improves equity of access to services. At least one action to improve equity of access to Elective Services should be included. These actions must be accompanied by a date for implementation of the action, an expected outcome, and a date by which the outcome will be achieved.	Value and high performance	1. Production planning: a) Review the effectiveness of a new surgical forecasting and monitoring tool and make updates to the tool if required b) Expand the surgical forecasting tool to include First Specialist Assessments and follow-up assessments. Outcome by 1 April 2019: Real time monitoring of theatre and outpatient throughput against the forecast plan, which will inform decisions about theatre allocation and outpatient clinic requirements. 2. Streamline the surgical pre-assessment model. Outcome by 1 July 2019: The new streamlined model will be more patient focused and cost efficient, with a reduction in the number of pre-assessment visits for some patients. 3. Analyse National Patient Flow data relating to declined referrals to identify any equity of access issues that need to be addressed. Outcome by 31 March 2019: Analysis provided to all clinicians to inform discussion on prioritization, including equity issues.	By 31 March 2019 By 30 June 2019 By 31 December 2018	Number of Elective Discharges SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Elective Services Patient Flow Indicators

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	Cancer Services	Implement improvements in accordance with national strategies and demonstrate initiatives that support the areas outlined below. All initiatives will demonstrate clear strategies for addressing Māori health gain, equitable and timely access to services and the use of data to inform quality improvement across those initiatives. DHBs will describe actions to: - ensure equity of access to timely diagnosis and treatment for all patients - implement the prostate cancer decision support tool to improve the referral pathway across primary and secondary services - provide support to people following their cancer treatment (survivorship).	**Value and high performance**	1. Promote bowel screening alongside other screening programmes at events and other engagement opportunities for priority populations. (EOA) 2. Work with DHB staff, Regional Screening Services, and primary care partners to identify Māori and Pacific people who would benefit from being invited onto the bowel screening programme early following point of contact with health staff or at an event. (EOA) 3. Continue working with independent Māori and Pacific support services and subcontractors to ensure our priority populations access screening services. (EOA) 4. Work with our primary care partners to promote the uptake of the prostate cancer decision support tool to improve the referral pathway across primary and secondary services. 5. Scope and investigate options to enhance support to people following their cancer treatment (survivorship). 6. Scope and investigate options for an enhanced tracking tool for cancer patients to improve the efficiency of referrals and coordination of care. 7. Participate in work with other Central Region DHBs, the Central Cancer Network, and the Cancer Society to deliver survivorship programmes for Māori.[15] (EOA)	Q1-4 Q1-4 Q1-4 Q1-4 Q4 Q4 Q1-4	PP30: Faster cancer treatment SI3: Ensuring delivery of Service Coverage SI10: Improving cervical screening coverage SI11: Improving breast screening rates No. of bowel screens

[15] Please refer to the Central Region's Regional Service Plan 2018/19.

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	Healthy Ageing	Deliver on actions identified in the Healthy Ageing Strategy 2016, involving older people in service design, co-development and review, and other decision-making processes[16], including: - working with ACC, HQSC and the Ministry of Health to promote and increase enrolment in your integrated falls and fracture prevention services as reflected in the associated "Live Stronger for Longer" Outcome Framework and Healthy Ageing Strategy - contributing to DHB and Ministry led development of Future Models of Care for home and community support services. In addition, please outline current activity to identify drivers of acute demand for people 75 plus presenting at ED (or at lower ages for disadvantaged populations).	**Closer to home**	*Ageing well* 1. Re-tender Home and Community Support Services for people over 65 years of age to improve the independence of older people in the community by 1 April 2019. This includes ensuring the provision of culturally appropriate services to Māori and Pacific people. (EOA) *Acute and Restorative care* 2. Develop a community hub model for integrating DHB community services with primary care services, to establish proactive health care teams in different locations by 30 June 2019. (Also an Integration activity). 3. Implement the 3 DHB Older Persons Falls Management Model in the community, including proactive identification of older people at risk of falls, and access to strength and balance programmes and other interventions. *Living Well with Health Conditions* 4. Promote dementia-friendly Hutt Valley communities in partnership with Alzheimers New Zealand. *Support for people with high and complex needs* 5. Support and deliver training for staff across secondary, primary and community healthcare providers to undertake advance care planning conversations. 6. Implement a frailty screening approach for use in ED, so that frail patients can be identified early and provided appropriate care and support (including activities to reduce deconditioning). *Respectful end of Life* 7. Implement new model of care for specialist palliative care services, embedding a palliative care approach within primary and community care. 8. Implement interRAI Palliative care assessment tool. 9. Implement Te Ara Whakapiri[17] across hospice and provider arms services to promote quality care at the end of life.	Q1-4 Q4 Q1-4 Q1-4 Q1-4 Q1-4 Q1-4 Q1-4 Q1-4	PP23: Implementing the Healthy Ageing Strategy SI7: SLM total acute hospital bed days per capita OS8: Acute readmission to hospital

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	Disability Support Services	Commit to develop e-learning (or other) training for front line staff and clinicians by the end of quarter 2 2018/19 that provides advice and information on what might be important to consider when interacting with a person with a disability. (Some DHBs have developed tools which could be shared, contact DSS). Commit to report on what % of staff have completed the training by the end of quarter 4, 2018/19.	**One team**	1. E-Learning Tool: The E-Learning Tool (an educational disability literacy tool) is in place to improve decision making within clinical situations. For 2018/19 the current 3DHB e-learning tool will be reviewed with a focus on Māori and Pacific usage and outcomes. 2. Continue to promote *Disability Support Solutions – Patients as Experts and Partners in Care* to improve the communication between disabled patients and clinicians and reduce unsafe longer admissions. 3. Work with HVDHB's Māori and Pacific Units to support the uptake of Disability Alerts for Māori and Pacific populations.[18] (EOA)	Q2-4 Q1-3 Q1-4	SI14 Disability support services
	Improving Quality	Identify actions to improve equity in outcomes and patient experience by demonstrating planned actions to: - work to improve equity in outcomes as measured by the Atlas of Healthcare Variation (DHB to choose one domain from: gout, asthma, or diabetes) - improve patient experience as measured by your DHB's lowest-scoring question in the Health Quality & Safety Commission's national inpatient experience surveys.	**Value and high performance**	1. Continue to implement the respiratory work programme to address asthma related hospital admissions and disparities for Māori and Pacific. This includes: - proactive management planning (including flu vaccination, medication review and referral to Well Homes) in general practice for those with previous hospital admissions - completing and distributing practice variation analysis of reliever and preventer inhaler prescribing and dispensing by ethnicity, to highlight and address any inconsistencies - providing specialist support for primary care (case collaboration model of care) in respiratory care, targeted to practices with the greatest population need. (EOA) (Also an Integration activity). 2. Continue to improve the use of patient experience data to drive service improvement and increase patient satisfaction with service delivery. This includes developing a quality improvement project focusing on improving the advice given to patients about medication side effects.[19]	Q3 Q4	SI8: SLM patient experience of care SI1: Ambulatory sensitive hospitalisations

[16] Action 26 of the Healthy Aging Strategy.

[17] *Te Ara Whakapiri: Principles and guidance for the last days of life* outlines the essential components and considerations required to promote quality care at the end of life for all adults in New Zealand.

[18] Disability Alerts contain specific information provided by the patient on how best to meet their support needs.

[19] In February 2018, the following question scored 29% from the total respondents 'Did a member of staff tell you about medication side effects to watch for when you went home?'

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
	Climate Change	Commit to individually and collectively make efforts to reduce carbon emissions and, where appropriate, promote the adoption of CEMARS (or other carbon neutral scheme). Commit to undertake a stocktake to be reported in quarter 2 to identify activity/actions being delivered, including procurement, that are expected to positively mitigate or adapt to the effects of climate change.	Value and high performance	1. Review sustainable options around food services, including reduction in power consumption, recycling (including removal of polystyrene cups), and composting. 2. Replace thirty hospital fleet petrol vehicles with hybrid vehicles. 3. Review of the way hospital fleet vehicles are used, including the potential for reducing trips and car pooling. 4. Establish a sustainability steering group to oversee efforts to reduce carbon emissions. 5. Work with local Councils and other interested groups to network and improve sustainability within the Hutt Valley region.	Q1 Q1-2 Q2 Q1 Q1-4	PP40 Responding to climate change
	Waste Disposal	Provide actions to raise awareness and actively promote the use of your DHB's pharmaceutical waste collection and disposal arrangements. Commit to undertake a stocktake to be reported in quarter 2 of 2018/19 to identify activity/actions to support the environmental disposal of hospital and community *(eg, pharmacy)* waste products (including cytotoxic waste).	Value and high performance	1. Establish a Sustainability Committee focused on communication, education, and promoting the use of pharmaceutical waste collection and disposal arrangements. 2. Establish a new water fountain in the hospital café to encourage staff to use their own refillable water bottles and reduce our waste footprint. 3. Review alternative solutions for waste to reduce environmental impact at landfill. 4. Undertake a stocktake to identify activity/actions to support the environmental disposal of hospital and community waste products (including cytotoxic waste). 5. Ensure appropriate management of hazardous substances to avoid adverse health effects from direct or indirect exposure and/or related environmental contamination. (RPH)[20]	Q1 Q1 Q4 Q2 Q1-4	PP41 Waste disposal

[20] Regional Public Health activity.

Government Planning Priority	Focus Expected for the DHB	Link to NZ Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Fiscal Responsibility	Commit to deliver best value for money by managing your finances in line with the Minister's expectations. Local improvement activities to respond to Government intentions (DHBs required to include actions in this sections will be advised).	Value and high performance	HVDHB will continue to deliver best value for money by managing its finances in line with the Minister's expectations.		Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan. In particular, for Elective Services, identify local actions to support planned Elective activity in the regional service plan across, Workforce, Clinical Leadership, Quality and Pathways. There is a strong focus on regional collaboration in 2018/19 for Orthopaedics, Ophthalmology, Vascular and Breast Reconstruction.	One team	HVDHB will collaborate with our regional partners and contribute to the following activities. 1. Regional clinical leadership to support effective decision making. 2. A regional review of current orthopaedic workforce, and the development and implementation of a regional orthopaedic workforce plan to meet anticipated delivery levels. 3. The development and implementation of regional models of care for vascular surgery, age-related macular degeneration and glaucoma, and breast reconstruction surgery. 4. Regional implementation of Kia Ora Hauora, a Māori health workforce development programme. 5. The development and implementation of an integrated 3DHB Strategic Mental Health Plan across the sub-region to 2030, with an emphasis on actions to be taken in the next five years including a strong focus on achieving equitable access and outcomes for all. 6. The development and implementation of early intervention programmes to support patients in the community prior to there being a need for surgical intervention. 7. Work to ensure services (such as radiology, ophthalmology and orthopaedics) are sustainable, affordable, and delivered as local as possible and as specialised as necessary.	Q1-4	SI2: Delivery of Regional Service Plans (RSP)

2.2 Financial Performance Summary

PROSPECTIVE STATEMENT OF FINANCIAL PERFORMANCE (COMPREHENSIVE INCOME) FOR THE THREE YEARS ENDED 30 JUNE 2019, 2020 AND 2021

Statement of Comprehensive Income	2016/17 Audited Actual $000	2017/18 Actual $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Revenue					
Ministry of Health Revenue	412,073	429,340	449,770	458,567	467,538
Other Government Revenue (including other DHBs)	107,031	113,465	112,602	113,728	114,865
Other Revenue	7,442	7,640	5,104	5,155	5,207
Total Revenue	**526,546**	**550,445**	**567,475**	**577,450**	**587,609**
Expenditure					
Personnel	168,951	175,325	185,086	188,788	192,752
Outsourced	15,740	17,002	11,556	11,682	11,882
Depreciation and Amortisation	13,306	13,673	14,136	14,136	14,136
Clinical Supplies	24,588	27,876	25,736	25,736	26,173
Infrastructure and Non Clinical	16,500	14,171	14,300	14,367	14,572
Payments to other DHBs	89,238	93,040	97,633	99,586	101,578
Payments to Non-DHB Providers	191,450	202,382	210,801	215,017	219,318
Interest	2,277	51	71	71	71
Capital Charge	5,864	10,092	12,070	12,070	12,070
Other expenses	2,434	3,724	4,134	4,153	4,219
Total Expenditure	**530,347**	**557,336**	**575,524**	**585,606**	**596,770**
Other Comprehensive Income					
Revaluation of Land and Building	4,010	38,246	-	-	-
Total Comprehensive Income/(Deficit)	**211**	**31,355**	**(8,049)**	**(8,156)**	**(9,161)**

PROSPECTIVE FINANCIAL PERFORMANCE BY OUTPUT CLASS FOR THE THREE YEARS ENDED 30 JUNE 2019, 2020 AND 2021

Prospective Summary of Revenues and Expenses by Output Class	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Early Detection			
Total Revenue	154,246	157,093	160,012
Total Expenditure	155,566	158,513	161,563
Net Surplus / (Deficit)	**(1,320)**	**(1,420)**	**(1,551)**
Rehabilitation & Support			
Total Revenue	74,427	75,791	77,182
Total Expenditure	73,704	75,135	76,621
Net Surplus / (Deficit)	**723**	**655**	**561**
Prevention			
Total Revenue	24,884	25,202	25,553
Total Expenditure	25,299	25,653	26,068
Net Surplus / (Deficit)	**(415)**	**(451)**	**(515)**
Intensive Assessment & Treatment			
Total Revenue	313,971	319,418	324,917
Total Expenditure	321,008	326,358	332,572
Net Surplus / (Deficit)	**(7,037)**	**(6,940)**	**(7,655)**
Consolidated Surplus / (Deficit)	**(8,049)**	**(8,156)**	**(9,161)**

SECTION THREE: Service Configuration

3.1 Service Coverage

All DHBs are required to deliver a minimum of services, as defined in *The Service Coverage Schedule*, which is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability Act 2000, and is updated annually.

Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs. Hutt Valley DHB may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services.

The Hutt Valley DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2018/19.

3.2 Service Change

The table below describes all active service changes that have been approved or proposed for implementation in 2018/19.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Surgical service delivery changes	The DHB is reviewing the best service delivery models for the Hutt Valley population in relation to ophthalmology services and bariatric surgery.	• Value for money • Improved clinical sustainability • Improved health outcomes • Improved access to services for the Hutt population, closer to home	Hutt and Capital and Coast
Community Pharmacist Services	Implement national community pharmacy contracting arrangements once agreed and work with consumers and other stakeholders to develop local pharmacist service. Review local service delivery through Community Pharmacies and other pharmacist service providers, including the long term conditions service.	• More integration across the primary care team • Improved access to pharmacist services • Consumer empowerment • Safe supply of medicines to the consumer • Improved support for at-risk populations • More use of pharmacists as a first point of contact within primary care.	National
National Transport Agreement	Change to taxi transport for patients undergoing renal dialysis. Provider change and also patients supported may change depending on patient's clinical need.	• Appropriate usage of NTA using the national criteria	Hutt and Capital & Coast
Cancer Services	The three cancer services (Haematology, Medical, Oncology) all have experienced increasing demand which has led to capacity and resource constraints. A programme will be developed for these services that will: – identify opportunities for performance improvement implement a sustainable performance improvement process, including improved access to performance information.	• To manage demand and ensure the provision of affordable, high quality and safe services into the future.	Regional and Local

Sub-regional clinical services planning	As part of Hutt DHB's clinical services plan development, further work is now required to understand the sub-regional opportunities in the configuration of specialist hospital services in particular. A programme of work will be initiated to review potential configurations of some specialist services across HVDHB and CCDHB.	• Value for money • Improved clinical capacity and sustainability • Improved health outcomes	Hutt and Capital & Coast
Home and community support services	The DHB is reviewing its commissioning of Home and Community Support Services for people over 65 years of age, which may result in the procurement of these services in 2018/19. This may result in new providers entering the market for these services, and will result in the transition of some clients from the existing provider to another provider.	• Improved health outcomes • Address health inequities • Improved responsiveness to older persons	Hutt and Capital & Coast
Inpatient mental health services models of care	Following significant issues with the physical space of our Te Whare Ahuru mental health inpatient unit, the DHB has embarked on a revised model of care for inpatient services to best determine the options for a facility rebuild, as well as the options for improved step down acute options.	• Improved health outcomes • Improved patient experience • Improved responsiveness to Māori health	Local
Community Podiatry	Following a review of community-based podiatry services, the DHB has capped the number of funded visits for people requiring community-based podiatry visits to up to four per year. Patients who can be appropriately managed by their primary care team (as per national assessment criteria) will also shift from receiving services from a podiatrist to their primary care team.	• Better value for money • Patients appropriately managed by the right health care professional	Local
Community integration	Following a review of the way in which our DHB community teams operate across the system (and most importantly with primary care) a project has been established to consider how the DHB community workforce can better integrate with primary care teams. The workforce will work differently with different patient groups.	• Value for money • Improved responsiveness • More time spent on clinical care • Improved outcomes for elderly in particular	Local
Community Pharmacy	Following the development of a Hutt Valley pharmacist services strategy, the DHB will consult with stakeholders on the core components of the strategy, and move to implement the resulting key recommendations. In conjunction with the new agreement for community pharmacy services, the DHB will review the community pharmacy long term conditions service and consult with stakeholders on any proposed changes.	• Improved health outcomes • Address health inequities • Value for money	Local
Mental health	An investment review of local mental health services is near completion and that, along with guidance from the mental health inquiry team, will form the basis of an investment approach for the next 10 years which may see changes in what is delivered, where and by whom.	• Improved health outcomes • Address health inequities • Value for money	Local
Whānau ora	The DHB has been working with the two Whānau Ora providers in the Hutt Valley to develop a new agreement with new requirements and new reporting mechanisms. If implemented this will change the way services are funded and how.	• Improved health outcomes • Address health inequities • Value for money	Local
Palliative care	Following a review of palliative care services, the DHB is working with Te Omanga Hospice to review the resourcing and services they provide to palliative care patients. The proposed model of care is a departure to the current model.	• Improved health outcomes • Address health inequities • Value for money	Local
Clinical Services Plan	With the Clinical Services Plan nearly complete, an implementation plan will be developed that will see changes in how clinical services are currently configured. At this stage, the quantum of change in the first year is not known.	• Improved health outcomes • Address health inequities • Value for money	Local

SECTION FOUR: Stewardship

4.1 Managing our Business

Regional Public Health

Regional Public Health (RPH) is the public health unit for the sub-region (Wairarapa, Hutt Valley, and Capital & Coast DHBs). Organisationally, RPH is part of Hutt Valley DHB. The three DHBs work in partnership with RPH in their work on health promotion/improvement, enhancing the effectiveness of prevention activities in other parts of the health system, and regulatory services. The details about the activities of RPH are contained in the Regional Public Health 2018/19 Annual Plan.

A key focus for 2018/19 is collaboration on the development of a sub-regional health promotion work programme. The programme will demonstrate how RPH, the DHBs, PHOs, and community providers are leveraging the investment and coordinating their health promotion activities, both locally and sub-regionally, to deliver collective impact on national and local priorities. Improving equity of outcomes for Māori, Pacific, and people on low incomes will be a focus throughout the work programme.

Organisational performance management

Hutt Valley DHB's performance is assessed on both financial and non-financial measures, which are measured and reported at all levels of the organisation. These are reported daily, weekly, fortnightly or monthly as appropriate.

Funding and financial management

The Hutt Valley DHB's key financial indicators include performance against the DHB operating budget, FTE management within the FTE budget, and DHB cash position. These are assessed and reported through Hutt Valley DHB's performance management process to the Executive Leadership Team, the Finance Risk and Audit Committee and the Board on a monthly basis. The DHB's cash position is also monitored on a daily basis by the DHB finance team. Further information about Hutt Valley DHB's planned financial position for 2018/19 and out years is contained in the Financial Performance Summary section of Hutt Valley DHB's Statement of Performance Expectations 2018/19.

Investment and asset management

In 2018/19 the Hutt Valley DHB will progress work on its integrated strategic investment planning programme. This work will be guided by a number of plans being developed that sit under our overarching strategy in *Our Vision For Change*. These plans include:

- A Māori Health Strategy to provide detailed guidance on achieving equitable health outcomes for Māori in Hutt Valley DHB.
- A Wellbeing Plan focussed on prevention, strengthening whānau and communities, and addressing the wider determinants and environmental factors that impact our physical and mental wellbeing.
- A Clinical Services Plan for the Hutt Valley, which examines strategic options for service changes to achieve health improvements for our population in a clinically and financially sustainable manner.
- An infrastructure plan for the hospital campus that aligns our future infrastructure needs with our Vision for Change and our Clinical Services Plan. This will define the size and type of the likely footprint required on the hospital campus.

As these key planning milestones are achieved, Hutt Valley DHB's Long Term Investment Plan (LTIP) will be updated. In addition, the LTIP will reflect developments in regional planning programmes and strategies.

Shared service arrangements and ownership interests

Hutt Valley DHB has a part ownership interest in Allied Laundry and NZ Health Partnerships. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management

Hutt Valley DHB has a formal risk management and reporting system, with monthly reporting to the Hutt Valley DHB Finance, Risk and Audit Committee via the Executive Leadership Team. The Hutt Valley DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality assurance and improvement

Hutt Valley DHB's approach to quality assurance and improvement is in line with 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 sustainable management of resources
- For our organisation – a thriving, socially responsible, organisation as a result of our culture, clinical leadership, engagement and workforce development.

Hutt Valley DHB's clinical and corporate governance structure ensures that systems are in place to optimise patient care and minimise risks, whilst continuously monitoring and improving the quality of clinical care. The framework for reporting on quality assurance activity occurs at every level across the hospital, with our primary care partners, and across the sub-region. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

Hutt Valley DHB also has a strong and positive culture of continuously improving the quality and safety of the services we provide. Our quality goals are underpinned by a culture of working together at all levels across the Hutt Valley health system and with our neighbouring DHBs. Our culture encourages openness and transparency, learning from error or harm, and ensuring that the contribution of staff from all levels of the DHB for quality improvement and innovation are truly valued. We are working to strengthen multi-disciplinary team-based structures within the DHB to ensure that care and treatment options are well considered and patient centred. Quality improvement training and 'improvement clinics' are also provided to build understanding of quality improvement throughout the organisation.

4.2 Building Capability

Capital and infrastructure development

Key strategic capital investments continue to be IT related, including the programme of work on the Regional Informatics Programme.[21] Investment will be required on the DHB infrastructure, and this will be informed by the Clinical Services Plan and the Master Site Plan. Hutt Valley DHB is also improving the effectiveness and efficiency of human resources, and work is underway to upgrade and streamline our recruitment, induction, and performance management processes and systems across the DHB.

Workforce

Hutt Valley DHB is building a workforce that is responsive to, and reflects, the populations we service. We value cultural intelligence and are working to enhance and grow the cultural safety of our workforce. This work includes the development of a sustainable Māori workforce plan and further staff development of

[21] The Regional Informatics Programme is a significant programme that will centralise the acquisition, storage, retrieval, and use of patient information across the Central Region's six DHBs.

cultural safety, in particular Tikanga (Māori customs and traditional values) and Te Ao Māori (the Māori world). Our Pacific Health Unit continues to deliver cultural support through training for health practitioners within the hospital and out in primary care. These activities support our collaboration with primary care partners to improve and achieve health equity and outcomes for Māori and Pacific people.

Enhancing employee engagement remains a key focus and we are developing a whole of DHB strategic workforce development plan. Our aim is to make Hutt Valley DHB a place where our people love to work and where our patients receive the best possible care 'every person, every time'. Together we have created a vision for people's experience working and being cared for here, and we continue to embed our core values[22] (including the health, safety and wellbeing of staff) into how we work together to deliver a great service to our community.

A nursing workforce strategy will be developed that will identify and bring together a number of existing initiatives, including developing the DHB's Kaiāwhina workforce (Health Care Assistants), enhancing resilience of the nursing workforce, and implementation of the Care Capacity Demand Management project.[23] Developing clinical workforces for practicing at the top of scope and implementing flexible work models will support the introduction of new models of care. Work will continue on developing the essential support services staff, through NZQA training and extending the Gateway programme in collaboration with nursing.[24]

To ensure a consistent approach to leadership and workforce planning, Hutt Valley DHB works collaboratively with the national and regional DHB General Managers Human Resources group, Central Technical Advisory Services (through the Regional Director – Workforce), Health Workforce New Zealand and the State Services Commission. Further detail about the Central regional approach to workforce is contained in the 2018/19 Central Regional Service Plan.

Co-operative developments

Hutt Valley DHB works and collaborates with a number of external organisations and entities on delivery of programmes and initiatives contributing to the Hutt Valley health system. These organisations and entities have a role in delivering the priority action areas noted in Hutt Valley DHB's Annual Plan.

4.3 Workforce

Healthy Ageing Workforce

During 2018/19 the DHB will work closely with regional DHB shared services to continue its work to identify the workforce requirements around the service delivery needs for services to older people and their family / whānau / informal carers. This work builds on current data collection processes and continues within the context of existing sub-regional service developments and national workforce programmes, including the ongoing implementation of pay equity, guaranteed hours, in-between travel and regularisation. The work will enable development of a workforce plan that ensures those working with older people have the training and support they require to deliver high-quality, person-centred care.

The workforce plan will:

- focus on the primary, secondary and tertiary service requirements and endeavour to bring together the respective workforces needed to deliver these services effectively at the DHB and regional levels

[22] Our core values are: *Always caring, Can do, In partnership, and Being our best.*

[23] Care Capacity Demand Management is a programme for matching care capacity with care demand, and aims to enable staff to provide high quality and safe care to our patients, improve the work environment and improve organisational efficiency.

[24] Gateway is a government funded programme that provides opportunities for students to participate in workplace learning and achieve workplace qualifications while still at school.

- include strategies to support specialist workforces to deliver education and training sessions for non-specialist workforces
- prioritise allied health, kaiāwhina and carer and support staff workforces
- identify and prioritise other vulnerable workforces
- refer to and incorporate guidance and actions outlined in the Healthy Ageing Strategy.

Health Literacy

Hutt Valley DHB works closely with its contracted providers, regional DHB shared services, and Regional Public Health to promote and co-ordinate action to raise awareness of, and build skills in, health literacy practice among the health workforce and across the health system. Activities to build health literacy are being progressed by Hutt Valley DHB under each of the six dimensions of a health-literate organisation.[25] Examples include:

- *Leadership and management:* The importance of working in partnership with patients and their whanau, and genuinely listening and enhancing heath literacy, is reflected in HVDHB's core organisational values (*Always caring, Can do, In partnership, and Being our best*) and in the co-design processes within the integration programme.
- *Consumer involvement:* Hutt Valley DHB receives consumer feedback through its complaints and compliments processes, patient experience surveys and consumer group forums. This information is analysed and directly informs continuous quality improvements. Hutt Valley DHB is also establishing a Consumer Council – with members from diverse backgrounds, experiences and knowledge – to provide advice to the DHB's leaders and Board as an important voice in decision-making.
- *Workforce:* Hutt Valley DHB encourages and supports staff to develop effective health literacy practices, including courses and workshops offering advice on communicating with patients, both in person and in writing.
- *Meeting the needs of the population:* Health promotional activities and initiatives are undertaken by contracted providers (such as primary care and Māori and Pacific providers), collaborative partners (such as Healthy Families Lower Hutt), and Regional Public Health in a variety of settings where Hutt Valley residents work, learn and play. These activities raise awareness and promote healthy choices across a range of topics.

  Pacific and Māori health teams work with patients to make them feel more at ease and to support them while in the hospital. In the community, Whānau Ora navigators work closely with whānau to help them achieve their health goals.
- *Communication:* Hutt Valley DHB has embraced the Choosing Wisely campaign, which aims to promote a culture where patients and health professionals have well-informed conversations around their treatment options. This leads to improved health literacy and a better understanding of what really matters to patients, as well as better decisions and improved outcomes (and where low-value and inappropriate clinical interventions are avoided).

Care Capacity Demand Management

The Care Capacity Demand Management (CCDM) programme enables the DHB to invest effectively by getting an accurate forecast of patient demand and matching the required resources as closely as possible (in staff numbers and skill mix). Hutt Valley DHB is committed to fully implementing the CCDM programme by 30 June 2021.

[25] Ministry of Health. 2015. *Health Literacy Review: A guide*. Wellington: Ministry of Health.

4.4 Information Technology and Communication Systems

Information technology and communications systems (ICT) are integral to shorter, safer patient journeys, supporting new models of care and service delivery, and sustainable health services for our population. Hutt Valley DHB works with sub-regional and regional DHBs to invest in a range of improvements to our ICT systems that are aligned to the regional priorities and Digital Health 2020. Updates on specific projects are included below.

Implementation of the National Maternity System

The National Maternity System is a new way of collecting, sharing and viewing maternity and neonatal data that will support women to be involved in their own care and, in time, enable them to have electronic access to their maternity information. Planning for the adoption of the National Maternity System is continuing with implementation planned for 2019/20.

Provision of health services via digital technology

Hutt Valley DHB is working to deploy a modern and integrated digital solution that enables regional sharing of information, optimal use of clinical resources, and new models and processes of care to be supported. In 2018/19, work is being progressed on a common regional Shared Care Record for use by community, primary, and hospital health services across the Central Region. The Shared Care Record allows authorised health practitioners involved in a patient's care to access up-to-date health information from the patient's medical centre. It also enables the patient to view and participate in their care plans with online, self-service options.

Implementation of establishing a platform for deployment of eVitals

eVitals is a system for the digital collection of nursing observations and assessments alerting clinicians to deterioration in a patient's health. The real-time system eliminates the need to search for records to identify patterns, ultimately resulting in more clinical time to focus on the patient. Hutt Valley DHB will pilot an eVitals system in 2018/19.

Implementation of access to NZePS community dispensed medicines for medicines reconciliation

The NZ ePrescription Service provides a secure messaging channel for prescribing and dispensing systems to exchange prescription information electronically. It enables a health practitioner to review the medicines the patient is actually taking and check them against what they should be taking (medicines reconciliation). In 2018/19, Hutt Valley DHB will implement hospital access to the NZ ePrescribing Service (dispensing) and Medi-Map (rest homes) to support medicines management and reconciliation.

Sharing of data between secondary and primary providers in the Mental Health & Addiction service

An integrated client management system between providers of mental health services is expected to be completed in 2018/19.

Further details about the IT projects and their milestones are provided in the table below.

Government Planning Priority	DHB Key Response Actions to Deliver Improved Performance		Measures
	Activity	Milestones	
National Maternity System: implementation of the National Maternity System	1) Complete the planning for adoption of the National Maternity System with a view of implementation in 2019/20	**Q4**	Regular Reporting to Executive Leadership Team Quarterly update meetings with the MoH Digital Portfolio Team
Digital Health Services: provision of health services via digital technology across the health system; for example telehealth, integrated care and working remotely	1) Complete transition to the Indici Shared Care Record	**Q2**	Regular Reporting to Executive Leadership Team
	2) Progressively expand the use cloud based tools to support team based communications, Multi- Disciplinary Meetings and telehealth/virtual care	**Ongoing**	Reporting to the 3DHB Information Management Alliance and the Hutt Valley Alliance Leadership Team (Hutt INC).
	3) Transition to a smart GP eReferrals platform	**Q4**	Quarterly update meetings with the MoH Digital Portfolio Team
	4) Implement enablers for a Community Health Service including single referral point and staff scheduling tools	**Q3**	
	5) Implement 1-Click Access for GPs to their patient's hospital record	**Q2**	
	6) Implement a Shared Care Planning tool using Indici	**Q4**	
Patient Observations : implementation of establishing a platform for deployment of eVitals	1) Business Case and pilot for a Patient Observations Platform	**Q3**	Business case signed off/ pilot completed and assessed
	2) Plan for the rollout of Patient Observations	**Q4**	Quarterly update meetings with the MoH Digital Portfolio Team
Medication Management: implementation of access to eNZPS community dispensed medicines for medicines reconciliation	1) Implement hospital access to NZ ePrescribing Service (dispensing) and Medi-Map (rest homes) to support medicines look up / reconciliation	**Q3**	Monthly reporting to the 3DHB eMedications Strategy Governance Group Regular Reporting to Executive Leadership Team
	2) Develop an eMedication Management Roadmap	**Q2**	Quarterly reporting through to MoH Digital Portfolio Team
	3) Business case and RFP for a Hospital ePrescribing Solution	**Q4**	
MHAIDS : sharing of data between secondary and primary providers in the Mental Health & Addiction service	1) Completion of Phase 2 of the Client Referrals Pathways project to complete the fully integrated client management system between secondary and primary providers of mental health services.	**Q4**	Regular Reporting to Executive Leadership Team Quarterly update meetings with the MoH Digital Portfolio Team

Government Planning Priority	DHB Key Response Actions to Deliver Improved Performance		Measures
	Activity	Milestones	
IT Planning : demonstrate how they plan to implement Application Portfolio Management including the lifecycle for IT systems ie, planned upgrades, support, licence renewal, etc	1) Develop a reference architecture 2) Implement Asset Management and Application Catalogue systems for ICT systems & applications, linked to the reference architecture 3) Updated Long Term Investment Plan for DHB critical assets (Category 1 & 2) with upgrade dates and plans	**Q2** **Q2** **Q4**	Reporting through the Long Term Investment Plan Regular Reporting to Executive Leadership Team Quarterly update meetings with the MoH Digital Portfolio Team
IT Security commit to constructively engage with the Ministry and other health sector members in the establishment of a projected programme of IT Security maturity activities.	1) Assessment of security controls against the NZ Information Security Manual, including risks and mitigations 2) Develop a joint Wairarapa, Hutt Valley and Capital & Coast Security Work Programme for 2018-20 3) Engagement in the National Health Security Forum	**Q2** **Q3** **Ongoing**	Monthly reporting to the 3DHB Information Privacy and Security Governance Group Update meetings with the Ministry Chief Security Advisor Annual Operational Assurance Plan to Government Chief Information Officer
National/Regional Alignment Demonstrate National/Regional Alignment and where they are leveraging investments	1) Regional Clinical Portal : Complete Data Replication from Local to Regional Portal 2) Regional Radiology System : Complete Migration 3) National Screening Solution: Initiate scoping and planning 4) National EHR : Contribute to the development of a the Single Electronic Health Record 5) National Maternity Clinical Information System	**Q3** **Q4** **Q4**[26] **As required**[27] **See Maternity System above**.	Regular Reporting to Executive Leadership Team Quarterly reports from Regional ICT Lead.

[26] Dependent on the Ministry of Health completing design and establishment of a National Platform, and the development of a National schedule for DHB transition.

[27] Dependent on Cabinet approval of the Indicative Business Case.

Government Planning Priority	DHB Key Response Actions to Deliver Improved Performance		Measures
	Activity	Milestones	
Digital Capability: Demonstrate plan and initiatives aimed at improving the digital capabilities within their organisation.	1) Pilot of Electronic desk-based and Mobile Laboratory Ordering	**Q4**	Regular Reporting to Executive Leadership Team
	2) Further development of Ward and Service Electronic Whiteboards	**Q4**	Quarterly reports from Regional ICT Lead.
	3) Implement of a Capacity Planning tool to forecast and manage demand for services	**Q2**	
	4) Mobile Application Development Programme to develop high value mobile clinical apps	**Q4**	
	5) Implement a Scanning capability for medical records	**Q1**	
	6) Implement Office 365 suite of tools	**Q4**	
	7) eMedication Management	**See Medication Management above**	

Further details about regional IT initiatives are contained in the 2018/19 Central Regional Service Plan.

SECTION FIVE: Performance Measures

2018/19 Performance Measures

The DHB monitoring framework aims to provide a rounded view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- achieving Government's priority goals/objectives and targets or 'Policy priorities'
- meeting service coverage requirements and supporting sector inter-connectedness or 'System Integration'
- providing quality services efficiently or 'Ownership'
- purchasing the right mix and level of services within acceptable financial performance or 'Outputs'.

Each performance measure has a nomenclature to assist with classification as follows:

Code	Dimension
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – establishment of baseline (no target/performance expectation is set)

Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2018/19.

The following tables set out the range of DHB performance measures for 2018/19.

5.1 Performance dimension: Policy priorities

Achieving the Government's goals/objectives and targets or policy priorities.

Performance Measure	Performance Expectation	Target Groups	Hutt Valley Target	National Target	Reporting Frequency	Reference to Key Health Priority in AP
HS - Support delivery of NZ Health Strategy	One brief example (single dot point) per strategy theme each quarter, to highlight an action, initiative or activity delivered in the quarter. These highlights will be included on the DHB quarterly dashboards for sharing with the Minister (no performance assessment will be made).				Quarterly	All
PP6: Improving the health status of people with severe mental illness through improved access	% population accessing specialist mental health services	Age 0-19	4.43%	-	Six-monthly	Mental Health
		Age 20-64	5.16%	-		
		Age 65+	1.8%	-		

Performance Measure	Performance Expectation	Target Groups	Hutt Valley Target		National Target	Reporting Frequency	Reference to Key Health Priority in AP
PP7: Improving mental health services using wellness & transition (discharge) planning	% clients discharged with a plan	Community clients	≥95%	Report on activities in Annual Plan	≥95%	Quarterly	Mental Health and Addictions Improvement Activities
		Long term clients					
		Inpatient clients					
	% clients with a plan of acceptable quality	Community clients	≥95%		≥95%	Quarterly	
		Long term clients					
		Inpatient clients					
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	% of people ≤19 years old seen by Mental Health Provider Arm	Within 3 weeks	≥80%	Report on activities in Annual Plan	≥80%	Quarterly	Addictions
	% of people ≤19 years old seen by Mental Health Provider Arm	Within 8 weeks	≥95%		≥95%		
	% of people ≤19 years old seen by Addictions Services (Provider Arm and NGO)	Within 3 weeks	≥80%		≥80%		
	% of people ≤19 years old seen by Addictions Services (Provider Arm and NGO)	Within 8 weeks	≥95%		≥95%		
PP10: Oral health: Mean Decayed/Missing/ Filled Teeth score at year 8	Mean DMFT for children examined in the Year 8 group	Year 1	<0.63		-	Annual	Child Wellbeing
		Year 2	<0.63				
PP11: Children caries-free at 5 years of age	% caries-free in children examined at 5 years old	Year 1	65%		-	Annual	Child Wellbeing
		Year 2	65%				
PP12: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to & including 17 years	% access to DHB-funded adolescent dental services	Year 1	>85%		-	Annual	Child Wellbeing
		Year 2	>85%				
PP13: Improving the number of children enrolled in DHB funded dental services	% of pre-school children enrolled in DHB-funded dental services	Year 1	≥95%		-	Annual	Child Wellbeing
		Year 2	≥95%				
	% of enrolled pre-school and primary school children overdue for their scheduled examinations	Year 1	≤10%		-		
		Year 2	≤10%				

Performance Measure	Performance Expectation	Target Groups	Hutt Valley Target	National Target	Reporting Frequency	Reference to Key Health Priority in AP
PP20: Improved mgmt for Long Term Conditions	Focus Area 1: Long Term Conditions	Report on delivery of actions and milestones			Quarterly	CVD and Diabetes
	Focus Area 2: Diabetes Services	Report on implementation of Living Well with Diabetes plan.		-	Quarterly	
		Improve, or where high maintain, proportion of patients with good or acceptable glycaemic control.				
	Focus Area 3: Cardiovascular Health Indicator 1: % eligible population who have had their cardiovascular risk assessed in the last five years	Māori males 35-44 years	90%	90%	Quarterly	
		Māori				
		Pacific				
		Other				
		Total				
	Focus Area 4: Acute Heart Service	Indicator A: % of high-risk patients receiving an angiogram within 3 days of admission	>70%	70%	Quarterly	Primary Care Integration
		Indicator B: % of Acute Coronary Syndrome (ACS) patients undergoing coronary angiography having registry data completion within 30 days of discharge	>95%	≥95%	Quarterly	
		Indicator C: % of ACS patients undergoing coronary angiography having registry data completion within three months day of discharge	>99%	≥99%	Quarterly	
		Indicator E: % of ACS patients who undergo coronary angiogram and have a pre-discharge assessment of left ventricular ejection fraction (LVEF)	≥85%	≥85%	Quarterly	Primary Care Access
		Indicator F: Composite Post ACS Secondary Prevention Medication Indicator: % ACS patients who undergo coronary angiogram and – in the absence of a documented contraindication/intolerance – are prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACEI/ARB (4-classes), and – those with LVEF<40% – a beta-blocker (5-classes)	≥85%	≥85%	Quarterly	

Performance Measure	Performance Expectation	Target Groups	Hutt Valley Target	National Target	Reporting Frequency	Reference to Key Health Priority in AP
	Focus Area 5: Stroke Services	Indicator A: % of potentially eligible stroke patients thrombolysed 24/7	≥10%	≥10%	Quarterly	Primary Care Integration
		Indicator B: % of stroke patients admitted to a stroke unit/service with a demonstrated stroke pathway	80%	80%	Quarterly	
		Indicator C: % of patients admitted with acute stroke transferred to inpatient rehabilitation services within 7 days of acute admission	80%	80%	Quarterly	
		Indicator D: % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge	60%	60%	Quarterly	
PP21: Immunisation coverage	% of children fully immunised at age 24 months	Māori	≥95%	Report on activities in the Annual Plan	≥95%	Quarterly	Child Wellbeing Immunisation Healthy Aging
		Pacific				
		Total				
	% of children fully immunised at age 5	Māori	≥95%		≥95%	Quarterly	
		Pacific				
		Total				
	% of eligible girls fully immunised against HPV	Māori	≥75%		≥75%	Annual	
		Pacific				
		Total				
	% of population aged 65 years and over immunised against influenza annually	Māori	≥75%		≥75%	Annual	
		Pacific				
		Total				
PP22 Improving system integration (SLM)		Report on delivery of actions and milestones to improve integration as identified in the Annual Plan.		-	Quarterly	Primary Care Integration Improving Quality
PP23: Implementing the Healthy Ageing (HA) Strategy		Part 1: Report on actions and milestones to deliver on commitment to implement the Heathy Ageing Strategy across 5 action areas: 1a: Future Models of Care 1b: Integrated Falls & Fracture Prevention and Rehabilitation services 1c: Actions to improve Equity 1d: Workforce regularisation 1e: Locally prioritised actions		-	Quarterly	Healthy Aging
		Part 2: InterRAI Assessment Conversion rate of Contact Assessment (CA) to Home Care assessment where CA scores are 4 – 6 for assessment urgency		Baseline to be established	Quarterly	

Performance Measure	Performance Expectation	Target Groups	Hutt Valley Target	National Target	Reporting Frequency	Reference to Key Health Priority in AP
PP25: Prime Minister's youth mental health project	Initiative 1: School Based Health Services	Progress report on actions to implement initiatives for Prime Minister's Youth Mental Health project		-	6-monthly	Mental Health
	Initiative 3: Youth Primary Mental Health				Quarterly	Primary Care Access
	Initiative 5: Responsiveness of primary care to youth				Quarterly	
PP26 the Mental Health & Addiction service development plan	Focus Area 1: Primary Mental Health	Narrative report and quantitative report on services delivered		-	Quarterly	Mental Health
	Focus Area 2: Suicide prevention and post vention	Report on activities		-		
	Focus Area 3: Improving crisis response	Report on actions making a difference		-		
	Focus Area 4: Improving outcomes for children	Report on progress implementing the *Supporting Parents, Healthy Children* guidelines and actions in the Annual Plan to improve outcomes for children		-		Child Wellbeing
	Focus Area 5 Improving employment and physical health needs of people with low prevalence conditions	Report of actions in the Annual Plan for improving the physical and employment outcomes of people with low prevalence conditions		-		
PP27 Supporting child wellbeing	Report on activities in the Annual Plan			-	Quarterly	Child Wellbeing
PP28 Reducing Rheumatic Fever	Reducing incidence of First Episode RF. (Hospitalisation rate per 100,000 popln.)	Māori	<1.6 per 100,000	<1.6	Contract reporting	Child Wellbeing
		Pacific				
		Total				
PP29 Improving waiting times for diagnostic services	Elective Coronary Angiography: % of accepted referrals receiving angiography within 90 days		95%	95%	Monthly	Access to Elective Services
	Computed Tomography : % of accepted referrals receiving scan within 42 days		95%	95%		
	Magnetic Resonance Imaging: % of accepted referrals receiving scan within 42 days		90%	90%		
	Urgent Diagnostic Colonoscopy: % of accepted referrals receiving procedure within 14 days		90%	90%		
	Urgent Diagnostic Colonoscopy: % of accepted referrals receiving procedure within 30 days		100%	100%		
	Non-Urgent Diagnostic Colonoscopy: % of accepted referrals receiving procedure within 42 days		70%	70%		

Performance Measure	Performance Expectation	Target Groups	Hutt Valley Target	National Target	Reporting Frequency	Reference to Key Health Priority in AP
	Non-Urgent Diagnostic Colonoscopy: % of accepted referrals receiving procedure within 90 days		100%	100%		
	Surveillance Colonoscopy: % of people receiving procedure within 84 days		70%	70%		
	Surveillance Colonoscopy: % of people receiving procedure within 120 days		100%	100%		
PP30 Faster Cancer treatment	% patients receiving their first cancer treatment (or other management) within 31 days from date of decision to treat		≥85%	≥85%	Quarterly	Access to Elective Services
	Report on activities in the Annual Plan			-		
PP31 Better help for smokers to quit in public hospitals	% adults admitted to public hospital as inpatients who smoke receiving brief advice and support to quit smoking		≥95%	≥95%	Quarterly	System Level Measures
PP32: Improving the quality of ethnicity data collection in the PHO and NHI registers	Progress report on implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).				6-monthly	Primary Care Integration Improving quality
PP33: Improving Māori enrolment in PHOs to meet national average	Maori enrolment in PHO		≥90%	≥90%	6-monthly	Primary Care Integration
PP36: Reduce rate of Māori under the Mental Health Act section 29: community treatment orders	Reduce the rate of Maori under the Mental Health Act (s29) by at least 10% by (reporting) year end.		10% reduction	10% reduction	Quarterly	Mental Health
PP37: Improve breastfeeding rates	% babies exclusively or fully breastfed at 3-months	Māori	70%		6-monthly	Child Wellbeing
		Pacific				
		total				
PP39 Supporting Health in Schools	Report on activities in the Annual Plan			-	6-monthly	Health in Schools
PP40 Responding to climate change	Report on activities in the Annual Plan			-	6-monthly	Climate Change
PP41 Waste disposal	Report on activities in the Annual Plan			-	6-monthly	Waste Disposal
PP43 Population mental health	Report on activities in the Annual Plan			-	6-monthly	Mental Health
PP44 Maternal mental health	Report on activities in the Annual Plan			-	6-monthly	Maternal Mental Health
PP45: Elective surgical discharges	100% of 6,192 publicly funded, casemix included, elective and arranged discharges for people living within the DHB region				Quarterly	Access to Elective Services

5.2 Performance dimension: System Integration

Meeting service coverage requirements and supporting sector inter-connectedness.

Performance Measure	Performance Expectation	Target Groups		Hutt Valley Target	National Target	Reporting Frequency	Reference to Key Health Priority in AP
SI1: Ambulatory Sensitive Hospitalisations (ASH)	Reduction in ethnic disparity for ASH rates per 100,000 population	Age 0-4	Māori	See System Level Measure Improve-ment Plan Appended	ASH targets set with aim to eliminate equity gap over 2-5 yr period	Quarterly	Child Wellbeing
			Pacific				
			Other				
		Age 45-64	Māori	Total population: ≤3948	ASH targets set with aim to eliminate equity gap over 2-5 yr period	6-monthly	Primary Care Integration
			Pacific				
			Other				
SI2: Delivery of Regional Service Plans (RSP)	Part 1: Progress Report	Regional progress report on RSP priorities agreed by all DHBs in Central region including actions to support Healthy Ageing strategy (interRAI and Dementia)			-	Quarterly	All regional priorities
	Part 2: Hepatitis C Virus (HVC)	Regional report: # people diagnosed with hepatitis C, by age			-	6-monthly	
		Regional report: # HCV patients who have had a Liver Elastography Scan in the last year, new & follow up by age and ethnicity			-		
		Regional report: # people receiving PHARMAC funded antiviral treatment per annum, by age and ethnicity			-		
SI3: Ensuring Delivery of Service Coverage	Narrative report covering 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				-	Quarterly	All priorities
SI4: Elective Services Standardised Intervention Rates (SIRs)	Major joints SIR per 10,000			21	21	Annual	Access to Elective Services
	Cataracts SIR per 10,000			27	27	Annual	
	Cardiac surgery SIR per 10,000			6.5	6.5	Quarterly	
	Percutaneous revascularisation SIR per 10,000			12.5	12.5	Quarterly	
	Coronary Angiography SIR per 10,000			34.7	34.7	Quarterly	
SI5: Delivery of Whānau Ora	Mental Health	Progress report			-	6-monthly	Mental Health Child Wellbeing
	Asthma	Progress report			-		
	Oral health	Progress report			-		
	Obesity	Progress report			-		
	Tobacco	Progress report			-		
SI7: Total Acute Hospital Bed Days per capita	As specified in jointly agreed (by Hutt Alliance) SLM Improvement Plan. See SLM IP in the Appendix					Quarterly	Primary Care Integration Improving Quality
SI8: SLM Patient Experience of Care	As specified in jointly agreed (by Hutt Alliance) SLM Improvement Plan. See SLM IP Appended					Quarterly	
SI9: Amenable Mortality Rate	As specified in jointly agreed (by Hutt Alliance) SLM Improvement Plan. See SLM IP Appended					Quarterly	

Performance Measure	Performance Expectation	Target Groups	Hutt Valley Target	National Target	Reporting Frequency	Reference to Key Health Priority in AP
SI10: Improving Cervical Screening coverage.	% coverage for all ethnic groups	Māori Pacific Asian Other Total	>80%	>80%	6-monthly	Primary Care Integration
SI11: Improving Breast Screening coverage.	% coverage for all ethnic groups	Māori Pacific Other Total	>70%	>70%	6-monthly	Primary Care Integration
SI12: Youth access to and utilisation of youth appropriate health services	As specified in jointly agreed (by Hutt Alliance) SLM Improvement Plan. See SLM IP Appended				Quarterly	Primary Care Integration Child Wellbeing
SI13: Number of babies who live in a smoke-free household at six weeks post-natal	As specified in jointly agreed (by Hutt Alliance) SLM Improvement Plan. See SLM IP Appended				Quarterly	
SI14: Disability support services	Report on activities in the Annual Plan			-	6-monthly	Disability Support Services
SI15: Addressing local population challenges by life course	Report on activities in the Annual Plan			-	6-monthly	All priorities
SI16: Strengthening Public Delivery of Health Services	Report on activities in the Annual Plan			-	6-monthly	Strengthening Public Delivery of Health Services
SI17: Improving quality	Report on activities in the Annual Plan			-	6-monthly	Improving Quality
SI18: Improving newborn enrolment in General Practice	% of newborns enrolled in General Practice by 6 weeks of age		55%	55%	Quarterly	Primary Care Integration Immunisation Child Wellbeing
	% of newborns enrolled in General Practice by 3 months of age		85%	85%		
	Report on activities in the Annual Plan					

5.3 Performance Dimension: Ownership

Providing quality services efficiently.

Performance Measure	Performance Expectation	Target Groups	Hutt Valley Target	National Target	Reporting Frequency	Reference to Key Health Priority in AP
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)		1.45	1.45	Quarterly	Disability Support Services priority Improving Quality priority
	Part 2: Acute Inpatient standardised ALOS (ratio of actual to predicted, multiplied by the nationwide inpatient ALOS)		2.3	2.3		

Performance Measure	Performance Expectation	Target Groups	Hutt Valley Target	National Target	Reporting Frequency	Reference to Key Health Priority in AP
OS8: Reducing Acute Readmissions to Hospital Definition under review	Acute readmission rates to hospital within 28 days.	Total	<12.1%	<12.1%	Quarterly	Improving Quality Primary Care Integration
		Age 75+	<12.1%	<12.1%		
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus area 1 NHI identity data quality	% of new NHI registrations in error (causing duplication)	>1% and < =3%	>1% and < =3%	Quarterly	Improving Quality Living within our means
		% of non-specific ethnicity in new NHI registrations	>0.5 and ≤2%	>0.5 and ≤2%		
		% of updates to ethnicity in existing NHI records with a non-specific value	>0.5 and ≤2%	>0.5 and ≤2%		
		% of validated addresses	>76% and ≤85%	>76% and ≤85%		
		% invalid NHI updates	TBA	TBA		
	Focus area 2 National Collections data quality	% of NBRS records with accurate links to NNPAC and NMDS	≥97% and ≤99.5%	≥97% and ≤99.5%		
		% of National Collection records (PRIMHD, NMDS, NNPAC, NBRS) successfully loaded	≥98% and ≤99.5%	≥98% and ≤99.5%		
		% of edited diagnosis code descriptors submitted to the NMDS	≥75%	≥75%		
		% of NNPAC events loaded more than 21 days post month of discharge	≥95% and <98%	≥95% and <98%		
	Focus area 3 Quality of Mental; Health data (PRIMHD)	Routine audit		-		

5.4 Performance dimension: Outputs

Purchasing the right mix and level of services within acceptable financial performance.

Performance Measure	Performance Expectation	Target Groups	Hutt Valley Target	National Target	Reporting Frequency	Reference to Key Health Priority in AP
OP1 Mental Health output delivery against plan.	Variance of planned volumes for services measured by FTE		+/- 5%	+/- 5%	Quarterly	Mental Health
	Variance of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day.		+/- 5%	+/- 5%		
	Actual expenditure on delivery of programmes or places within variance of ytd plan.		+/- 5%	+/- 5%		

APPENDIX: System Level Measures Improvement Plan

HUTT VALLEY DHB HEALTH SYSTEM LEVEL MEASURES PLAN 2018/19

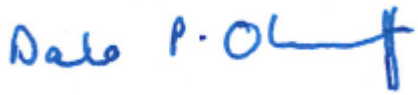
Introduction

This System Level Measures Improvement Plan is the culmination of integration and improvement work undertaken across the Hutt Valley Health System through the Alliance Leadership Team, Hutt INC. This Improvement Plan has been developed to drive the implementation of the Ministry of Health's System Level Measures Framework. The Improvement Plan will be submitted to the Ministry of Health as an Appendix to the 2018/19 Annual Plan.

The System Level Measures are set, defined and monitored nationally. Hutt INC has locally set and agreed the improvement milestones, contributory measures and actions in our key priority areas. Each System Level Measure milestone and contributory measure in the Improvement Plan is based on analysis of local trends to appropriately address the needs and priorities of our population[28].

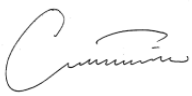
The integration work programme is focused on transforming the prevention and management of Long Term Conditions (LTCs), Child Health (in particular addressing ASH), Youth Health (in particular addressing AOD and mental health issues), Older Persons Health, Mental Health and addressing Acute Demand across the Hutt Valley Health System. The integration work programme aligns well with the SLMF as it works to bring about system wide changes to improve outcomes over a longer period of time. Hutt INC members and other partners[29] across the health system have contributed to our Plan, to ensure actions wider than the integration work programme are captured. Our improvement plan demonstrates the rationale and logic for each SLM and will continue to be monitored by Hutt INC.

Hutt Valley DHB
Dale Oliff, Chief Executive



Te Awakairangi Health Network
Bridget Allan, Chief Executive

Hutt Integrated Network of Care
Chris Masters, Acting Chair



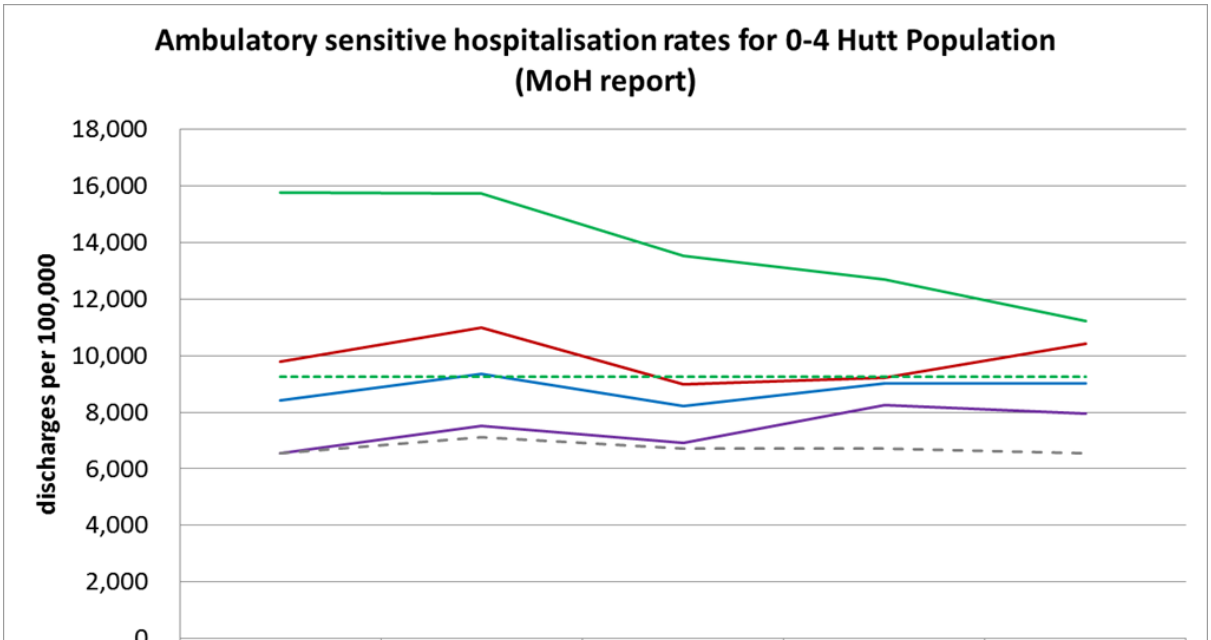
Cosine Primary Care Network Trust
Paul Rowan, Clinical Director and Trustee

[28] *This involved reviewing the System Level Measures (SLMs) and Contributory Measures (CMs) data, MoH guidance, building on our 17/18 Improvement Plan and priorities for 18/19.*

[29] *Including: PHO and DHB clinical, quality and management leads, Maori and Pacific leads, Regional Public Health, Community Health Providers, Network and 3DHB SLA/steering group members.*

Ambulatory Sensitive Hospitalisations for 0-4 year olds – 'keeping children out of hospital'

Where are we now?



	12 months to December 2013	12 months to December 2014	12 months to December 2015	12 months to December 2016	12 months to December 2017
Other	6,557	7,500	6,915	8,251	7,936
Maori	9,790	10,986	8,982	9,228	10,418
Pacific	15,780	15,741	13,524	12,685	11,226
Total	8,429	9,350	8,224	9,022	9,009
National	6,541	7,101	6,729	6,730	6,545
Target	9258	9258	9258	9258	9258

Hutt Valley has high rates of ASH admissions compared to the national average for all populations, but significantly higher rates for Maori and Pacific. Since 2013, there has been a steady decrease in the Pacific ASH rate however our Maori ASH rate remains relatively unchanged with slight fluctuations from year to year. Our top ASH conditions include respiratory (URTI, pneumonia, asthma), dental, gastro/dehydration and cellulitis.

Milestone

Our improvement plan aims to **reduce ASH rates** in 0-4 years per 100,000 children to 10,899 for Pacific and 10,091 for Maori by the end of Q4 18/19[30]. This aims to reduce the equity gap between Hutt Valley Maori and Pacific ASH rate and the New Zealand Total ASH rate by 5% and works to achieve our long term aim of eliminating the equity gap. Reducing ASH rates and disparities for Maori and Pacific remains a top priority for the Hutt Valley and our improvement plan outlines the well-established work programme in this area.

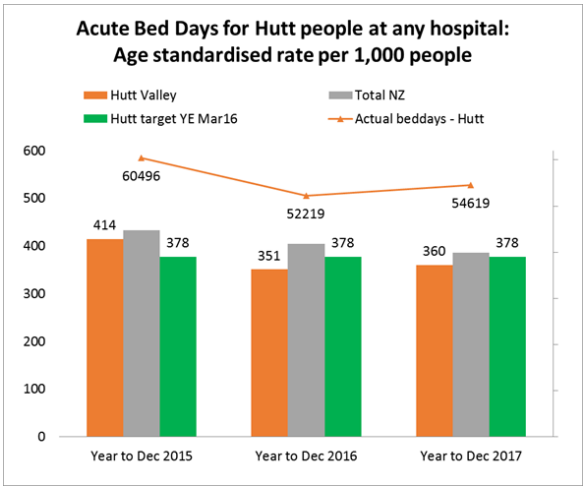
SLM	Improvement milestone by end of Q4 17/18
Hutt Valley total 0-4 years ASH rate per 100,000 children	Maori: 10,091 admissions per 100,000 children Pacific: 10,899 admissions per 100,000 children Note baseline: 12months to December 2017 HV rate total: 9009, Maori: 10418, Pacific: 11226, Other: 7936. NZ rate total: 6545

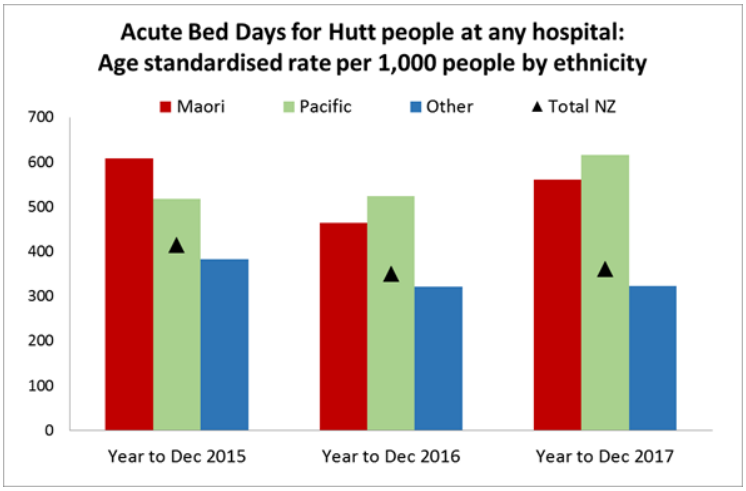
[30] *Note: baseline rate is calculated at 12months year ending December 2017.*

Aim	Actions	Contributory Measures
Reduce ASH rate in 0-4 years per 100,000 to 10,899 for Pacific and 10,091 for Maori by the end of Q4 18/19.	Continue to implement the respiratory work programme throughout 2018/19 to address asthma and respiratory related hospital admissions and disparities for Māori and Pacific. This includes: • Proactive management in general practice for children with previous asthma and respiratory related hospital admissions. • Provide specialist support for primary care in respiratory targeted to practices with the greatest population need. • Increase capacity of the Whānau Respiratory Support Service to improve access to wrap-around support in the community for tamariki and their whānau with respiratory disorders (especially for Maori and Pacific). Increase preventative oral health initiatives and early intervention by: • Health promotion and resources targeting Māori and Pacific • Delivering on-going training to Well Child/Tamariki Ora nurses to "lift the lip" • Increasing examinations for pre-schoolers in target populations • Increasing preventative treatments to target populations • Managing caries in a child-friendly way • Active follow-up of children who miss appointments. Continue to Improve acute and proactive care for people in general practice through the implementation of Health Care Home with an equity focus throughout 18/19. Provide extended care in general practice (especially for childhood ASH conditions) by expanding Primary Options for Acute Care (POAC) to improve acute management in the community by December 2018. Complete the paediatric service review and implement findings to improve primary care access to acute paediatric assessment clinics by July 2019. Continue the automated referral system and increase the number of housing assessments and interventions throughout the well homes healthy housing service throughout 2018/19 (especially for Maori and Pacific). Identify options to establish a wrap-around service to better support children and whānau at risk of poor health and social outcomes by July 2019. This includes: • Complete a stocktake of services provided in the first 1000 days of life to whānau with complex health and social outcomes, to identity any gaps in pathways of care or services. • Co-design potential solutions with health and social service community providers to address service gaps and improve outcomes for tamariki and whanau with complex health and social outcomes.	Asthma and respiratory related ED attendance and hospital admission rate and number for 0-4years (Total & reduce disparity for Maori and Pacific). Paediatric acute readmission rate for 0-4years within 28 days. Dental examination arrears rate (overdue for annual examination) for preschool children aged 0-4 (Total and reduce disparity for Maori and Pacific). Immunisation rate at 8 months (95% target and ensure equity for Maori and Pacific). POAC volumes delivered in primary care for children by ethnicity (Total and ensure equity for Maori and Pacific). Shorter stays in ED 6 hour target by service (90% especially for the paediatric service). Housing sensitive hospitalisation rates by ethnicity (Total & reduce disparity for Maori and Pacific).

Acute Hospital Beds days per Capita – 'Using Health resources effectively'

Where are we now?





Hutt Valley has lower rates of acute hospital beds days per capita than the national average and is primarily due to focused work to improve acute flow. Our acute inpatient Average Length Of Stay (2.30 days) is lower than national average and this is balanced by a standardised acute readmission rate (12.1%) that is in line with the national average.

Acute bed day rates are higher in 0-4 years, 65+ age groups and disparities exist with higher acute bed day rates for Maori and Pacific. This rate fluctuates but increased in the last year for both Maori and Pacific.

The DRG clusters with the highest acute bed days are:

- Total Hutt Valley: Respiratory Infections/Inflammations, Stroke and Other Cerebrovascular Disorders, Heart Failure and Shock.
- Maori: Heart Failure and Shock, Cellulitis, Stroke and Other Cerebrovascular Disorders.
- Pacific: Respiratory Infections/Inflammations, Respiratory Diagnosis with Non-Invasive Ventilation, Cellulitis.

Milestone

Our improvement plan target aims to **reduce acute hospital bed days per capita** for Maori to 542 bed days per 1,000 people and for Pacific to 596 bed days per 1,000 people by the end of Quarter 4, 2018/19. This aims to reduce the equity gap between Hutt Valley Maori and Pacific acute hospital bed day rate and the New Zealand Total rate by 5% each year to achieve our long term target of eliminating the gap[31]. Given our performance in acute bed days, ALOS and readmission rates, the actions in this SLM are focused on community based interventions to avoid hospital admission and reduce disparities.

SLM	**Improvement milestone by end of Q4 17/18**
Hutt Valley total standardised ABD rate per 1,000	Maori: 542 bed days per 1,000 people Pacific: 596 bed days per 1,000 people Note baseline at Dec 2017: HV rate: Maori: 561, Pacific: 615, Other: 323 NZ rate: 386

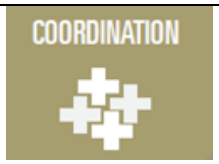
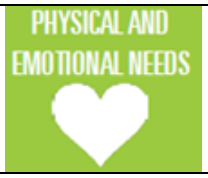
[31] *Note: baseline rate is calculated at 12months year ending December 2017.*

Aim	Actions	Contributory Measures
Reduce Acute Hospital bed day rate per 1,000 people to 542 bed for Maori and 596 bed days for Pacific.	Provide extended care in general practice (especially for ASH conditions) by expanding both the uptake and scope of Primary Options for Acute Care (POAC) to improve the management of acute conditions in the community by December 2018. Continue to Improve acute and proactive care for people in general practice through the implementation of Health Care Home throughout 18/19. Implement the 2018 integrated acute demand initiatives as part of winter surge planning including: winter wellness communications, proactive follow up in primary care for respiratory and LTC patients; same day acute appointment availability in general practice, educational messaging in ED for T4 and T5 patients and acute paediatric hospital flow project. Continue to implement the general medicine service improvement programme throughout 2018/19 including red to green to improve inpatient flow and implementing a specialist support for primary care model. Continue the respiratory work programme including the implementation of: • Respiratory specialist support targeted to general practice with the greatest need, • Expand acute care plans and ambulance management for COPD patients to self-manage and access services in the community. Implement the 3 DHB Older Persons Falls Management Model in the community, including proactive identification of older people at risk of falls, and access to strength and balance programmes and other interventions.	POAC volumes delivered in primary care by condition and ethnicity (Total and ensure equity for Maori and Pacific). ASH rates 0-4 and 45-64 (Total and reduce disparity for Maori and Pacific). Shorter stays in ED 6 hour target (90% and ensure equity for Maori and Pacific). Acute hospital admissions, acute ALOS and acute readmission rate (Total and ensure equity for Maori and Pacific). COPD and respiratory related ED attendances and hospital admissions (Total and reduce disparity for Maori and Pacific). The number of people accessing strength and balance programmes in the community. Falls related hospital admissions in people aged 65+.

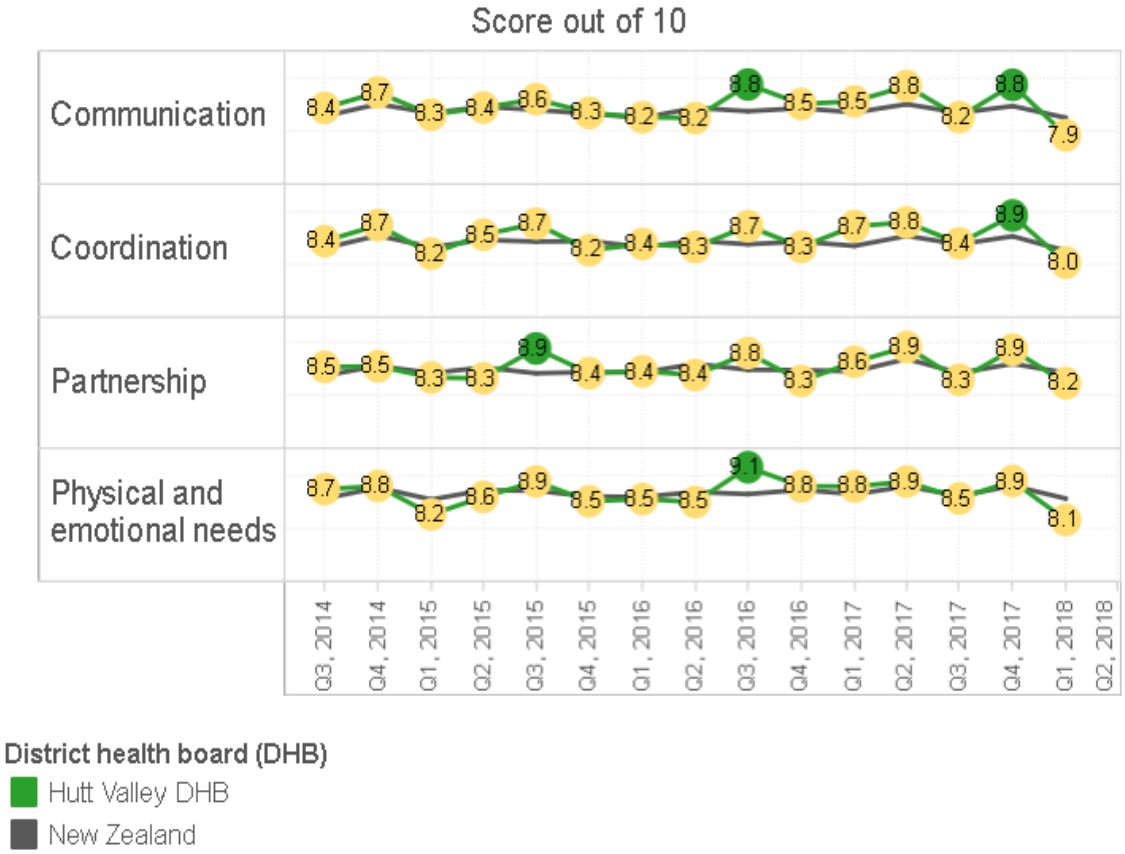
Patient Experience of Care – 'Patient-Centred care'

Where are we now?

Hutt Valley National Inpatient Survey Results[32]:

Domains (Quarter 1 data 2018)				
HV Total	**7.9 (8.1)**	**8.0 (8.1)**	**8.2 (8.4)**	**8.1 (8.3)**
HV Maori	**7.3**	**7.9**	**8.3**	**7.5**
HV Pacific	**9.3**	**8.7**	**9.3**	**9**
NZ Average	**8.2**	**8.2**	**8.4**	**8.5**

[32] *Note: HQSC published data is adjusted for demographics (scores in black). Cemplicity data (scores in red) provides domain scores by ethnicity. Hutt Valley is investigating options to have consistent data across both of these data sources.*



The Hutt Valley National Inpatient Experience Survey scores by domain fluctuate slightly each quarter but remain in line with the national average. There is 100% participation in our district and the Hutt Valley survey response rate remains around the national average (28% in February 2018).

As occurs nationally, there is no special cause variation in the survey results in each of the domains for Hutt Valley DHB. The Hutt Valley DHBs lowest scoring question is in the communication domain with 29% of patients answering 'yes' to "Did a member of staff tell you about medication side effects to watch for when you went home?".

Our improvement plan actions are focused on quality improvement in this domain and specifically to improve the information given to patients about the medication side effects to watch for when patients go home. We will continue to monitor survey response rate and scores by ethnicity to better understand any equity issues that may exist and our consumer co-design work will also support improvements in patient experience of care, especially for Maori and Pacific.

Hutt Valley National Primary Care Survey Results:

Domains (Data at May 2018)	COMMUNICATION	COORDINATION	PARTNERSHIP	PHYSICAL AND EMOTIONAL NEEDS
HV Total	**8.5**	**8.5**	**7.6**	**7.6**
HV Maori	**8.4**	**7.9**	**7.5**	**7.8**
HV Pacific	**7.8**	**7.9**	**7.3**	**7.4**
NZ Average	**8.5**	**8.5**	**7.6**	**7.8**

The primary care patient experience survey has recently been rolled out in the Hutt Valley with 90% participation (19/21 general practices participating).

Hutt Valley survey results by domain are now available and have fluctuated slightly each quarter but remain in line with the national average The Hutt Valley response rate also remains around the national average at 25%. Once rolled out across the Hutt Valley we will continue to monitor response rate and scores by ethnicity to better understand any equity issues that may exist with patient experience of care.

Our improvement plan focuses on continuing to roll out the primary care patient experience of care survey to achieve 100% participation by practices and to increase distribution and response rate. We aim to utilise survey results to identify priorities to advance quality improvement. Our consumer co-design work and patient portal roll out will also support improvements in patient experience of care.

Milestone

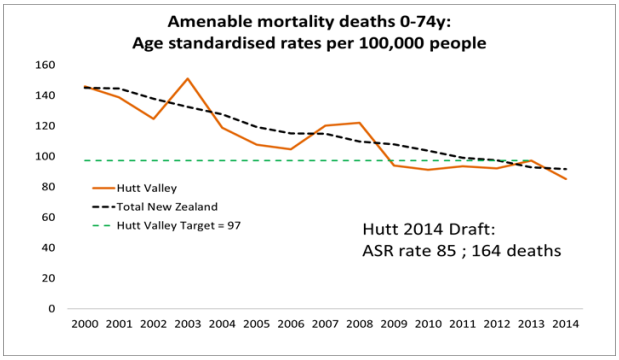
Our improvement plan target aims to **improve our performance in the communication domain** of the Inpatient National Patient Experience of Care to 8.2 (current national average) by Quarter 4, 2018/19[33].

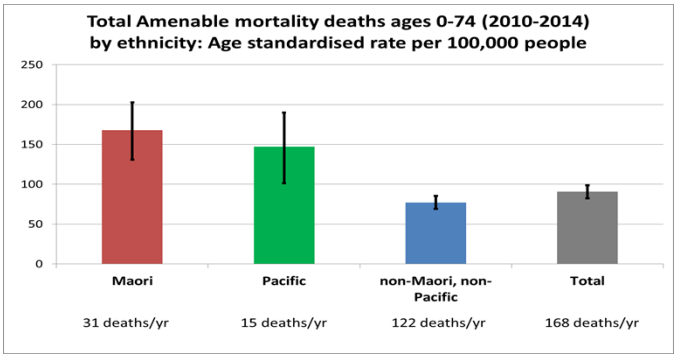
Aim	Actions	Contributory Measures
Improve the score of the communication domain in the Inpatient National Patient Experience of Care to 8.2 by Quarter 4 2018/19.	Continue to improve the use of consumer experience data to drive service improvement and increase patient satisfaction with service delivery. This includes developing a quality improvement project focusing on improving the information given to patients about medication side effects to watch for when patients go home. Continue consumer engagement and co-design in the development and implementation of the ALT work programme throughout 2018/19. Complete the roll out of primary care patient experience survey in general practice by July 2019. Review primary care survey scores and identify areas to advance quality improvement with practices by March 2019. Ongoing promotion of the Health Navigator patient information website throughout 2018/19 to improve uptake from health services and community members. Continue to roll out and increase the uptake of the Patient Portal in general practice throughout 2018/19.	Performance in the lowest question score - inpatient survey. Response rate for in-patient and primary care patient experience survey (total and monitor by ethnicity). Hutt Valley practices participating in PES (100%). Performance in the lowest question score - primary care survey. Utilisation of the health navigator website. Patient portal uptake by practice and the number of patients activated (Total and ensure equity for Maori and Pacific).

[33] *Note: baseline rate is calculated at Quarter 1 Data 2018 (survey administered in February and results issued May).*

Amenable Mortality Rates – Prevention and Early Detection

Where are we now?





Amenable Mortality in the Hutt Valley is reducing over time in line national average. The most recent data shows a slightly lower rate compared to the national average. However significant disparities exist with higher rates for Maori and Pacific. The top causes of amenable mortality in the Hutt Valley are: Coronary Disease, COPD, Suicide, CVD, Breast Cancer and Diabetes.

Milestone

A wide range of factors and contributory measures impact on amenable mortality and many of these go beyond the influence of the health sector or local DHB and will take time to have an impact. Influencing amenable mortality rates and reducing disparities for Maori and Pacific is a key part of the Hutt Valley Health Systems longer term strategy. Implementing the Clinical Services Plan and Wellbeing plan over the next 5 years will support this through improving the responsiveness and configuration of our clinical services, taking a stronger prevention approach and focussing on wider social determinants of health.

A number of the conditions contributing to our amenable mortality rate are influenced by the wider determinants of health and environmental factors that impact on wellbeing (e.g. activity levels, nutrition and smoking). The actions in our improvement plan focus on prevention by strengthening community wellbeing, access to screening and early intervention, enhancing the management of long term conditions and targeted support for Maori and Pacific to reduce disparities.

It is anticipated that our key interventions will improve our amenable mortality rate over a longer period of time. Therefore our improvement plan target aims to address disparity and **reduce our amenable mortality rate** per 100,000 people aged 0-74 years to 162 for Maori and 132 for Pacific by 2026/27 (deaths in 2019-2023)[34].

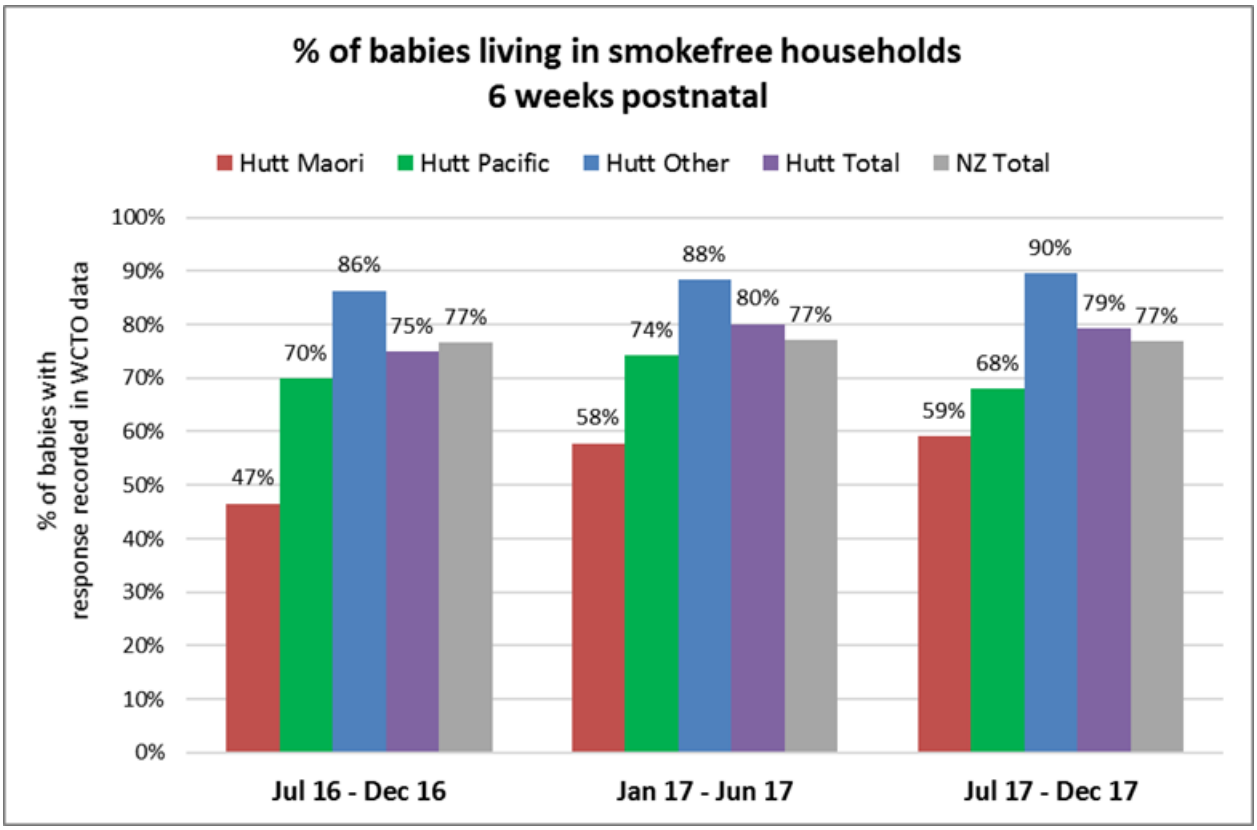
SLM	Improvement milestone by end of Q4
Hutt Valley total age standardised Amenable Mortality rate per 100,000 aged 0-74 years	162 per 100,000 people aged 0-74 years for Maori. 132 per 100,000 people aged 0-74 years for Pacific. Current Baseline rate 2014: (deaths in 2011-2015): HV total: 97, Maori: 167, Pacific: 136, Other: 82 NZ rate: 95

[34] *Note: baseline rate is calculated from 2014 data (deaths in 2011-2015). There is currently a time lag for mortality data - mortality rate for deaths in 2019-2023 will not be reported until financial year 2025/26.*

Aim	Actions	Contributory Measures
Reduce our age standardised amenable mortality rate by 2026/27 (deaths in 2019-2023) to: • 162 per 100,000 people aged 0-74 years for Maori • 132 per 100,000 people aged 0-74 years for Pacific	Launch and progress the implementation of a Wellbeing Plan that focuses on prevention, strengthening whānau and communities, and addressing the wider determinants and environmental factors that impact wellbeing in the Hutt Valley. The key focus areas of the plan are: housing, healthy lifestyles and physical activity, alcohol and other drugs, tobacco, wellbeing at work, and tamariki and whanau with complex social needs impacting their wellbeing. Initiatives will be targeted to Māori and Pacific, as populations disproportionately represented in wellness statistics. Improve the management of CVD in primary care by implementing variation analysis of CVD risk and management by July 2019. Improve the management of Long Term Conditions throughout 2018/19 by implementing specialist support for primary care (targeted to areas of greatest need), strengthening risk stratification and proactive care planning in general practice (through Health Care Home) and access to self-management programmes (virtual tools, community based rehabilitation and exercise programmes). Improve the suicide prevention response in the Hutt Valley including: • Collaborate with local council to implement training for community groups and key stakeholders around suicide prevention and supporting first symptoms of mental health. This training will help better equip a diverse range of people within community settings to engage with people experiencing mental health difficulties. Implement national screening programmes (cervical, breast and bowel screening) that ensures equity of access to timely diagnosis for all patients. This includes: • Promote bowel screening alongside other screening programmes at events and other engagement opportunities for priority populations. (EOA) • Continue working with independent Māori and Pacific support services and subcontractors to ensure our priority populations access screening services. (EOA) • Close liaison with DHB Māori and Pacific cultural support staff to ensure culturally appropriate care is provided to Māori and Pacific. • Work with DHB staff, Regional Screening Services, and primary care partners to identify Māori and Pacific people who would benefit from being invited onto the bowel screening programme early following point of contact with health staff or at an event. (EOA) • Work with our primary care partners to promote the uptake of the prostate cancer decision support tool to improve the referral pathway across primary and secondary services. Continue to implement and embed actions to achieve faster cancer treatment target. This includes: • Scope and investigate options for an enhanced tracking tool for cancer patients to improve the efficiency of referrals and coordination of care.	Percentage of enrolled PHO population that currently smoke (Total and reduce disparity for Maori and Pacific). Percentage of children identified as obese in B4 schools check (Total and reduce disparity for Maori and Pacific). Percentage of eligible population assessed for CVD risk in last 5 years (90% target and ensure equity for Maori and Pacific). Percentage of diabetes patients with HBA1C control <64mmol (Total and ensure equity for Maori and Pacific). COPD ED attendance and hospitalisation rate (Total and reduce disparity for Maori and Pacific). Hutt Valley suicide rate (total and monitor by ethnicity). Breast, cervical screening coverage to meet national targets and bowel screening rates (Total & reduce disparity for Maori and Pacific). Percentage of patients receiving their first cancer treatment within 31 days from date of decision to treat (85% and ensure equity).

Proportion of babies who live in a smoke free household by 6 weeks postnatal – 'Healthy Start'

Where are we now?



The most recent data shows that 79% of Hutt Valley babies screened at the first Well Child Tamariki Ora core check were living in smokefree households which is slightly higher than the national rate. There are significant disparities for Maori and Pacific with 59% of Maori babies and 68% of Pacific babies living in smokefree households. There are also disparities in WCTO identification and recording of smoking status for Maori whanau.

Milestone

Our improvement plan aims to address disparity and **increase the percentage of babies living in a smokefree household** at the WCTO first core contact for Maori to 64% and Pacific to 73% by the end of Quarter 4, 2018/19[35].

There is a need to improve the identification and data collection with WCTO providers to ensure all whanau are asked about smoking status and this is recorded during child's first WCTO core check. 94% of all babies seen by WCTO providers had a smoking status recorded, but there are disparities for Maori with only 88% of Maori babies have their smoking status recorded. As the quality of the data available in the Hutt Valley improves this may initially reduce the percentage of children living in a smokefree household.

Continuing to reduce smoking rates across the population as a whole and reducing disparities particularly for Maori remains a key priority for the Hutt Valley Health System. Our improvement plan actions have a strong

[35] *Note: baseline rate is calculated at 6 months ending December 2017.*

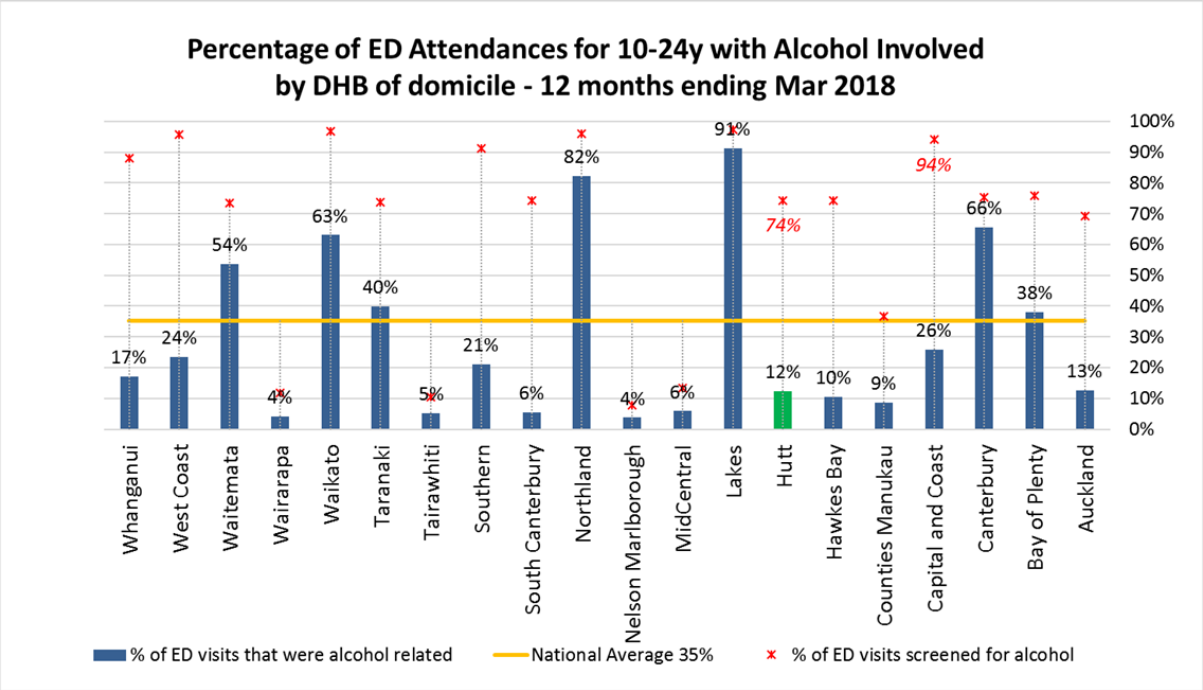
focus on reducing smoking rates for our Maori and younger generations and anticipate these actions will improve our overall performance and reduce disparities, especially for Maori in this SLM[36].

Aim	Actions	Contributory Measures
Reduce the equity gap towards the NZ average by improving the % of babies living in a smokefree household at the WCTO first core contact for Maori to 64% and Pacific to 73% by the end of Quarter 4, 2018/19.	Launch and implement a Wellbeing Plan, including the development of a Hutt Valley Health System tobacco control plan with key partners across council, primary and secondary care, community providers and regional public health by July 2019. Continue to focus on providing smoking brief advice in hospital and primary care, and continue to implement an incentive programme to increase smoking cessation referrals and access to culturally and youth appropriate smoking cessation services targeted to young Māori mothers. Continue to work with primary care services to improve newborn enrolment rates, and the quadruple enrolment of newborns with a Primary Health Organisation, Well Child/Tamariki Ora, Community Oral Health, and immunisation services. Work with locally funded WCTO providers to implement smoking ABC and referrals to smoking cessation services. Continue to support WCTO providers to improve enrolment rates and first core check targets especially for Maori and Pacific children.	Better help for smokers to quit in primary care (90% target & ensure equity for Maori) and in hospital (95% and ensure equity for Maori). Referrals to smoking cessation services and increase the number of people quitting smoking (Total and ensure equity for Maori and Pacific). PHO newborn, WCTO and dental enrolment rates (Total and ensure equity for Maori and Pacific). WCTO first core check targets (Total and reduce disparity for Maori).

[36] *LMCs and WCTO providers are significant contributors to this SLM. Ministry of Health will have greater influence in this area (as funders of national contracts with private LMCs and the largest WCTO provider).*

Youth access to and utilisation of youth appropriate health services – 'youth are healthy, safe and supported'

Where are we now?



We have selected Alcohol-related ED presentations for 10-24 year olds as our youth SLM. Recent alcohol related ED presentation data (for the 12months ending March 2018) shows 12% of ED visits for Hutt Youth were identified as alcohol related. This is lower than the national average at 35% and is likely to be an identification and data capture issue with only 74% of ED presentations being screened for alcohol. Local Hutt Valley hospital data shows disparities are apparent with higher alcohol related ED presentations for Maori compared to other ethnicities.

Milestone

Our improvement plan aims to **improve the identification of alcohol related ED presentations** in the Hutt Valley by increasing screening for alcohol related ED presentations for youth at Hutt Hospital to 80% by the end of Q4 2018/19.

Now that data is being collected nationally, our improvement plan focuses on improving screening, recording and data quality in Hutt Hospital ED. This will enable us to better understand local data to inform further quality improvement. As recording and data capture improves this may initially increase in alcohol related ED presentations for youth at Hutt Hospital. Our plan also focuses on actions to complete a broader youth health review and to improve youth access to primary, community and secondary services for Mental Health and AOD (especially for Maori and Pacific youth) which is a key priority area for youth in the Hutt Valley and will work to improve outcomes and reduce disparities for youth over a longer period of time.

Aim	Actions	Contributory Measures
Increase alcohol related ED presentation screening for youth attending Hutt Valley ED to 80% by the end of Q4 2018/19.	Work to improve screening and data collection on alcohol related presentation in Hutt Hospital ED. Complete the review of youth health services in the Hutt Valley and identify areas for improvement by December 2018. Continue to improve access to treatment for young people with alcohol and other drugs and co-existing problems (AODCEP) through: • Expanding primary and community health services to improve access to AOD and Mental Health support in the community for young people. • A youth AOD specialist service within MHAIDs to improve access to specialist support for young people. • Providing Mental Health and AOD consult liaison and specialist support to primary and community services. Continue to implement the ICAFs improvement programme throughout 2018/19 to improve access to specialist child and youth mental health services. Continue to support Healthy Families and work with community, council and industry to reduce the sale of alcohol to minors and limit the supply and availability of alcohol by off licence premises in the Hutt Valley.	Alcohol related ED presentations (Total and reduced disparity for Maori). TBC from Youth health review. The number of 15-24year olds accessing AOD and mental health services from primary and community providers (Total and ensure equity for Maori and Pacific). ICAFs waiting time from referral to first contact (Total and ensure equity for Maori and Pacific). Percentage of premises that are compliant with the Sale of Liquor Act and work to limit the total number of off license premises in the Hutt Valley.