Hutt Valley District Health Board
2019/20 Annual Plan

September 2019

The photo on the front cover was kindly provided by Healthy Families, Lower Hutt – with the permission of the students from Saint Bernadette's School, Naenae, who were celebrating at Poly Odyssey 2018.

Hon Dr David Clark

MP for Dunedin North

Minister of Health | Associate Minister of Finance

11 NOV 2019

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

Dear Andrew

Hutt Valley District Health Board 2019/20 Annual Plan

This letter is to advise you I have approved and signed Hutt Valley District Health Board's (DHB's) 2019/20 Annual Plan for one year.

I have made my expectations on improving financial performance very clear. Current DHB financial performance is not sustainable, despite Government providing significant funding growth to DHBs in the past two Budgets. I am approving your plan on the expectation that you will continue to focus on opportunities for improving financial results for 2019/20 and into 2020/21 and beyond. The out-years have not been approved.

I am aware that you have advised the Ministry of Health (Ministry) of a deteriorating out-years position. I have asked the Ministry to request detail on the development of your savings plans for out-years as part of your 2019/20 quarter two report. I expect this report will include a granular and phased focus on cost containment, productivity and efficiency, quality, safety and Māori health and equity.

It is critical that a strong and deliberate approach is taken to out-year financial plans including your operating revenue, expenditure budgets and specific sustainable savings plans.

It is expected that as Chair, along with your Board, you will continually manage and monitor your cash position on a monthly basis with an ongoing year forecast. Should the DHB experience liquidity issues, please keep the Ministry informed of the likely timing of the need for liquidity support. Signalling the need for equity in the Annual Plan does not imply that an equity request will be approved. The available equity is limited and applications for equity support will be subject to a rigorous prioritisation and approval process.

I am aware you are planning a number of service reviews in the 2019/20 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

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

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders that will deliver on our Government's Wellbeing priorities.

I am looking forward to seeing continued support and progress in these priority areas and ask that you maintain a strong oversight of your team against the actions identified in your annual plan.

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 2019/20 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr David Clark
Minister of Health

cc Ms Fionnagh Dougan
Chief Executive
Hutt Valley District Health Board
Fionnah.Dougan@ccdhb.org

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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 2019/20 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 2018, 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 on how best to 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 we began the journey of implementing *Our Vision for Change.* The strategy identifies three key strategic directions for the board: Support Living Well; Services Closer to Home; and Shorter, Safer, Smoother Care. These are being 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, our Pacific Health Plan, our Pharmacist Services Strategy and our 3DHB Mental Health Strategy. These plans 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.

Our 2019/20 Annual Plan addresses key strategic imperatives for our organisation to improve health equity across all populations in the Hutt Valley district. It 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 Joint Chief Executive

As the new Joint Chief Executive for both Capital & Coast DHB and Hutt Valley DHB, I am committed to both DHBs working together to plan and provide health services across the greater Wellington region. This collaborative approach is evidenced in a number of the work-streams outlined in the 2019/20 Annual Plan, where activity is being planned for consistent delivery across three DHB's - Capital & Coast, Hutt Valley, and Wairarapa.

In line with the Minister's expectations, our emphasis in this plan is on actions that contribute to a strong and equitable public health and disability system. This includes work to improve the health and wellbeing of children, and work with cross-sector organisations to address the determinants of health and reduce the growing pressure on emergency services. The plan is also focussed on strengthening our mental health services and improving health equity. 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 care and improve the health of all groups in our population.

1.3 Signature Page

Agreement for the Hutt Valley DHB 2019/20 Annual Plan

between

Hon Dr David Clark
Minister of Health
Date: 11 November 2019

Andrew Blair
Chair
Hutt Valley DHB
Date: 31 October 2019

Fionnagh Dougan
Chief Executive
Hutt Valley and Capital & Coast DHBs
Date: 31 October 2019

About Hutt Valley District Health Board

What we do

The Hutt Valley District Health Board (DHB) is one of twenty DHBs in New Zealand charged by the Crown with improving, promoting and protecting the health and independence of their resident populations. Like all DHBs, we receive funding from the Government to purchase and provide the services required to meet the health needs of our population and we are expected to operate within allocated funding.

In accordance with legislation and government objectives, we use that funding to:

- *Plan* the strategic direction of our health system and, in collaboration with clinical leaders and alliance partners, determine the services required to meet the needs of our population.
- *Fund* the health services required to meet the needs of our population and, through collaborative partnerships and performance monitoring, ensure these services are safe, equitable, integrated and effective.
- *Provide* a significant share of the specialist health and disability services delivered to our population, and to the population of other DHBs, where more specialised or higher-level services are not available.
- *Promote* and protect our population's health and wellbeing through investment in health protection, promotion and education services and delivery of evidence-based public health initiatives.

While Hutt Valley DHB is the lead provider of health services for the people of the Hutt Valley, it shares this responsibility with Primary Healthcare Organisations (PHOs), the Accident Compensation Corporation (ACC), and Non-Government Organisations (NGOs). This means there are health services provided in the Hutt Valley that are not commissioned by the DHB and this creates a requirement to build local partnerships and an integrated health system response by working with all of these partners, including local Māori, social sector agencies, and councils.

The Treaty of Waitangi

In planning and providing health services, we pay particular attention to the health needs and aspirations of our Māori population. There are well-documented and preventable inequities in the determinants of health between Māori and non-Māori, and these flow through to inequities in health outcomes. Our intention is that we will target, plan and drive our health services to create equity of health care for Māori to attain good health and well-being, while developing partnerships with the wider social sector to support whole of system change.

Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities through the founding document of Aoetaroa, The Treaty of Waitangi. Hutt Valley DHB values the Treaty 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 representation has been provided on Hutt Valley DHB's advisory committees and its Alliance Leadership Team. Hutt Valley DHB has also established an Iwi Relationship Board to formalise the relationship between local Iwi and the DHB, build on relationships, and share aspirations and strategic directions.

Our population

Hutt Valley DHB covers the Te Awakairangi area – the Hutt Valley – and serves approximately 150,000 people. Our District Health Board covers both Upper Hutt City and Hutt City. People under 25 years of age account for 32 percent of the Hutt Valley population and those aged 65 years of age account for approximately 15 percent. The Hutt Valley's population is ethnically diverse; 17 percent of our population identify as Māori, 8 percent as Pacific peoples and 75 percent as New Zealand European, Asian and Other. Overall, the Hutt Valley area has similar proportions of those living in the highest and lowest deprivation areas. However, these overall figures mask the extremes in deprivation seen in the Lower Hutt area, where there is a greater proportion of the population living in the most deprived areas.

The needs of an ageing population

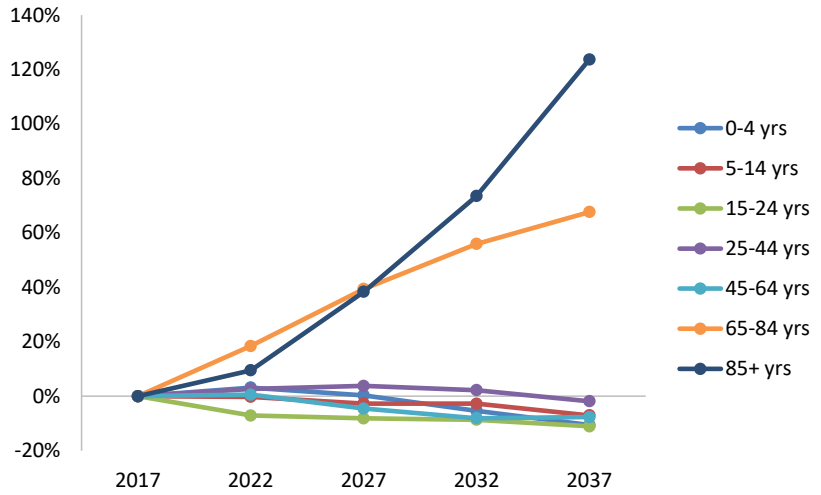
As our population ages, we are seeing more people with long-term health conditions and multi-morbidities. People are living longer than previous generations, but are living longer in poorer health.[1] This is particularly so for Māori, Pacific people, refugees, disabled people and those living with a mental illness:

> *Māori males aged 65 can expect the shortest remaining time of living without disability or long-term illness (5.5. years on average) and the highest proportion of remaining time lived with disability requiring support.*[2]

Ageing leads to a gradual decrease in physical and mental capacity and an increasing risk of age-related health conditions (often several at the same time). Old age can also be characterised by the emergence of syndromes such as frailty, delirium and urinary incontinence.[3] Older people are not a homogeneous group and many people over the age of 65 years will continue to be active and independent members of their communities. However, as a result of increasing health and social care needs, older people generally require a far greater share of health care resources than younger people.

Our total population is not expected to grow substantially over the next 20 years (just under 5% or around 7,000 people), although there are both short- and long-term plans for housing development in Lower Hutt and Upper Hutt cities. However, there will be a significant increase in the number of older people, with current projections suggesting that in 2038 almost one in four people will be aged over 65 years. The population aged over 80 will double. The overall number of children and working-age adults is expected to decline.

Figure 1 Hutt Valley growth by age group



Source: Statistics New Zealand population projections prepared for the Ministry of Health.

[1] http://www.who.int/news-room/fact-sheets/detail/ageing-and-health Ministry of Health. 2018. *Health and Independence Report 2017. The Director-General's Annual Report on the State of Public Health.* Wellington: Ministry of Health.

[2] Associate Minister of Health 2016. *Health Ageing Strategy.* Wellington: Ministry of Health.

[3] http://www.who.int/news-room/fact-sheets/detail/ageing-and-health.

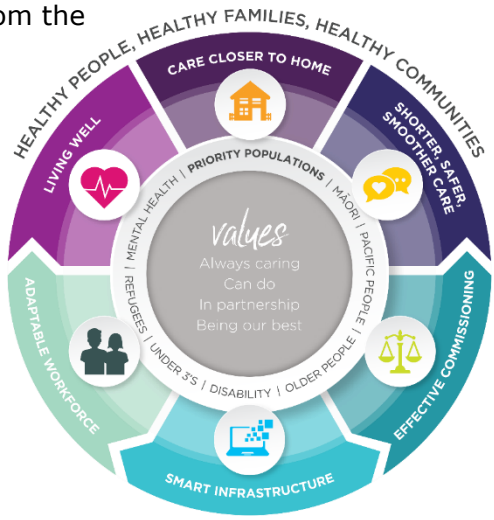
As a consequence of our changing population, increased demand will occur across our health system in community care, primary care, aged residential care and in the hospital at the same time as our working-age population decreases.

Our Vision for Change

In 2017, we introduced *Our Vision for Change – How We Will Transform the Health System 2017-2027.* This strategy articulates Hutt Valley DHB's high-level strategic objectives and our vision for:

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

Our people, whānau and communities have told us what is needed from the Hutt Valley health system in order to achieve *Our Vision for Change*. These strategic objectives include services being organised and delivered equitably, whānau being owners of their care, a focus on prevention and early intervention, care delivered closer to people's homes, coordinated health and social services, and a health system that is clinically and financially sustainable.



Key strategic directions and enablers have been identified to guide and support us towards creating the future health system we want. Our key strategic directions are: support living well, shift care closer to home, and deliver shorter, safer, smoother care. Our key strategic enablers are: adaptable workforce, smart infrastructure and effective commissioning.

Strategic Framework

We have developed a number of plans to support us to meet the challenges ahead and achieve *Our Vision for Change*. Together these plans reflect our Hutt Valley DHB's strategic framework.

Figure 1 Hutt Valley DHB's Strategic Framework

- Our Clinical Services Plan 2018-2028 provides an outline of how we will need to reconfigure our clinical services over the next 5-10 years to address growing health demands.
- Our Wellbeing Plan: A Thriving Hutt Valley focusses on prevention, strengthening whānau and communities, and addressing the wider determinants and environmental factors that impact our physical and mental wellbeing.
- Te Pae Amorangi, Hutt Valley DHB's Māori Health Strategy to 2027, details our commitment to improving the health of Māori in our district through five priority areas: workforce, organisational development and cultural safety, commissioning, mental health and addictions, and the first 1,000 days of life.
- Our Pacific Health Action 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.
- Living Life Well, our 3DHB[4] Mental Health and Addictions Strategy 2019-2015, sets the direction for mental health and addiction care to improve outcomes for our people, their whānau, and our wider communities.

The work of implementing our strategic plans has begun. We are developing and progressing work programmes to drive the changes we need to make. Hutt Valley DHB has established a Project Management Office, which is supporting a number of projects to improve hospital integration with community services, and enhance patient flow and efficiency within hospital.

As well as changes to our own services, we are also working closely with Central Region DHBs[5] to plan and coordinate our services together. We are working closely with Capital & Coast DHB, in particular, to plan, coordinate, and integrate our hospital services and care pathways as much as possible, so that together both DHBs provide high-quality and timely services to our populations. This joint planning work across our network of hospitals (at Wellington, Kenepuru, and Hutt Hospital) will improve the clinical and financial sustainability of our health system. We are also working towards the development of a combined Long Term Investment Plan for Capital & Coast DHB and Hutt Valley DHB.

Alignment with national strategies

This Annual Plan has been developed to align with the Government's priorities for the health system and our local strategic framework. The plan has been developed in cooperation with our local partners and stakeholders, in keeping with the collaborative approach for planning, supporting and delivering services in our district and across the sub-region.

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*.

[4] Hutt Valley, Capital & Coast, and Wairarapa DHBs.

[5] The 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.

Strategic discussions with the Ministry of Health

In July 2019, Hutt Halley DHB held strategic discussions with the Ministry of Health about the DHB's high-level planning intentions, which are summarised below.

Hutt Valley DHB will:

- Apply a strong **equity** lens to the work we have planned
- **Intensify support** to those who need it the most and simplify care for those who do not
- Focus on **children** and wellbeing
- Undertake a comprehensive **planning** approach to understanding and responding to the needs of our population
- Work in **collaboration** with wider partners and communities
- Address the **whole acute demand system**
- **Improve mental health services** and the responsiveness of the system
- Address our future **capital** infrastructure needs.

SECTION TWO: DELIVERING ON PRIORITIES

This section demonstrates Hutt Valley DHB's commitment to the Minister's Letter of Expectations and the agreed planning priorities.

2.1 Government Planning Priorities

The whole-of-government priority is:

Improving the wellbeing of New Zealanders and their families.

The health outcomes that will contribute to this are:

- We live longer in good health
- We have improved quality of life
- We have health equity for Māori and other groups.

To achieve the above, the Government has identified the following 2019/20 Planning Priorities for the health system:

- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention
- Better population health outcomes supported by a strong and equitable public health and disability system
- Better population health outcomes supported by primary health care
- Strong fiscal management.

Section Two outlines the key activities Hutt Valley DHB has planned for 2019/20 under each Planning Priority.

Health Equity

Achieving equity in health and wellness is a focus for Hutt Valley DHB. In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes. Equity actions are identified in the table below with code 'EOA', which means 'equitable outcome action'.

2.1.1 Improving child wellbeing

Child and youth wellbeing is a priority work programme for Government, the Ministry of Health and District Health Boards. This section identifies annual planning guidance for children and young people that contributes to the development and delivery of New Zealand's first Child and Youth Wellbeing Strategy (the Strategy) and preparing the Health and Disability sector for system transformation over time.

There is an expectation that annual plans reflect how DHBs are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

Annual plans should inform a comprehensive approach to prevention and early intervention services (primary and community health) provided to women of child bearing age, infants, babies, pre-school and school-aged children and youth and their families/carers.

DHBs should draw on the most relevant information necessary to evidence their approach.

<table>
<tr><th colspan="2">Immunisation</th><th colspan="3">This is an equitable outcomes action (EOA) focus area</th></tr>
<tr><td>DHB activity</td><td>Milestone</td><td>Measure</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td>1. Te Awakairangi Health[6] will provide specific training and practical skills development relating to equity, institutional racism and cultural safety for the primary care workforce. This will encompass the primary care workforce responsible for delivering immunisations. (EOA)</td><td>Q1-4</td><td rowspan="4">CW05: Immunisation coverage (8 month year olds, 5 year olds, 65+ year olds, and HPV)

CW08: Increased immunisation (2 year olds)</td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
<tr><td>2. Support the Outreach Immunisation Service to develop improved systems and processes (particularly with Medtech upgrades and its connection to the National Immunisation Register) to improve immunisation rates.</td><td>Q1</td><td rowspan="3">System outcome
We live longer in good health</td><td rowspan="3">Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
<tr><td>3. Develop collective strategies with Te Awakairangi Health and Regional Public Health to support general practices to engage with whānau who are not well engaged with their practice, in order to improve primary care access and immunisation rates.</td><td>Q1</td></tr>
<tr><td>4. Support general practices in high deprivation areas of the Hutt Valley to increase uptake of immunisations for whānau. (EOA)</td><td>Q1-4</td></tr>
<tr><td>5. Further strengthen our school-based immunisation programme (ie HPV and Boostrix immunisation) to better meet the needs of our Māori, Pacific and Asian populations by:
- initiating delivery with lower decile schools, which have higher numbers of Māori and Pacific students, at the beginning of the school year, so that there is more time later in the year to follow up if students miss their initial school-based vaccination
- providing education sessions within the school, prior to vaccination, supported by resources written in different languages
- following up with parents/caregivers for vaccination consent. This can include addressing any concerns that parents/caregivers have and providing them additional information with the use of interpreters where necessary. (EOA)</td><td>Q1-4</td><td>System outcome
We have improved quality of life</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
<tr><td>6. Align the Health Care Home at-risk payment with a requirement to meet the immunisation targets.</td><td>Q1</td><td></td><td></td><td></td></tr>
</table>

[6] Te Awakairangi Health is the largest Primary Health Organisation (PHO) operating in Hutt Valley DHB. The other PHO is Cosine, which supports one general practice in Hutt Valley DHB.

School-Based Health Services			**This is an equitable outcomes action (EOA) focus area**	
DHB activity Hutt Valley DHB, through Regional Public Health and the Regional Bee Healthy Dental Service, provides a number of health services in school settings. These include: • School-Based Health Services (primary care, mental health, and sexual health services) in decile 1 to 4 secondary schools • public health nurses in all primary and intermediate schools, with more intensive service provision in high deprivation areas • resources to teachers and parents on healthy choices and the prevention of illness (for example the Water-Only Schools toolkit) • immunisations and dental care in primary and intermediate school settings • advice to early childhood centres, including kohanga reo, on increasing wellness and building healthy environments • new entrant health assessments offered to children in decile 1-3 primary schools who did not complete a B4 School Check. In 2018/19, Hutt Valley DHB commissioned a review of the health service needs of local primary, intermediate and secondary schools (the school review). The results of the school review have highlighted that primary and intermediate schools have difficulty accessing some health and parenting/whānau support services. While the physical health needs of school children are well supported through the free GP visits and the public health nurses in schools, the review highlighted a lack of services for primary and intermediate school children experiencing mental distress and conduct problems. The report recommends: • Joint agency-funded counselling available to local primary and intermediate school children experiencing mental distress and conduct problems. • Working across health, education and social sector agencies to provide evidence-based parenting and whānau-support programmes to primary and intermediate schools. • Providing a comprehensive toolbox of resources to primary and intermediate schools, including clear referral processes to access help and support for children experiencing mental distress and conduct problems, and their parents/whānau.	**Milestone**	**Measure** Child wellbeing CW12: Youth mental health initiatives	**Government theme:** **Improving the well-being of New Zealanders and their families** **System outcome** We have health equity for Māori and other groups **System outcome** We live longer in good health **System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities **Government priority outcome** Make New Zealand the best place in the world to be a child **Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

To progress this work, Hutt Valley DHB will undertake the following activities: 1. Begin implementing the agreed recommendations from the school review, with a particular focus on schools in high deprivation areas, and with oversight from the Youth Health Steering Group.[7] (EOA) ***Youth Health Care in Secondary Schools*** 2. Continue to provide **primary care and mental and sexual health services** in the community through our One Stop Shops, and in decile one to four secondary schools though our youth health provider (Vibe). ***Improving the responsiveness of primary care to youth*** 3. Continue to support **youth participation** – including Māori and Pacific youth – on the Youth Health Steering Group, which oversees youth health and wellbeing initiatives. (EOA) 4. Continue to facilitate and provide administration support and advice to the Youth Health Steering Group. 5. Continue to provide a **social marketing** advisor role at the DHB to better engage with youth – particularly in the areas of tobacco, dental care, and wellbeing. 6. Roll out the **Long-Acting Reversible Contraceptives** programme to decrease the high rates of unplanned pregnancy. (Also a First 1000 Days activity) 7. Provide **free emergency contraception** from community pharmacies to women aged under 25 years old. The service is intended to help reduce unplanned teenage pregnancies and terminations of pregnancy. (Also a First 1000 Days activity) In addition to the above, the DHB is working closely with **Piki**, a 3DHB primary mental health pilot initiative, delivered by Tū Ora Compass Health PHO and Te Awakairangi Health, providing free mental health / alcohol or drug problem **support to young people** (18-25 years old). Hutt Valley DHB will also meet all its non-financial reporting obligations.	Q1 Q1-4 Q1-4 Q1-4 Q1-4 Q1	Child wellbeing CW12: Youth mental health initiatives		

[7] The Youth Health Steering Group is Hutt Valley DHB's equivalent to a 'Youth Service Level Alliance Team' and reports directly to the Hutt Inc (our Alliance Leadership Team).

<table>
<tr><th colspan="3">Midwifery workforce – hospital and LMC</th><th colspan="2">This is an equitable outcomes action (EOA) focus area</th></tr>
<tr><td>DHB activity</td><td>Milestone</td><td>Measure</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td rowspan="3">1. Develop, implement, and evaluate a midwifery workforce plan to support:
- undergraduate training, including clinical placements
- recruitment and retention of midwives, including looking at driving changes for models of care that use the full range of the midwifery workforce within DHBs
- service delivery mechanisms that make the best use of other health work forces to support both midwives in their roles and pregnant people.
2. Implement clinical training placements of Māori and Pacific midwives, where available. (EOA)
3. To progress implementation of Care Capacity Demand Management (CCDM) for midwifery, Hutt Valley DHB will:
- continue to include the maternity wards and midwifery staff in our CCDM standard operating procedures and essential care guidelines, and our CCDM work plans
- continue to use variance response management tools and processes in the maternity wards. These include TrendCare to predict patient demand for care and variance indicator scores displayed on capacity at a glance screens.
- annually calculate the midwifery and nursing FTE needed in maternity wards to implement CCDM and inform budgets
- continue to support our Director of Midwifery on the CCDM Steering Group and midwifery representation on the CCDM Variance Response Management working group.</td><td rowspan="3">Q4

Q4

Q1-4</td><td rowspan="3">Status update report</td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
<tr><td>System outcome
We live longer in good health</td><td>Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
<tr><td>System outcome
We have improved quality of life</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

First 1000 days (conception to around 2 years of age)			This is an equitable outcomes action (EOA) focus area	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
Most important focus areas				
1. Build strong networked services for tamariki and whānau experiencing high and complex social and/or health needs. This includes embedding DHB processes for identifying families and ensuring appropriate **cross-sector responses**. (EOA) (Also a SUDI activity)	Q4	PH01: ASH[10] rates for 0–4 year olds	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Reorient the paediatric outpatient service to enhance the provision of care in the community and **improve access to Māori and Pacific children**. (EOA)	Q2-4			
3. Roll out the **Long-Acting Reversible Contraceptives** programme to decrease the high rates of unplanned pregnancy. (This is also a School-Based Health Services activity)	Q1		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
4. Provide **free emergency contraception** from community pharmacies to women aged under 25 years old. The service is intended to help reduce unplanned teen pregnancies and terminations of pregnancy. (Also a School-Based Health Services activity)	Q1			
5. Implement initiatives to **reduce the percentage of deliveries by Caesarean** section among standard primiparae (the group of women who are considered to be 'low risk') from 20% to 15% by 30 June 2020.[8]	Q1-4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
Support for children to grow into a healthy weight				
6. Pilot a two year trial of **automated BMI equipment** in general practices serving high-need communities and in Māori and Pacific health providers, to support health practitioners and families to monitor and manage their children growing into healthy weights. The trial will also review user experience. (EOA)	Q4	Proportion of children at a healthy weight at age 4		
7. **Coordinate breastfeeding education and support** across health sector providers in the Hutt Valley with a particular focus of lifting Māori breastfeeding rates.[9] The plan is expected to include the development of clinical pathways, education processes, and consideration of renewed peer-to-peer models.	Q2			
8. Continue to fund Sport Wellington to deliver a **Maternal Green Prescription** programme, which supports pregnant women to maintain healthy weight gain in pregnancy and promotes healthy eating, exercise, and breastfeeding.	Q1-4			

[8] In 2018/19 the DHB had higher rates of Caesarean sections among standard primiparae compared to national figures. To reduce Caesarean rates, the DHB is implementing a number of initiatives. The DHB's Maternal Quality and Safety Committee is undertaking a large project focused on increasing normal vaginal deliveries and increasing primary birthing. In addition, each category 1 Caesarean section is being reviewed.

[9] Adolescents and adults who were breastfed as babies are less likely to be overweight or obese (World Health Organisation: https://www.who.int/features/factfiles/breastfeeding/en/)

[10] Ambulatory Sensitive Hospitalisation.

Family Violence and Sexual Violence (FVSV)			This is an equitable outcomes action (EOA) focus area	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Increase awareness and implementation of the **Violence Intervention Programme** (VIP) across the DHB by: - sharing anonymised stories of patients who have used VIP with the Board and the public - promoting the VIP internally at executive, committee and clinical council meetings - working with managers across the hospital to arrange VIP training for their staff. Increasing implementation of VIP is important because it will increase patient screening and follow up for victims of intimate partner violence.	Q1-4	Status update report	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Expand **VIP training amongst Emergency Department staff** to increase patient screening and follow up for victims of intimate partner violence. It is important that Emergency Department staff are well trained to screen, identify and respond to family and sexual violence because this is where victims are likely to present will injuries as a consequence of abuse.	Q2		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
3. Support the **Maternal Care and Child Wellbeing Multi Agency Group**, a cross-sectoral group that identifies pregnant women who are experiencing intimate partner violence and/or child protection concerns, and works with those involved and cross-sector agencies and organisations to prevent further harm. (EOA) [11] (Also a Cross-sectoral collaboration activity)	Q1-4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
4. Complete quality improvement activity by **reviewing our responses to women** who presented to Hutt Valley DHB after being injured by an intimate partner. Kokiri Māori Women's Refuge and Kokiri Mārae Social Services to be invited to participate in this review and provide feedback and support HVDHB to identify areas for change and development.	Q1-4			
5. Further develop **relationships with local Māori providers** in the Hutt Valley to strengthen our response to Māori experiencing family violence and sexual violence.	Q1-4			
6. Cultural responsiveness will continue to be incorporated into the VIP core training programme. **Kokiri Marae Māori Women's Refuge** will continue to support and attend VIP training as part of a panel of agencies to share knowledge with staff. (EOA)[12]	Q1-4			

[11] Māori women make up approximately 65% of the total referrals to the Maternal Care and Child Wellbeing Multi Agency Group.

[12] Hutt Valley DHB's Intimate Partner Violence Policy has been developed in accordance with the Treaty of Waitangi principles, recognising Te Whare Tapa Wha and kaupapa principles.

7. Continue to **enhance the responsiveness of the VIP to Pacific peoples** by providing: - Pacific representation (the Director of Pacific Health Unit) on the Hutt Valley VIP Advisory Group - representation from the local community Pacific Health Service on the Maternal Care and Child Wellbeing Multi Agency Group - brochures about getting help and support for family violence in Samoan and Tongan languages - information about Pasifika culture and context in the VIP training offered to all Hutt Valley DHB staff - core VIP training to staff in Hutt Valley DHB's Pacific Health Unit to better enable them to respond and support Pasifika women and their families experiencing family or sexual violence. (EOA)	Q1-4			

SUDI			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Deliver a **co-ordinated Smoke-free Action Plan** focussing priority populations[13], which includes: - improving the up-take of referrals to smoking cessation services - reviewing the DHB's smoke-free vaping policy - supporting councils in reviews of smoke-free and vaping policies (EOA) (Also a Cross-sectoral collaboration activity and a Smokefree 2025 activity)	Q1-4	PH01: ASH[14] rates for 0–4 year olds	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Continue to embed and support the **SUDI prevention programme** delivered by local Māori health providers to at-risk whānau across the Hutt Valley. This programme is coordinated by Kokiri Marae. Wahakura (woven flax safe-sleep bassinets for infants) and pepi pods are distributed as part of the programme. (EOA)	Q1-4		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
3. Provide pepi pods to Hutt Valley's Pacific Health Service (who provide Well Child/Tamariki Ora services) to distribute to pacific families. (EOA)	Q1-4			
4. Distribute pepi pods on the maternity ward to families identified as having a higher risk of SUDI. The DHB's Pacific population is considered a priority population for the distribution of safe sleep devices. (EOA) Hutt Valley DHB anticipates a minimum of 150 safe sleep devices to be distributed in 2019/20 (as contracted through the Crown Funding Agreement).	Q1-4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

[13] Māori (particularly Māori females and mothers), Pacific peoples, Rangatahi (young people), and mental health consumers.
[14] Ambulatory Sensitive Hospitalisation.

2.1.2 Improving mental wellbeing

The Government has a vision of a mental health, addiction and wellbeing system without barriers, that is easy to navigate, where no door is the wrong door. DHBs have an important role to play in achieving this vision.

We must work together to build a whole-of-system, integrated approach to mental health, addiction and wellbeing that provides options for New Zealanders across the full continuum of need.

There is an expectation that annual plans reflect how DHBs will embed a focus on wellbeing and equity at all points of the system, alongside an increased focus on mental health promotion, prevention, identification and early intervention.

Alongside building missing components of our continuum, annual plans should demonstrate how existing services can be strengthened to ensure that mental health services are cost effective, results focused and have regard to the service impacts on people who experience mental illness.

DHBs will provide a range of services that are of high quality, safe, evidence based and provided in the least restrictive environment.

Inquiry into mental health and addiction			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
Hutt Valley DHB will work with the Ministry of Health to implement Government's agreed actions following the Mental Health and Addiction Inquiry and implement relevant Budget 2019 initiatives. Hutt Valley DHB will undertake the following actions to improve and/or address the Inquiry's key areas of focus: ***Embedding a wellbeing focus*** 1. Launch the **Mauri Ora staff wellbeing programme**, including tools and resources for staff, to support a healthier and happier workplace where our wellbeing is valued. (Also a Workforce activity) ***Building the continuum / increasing access and choice*** 2. Review the impact of the **primary mental health services** provided by Te Awakairangi Health to improve access and responsiveness to adults and young people. (Also a Population Mental Health activity) 3. Work in partnership with the Ministry, Māori, Pacific people, young people, people with lived experience, NGOs, primary and community organisations, and other stakeholders to plan an integrated approach to mental health, addiction and wellbeing and **roll out new primary level responses** from Budget 2019. 4. Investigate additional **kaupapa Māori models of care** for mental health and addictions treatment. (EOA) (Also a Population Mental Health activity) 5. Collaborate with local council to provide **training sessions** around suicide prevention and supporting first symptoms of mental health (Mental Health 101) for key stakeholders, including community services and agencies, and the education sector and schools. (Also a Population Mental Health activity) ***Suicide prevention*** 6. Increase capacity and improve responsiveness to **suicide prevention and postvention** across the 3DHBs. This will include the centralisation of prevention and postvention functions from external providers back into CCDHB to enable a more integrated, joined up approach across NGOs, primary and secondary care providers. Strengthen the response to specific populations who are disproportionately affected by suicide (eg. Maori, Pacific, LGTBQI, youth). (Also a Population Mental Health activity)	Q1-4 Q1-4 Q1-4 Q1-4 Q1-4	MH01: Improving the health status of people with severe mental illness through improved access	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
			System outcome We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
			System outcome We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

Crisis response				
7. Complete a review of the **Triage and Urgent Response Service** (Te Haika)[15] and implement the findings to improve the response to acute referrals and triage for interventions. (Also a Mental Health and Addictions Improvement activity, an Addictions activity, and an Acute Demand activity)	Q1-4			
NGOs				
8. Hutt Valley DHB will identify how it will use cost pressure funding from Budget 2019 to ensure NGOs in the district are sustainable, particularly any providing AOD residential care, detoxification and continuing care.	Q1			
Workforce				
9. Work in partnership with workforce centres to strengthen current workforces, including a focus on retention, recruitment and training.	Q1-4			
10. Demonstrate a commitment to lived experience and whānau roles being supported and employed across all services.	Q1-4			
11. Support workforce development of the appropriate knowledge and skills to support people with mental health and addiction needs, for example through use of the Let's Get Real framework.	Q1-4			
Mental Health and Wellbeing Commission				
12. Work collaboratively with any new Commission.	Q1-4			
Forensics				
13. Work with the Ministry to improve and expand the capacity of forensic responses from Budget 2019.	Q1-4			
14. Contribute, where appropriate, to the Forensic Framework project.	Q1-4			

[15] Te Haika is part of the 3DHB Mental Health, Addiction and Intellectual Disability Service (MHAIDS).

Population mental health			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Increase capacity and improve responsiveness to **suicide prevention and postvention** across the 3DHBs. This will include the centralisation of prevention and postvention functions from external providers back into CCDHB to enable a more integrated, joined up approach across NGOs, primary and secondary care providers. Strengthen the response to specific populations who are disproportionately affected by suicide (eg. Maori, Pacific, LGTBQI, youth).	Q1-4	MH01: Improving the health status of people with severe mental illness through improved access	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Investigate additional **kaupapa Māori models of care** for mental health and addictions treatment. (EOA)	Q1-4		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
3. Collaborate with local council to provide **training sessions** around suicide prevention and supporting first symptoms of mental health (Mental Health 101) for key stakeholders, including community services and agencies, and the education sector and schools.	Q1-4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
4. Build community-based capacity to **better support children** of parents with mental illness and addiction problems (COPMIA) through family group-based and individual programmes.	Q1-4			
5. Review the impact of the **primary mental health services** provided by Te Awakairangi Health to improve access and responsiveness to adults and young people.	Q1			
6. Continue to implement the requirements of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.	Q1-4			
7. Develop and commence implementation of a 3DHB Mental Health and Addiction **Population Outcomes Framework**, which links the activities across the three DHBs with the desired outcomes and provides a means of tracking and reporting progress. (This is also a Maternal Mental Health Services activity).	Q2			
In addition to the above, the DHB is working closely with **Piki**, a 3DHB primary mental health pilot initiative, delivered by Tū Ora Compass Health PHO and Te Awakairangi Health, providing free mental health / alcohol or drug problem **support to young people** (18-25 years old).				

Mental health and addictions improvement activities			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Develop business case for the reconfiguration of **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. (EOA)[16]	Q1-4	MH02: Improving mental health services using wellness and transition (discharge) planning. MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Continue to monitor use of seclusion through the Restraint and Seclusion Elimination Monitoring and Advisory Group.	Q1-4		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
3. Co-design **seclusion reduction activities** with consumers, tāngata whaiora, family and whānau who use acute units, followed by testing of selected activities.	Q1-4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
4. MHAIDS will implement a revised **mental health clinical governance** structure to enhance its patient safety culture and encourage ongoing service improvement activity and review.	Q4			
5. Complete a review of the **Triage and Urgent Response Service** (Te Haika)[17] and implement the findings to improve the response to acute referrals and triage for interventions. (This is also an Addictions activity and an Acute Demand activity)	Q1-4			
6. Implement the **3DHB 'Acute Continuum of Care'** to better match need to service provision, enhance coordinated service provision across a range of providers, and improve integration and patient flow through the system. This will include supporting prioritised pathways with a focus on responding to Māori mental health needs.	Q1-4			

[16] The whanonga pono (guiding principles) that underpin the Te Whare Ahuru model of care and the reconfiguration project are informed by Te Ao Māori. For example, a key principle is the involvement of whānau in the recovery process, and the reconfiguration will include the ability for whānau to stay at Te Whare Ahuru.

[17] Te Haika is part of the 3DHB Mental Health, Addiction and Intellectual Disability Service (MHAIDS).

Addiction			**This is an equitable outcomes action (EOA) focus area**	
DHB activity MHAIDS provides community alcohol and drug assessment and treatment for adults living in the HVDHB region who have or are concerned they may have moderate to severe mental health and substance use disorders. The MHAIDS Opioid Treatment Service is based in Wellington and provides satellite clinics in Porirua, Kāpiti, Lower Hutt and Upper Hutt. 1. Provide the Ministry of Health with a list of all existing and planned alcohol and other drug (AOD) services in Hutt Valley district (including DHB contracted NGO services) by 30 September 2019. 2. Review current AOD NGO services followed by the development and co-design with key stakeholders of a **3DHB AOD model of care and practice pathway**, with particular focus on priority populations including Māori, Pacific and youth (EOA) 3. The 3DHBs will implement the final decisions on the proposal to move to a lead DHB model with one management structure for all secondary and tertiary mental health and AOD services across the 3DHBs to improve access. 4. Complete a review of the **Triage and Urgent Response Service** (Te Haika) and implement the findings to improve the response to acute referrals and triage for interventions. (Also a Mental health and addictions improvement activity and an Acute Demand activity)	**Milestone** Q1 Q1-4[18] Q3-4 Q1-4	**Measure** MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	**Government theme:** **Improving the well-being of New Zealanders and their families**	
			System outcome We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
			System outcome We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
			System outcome We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

[18] Implement relevant Budget 2019 appropriations related to the AOD Model of Care.

Maternal mental health services			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
HVDHB funds the following community-based primary maternal mental health services: - Nāku Ēnei Tamariki provides an intensive community-based maternal mental health and social support service targeting Māori, Pacific, and low income pregnant women, new mothers, and their whānau. - Lower Hutt Women's Centre provides community-based primary mental health services, targeted to Māori, Pacific, and low income women - general practice provides primary mental health services for low income Māori or Pacific people age 12 years and over.	NA	Status update report	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
1. Develop options to **improve access** to maternal mental health services supporting mild to moderate presentation, particularly for Maori, Pacific and those living in deprivation. (EOA)	Q1-4		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
2. Consider options to improve effective access to services according to presenting need, and **enhance service integration** to ensure the seamless transition of women between services.	Q1-4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
3. Develop and commence implementation of a 3DHB Mental Health and Addiction **Population Outcomes Framework**, which links the activities across the three DHBs with the desired outcomes and provides a means of tracking and reporting progress. (This is also a Population Mental Health activity).	Q2			

2.1.3 Improving wellbeing through prevention

Preventing ill health and promoting wellness is vital to improving the wellbeing of New Zealanders. As the population grows and ages, it is important to orient the health and disability system towards prevention. This preventive focus includes supporting people to live active and health lives, working with other agencies to address key determinants of health, and to identify and treat health concerns early in the life course and in the life of progress of the disease.

Cross-sectoral collaboration			This is an equitable outcomes action (EOA) focus area	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
			System outcome We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
In 2018 Hutt Valley DHB launched *Our Wellbeing Plan* for the Hutt Valley. 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. We will be working with Healthy Families, Regional Public Health, Māori and Pacific providers, local councils, and health and social sector providers and agencies (our key stakeholders) to develop and implement the Wellbeing Plan. Specific actions for 2019/20 include the following cross sector activities. 1. Develop and begin delivering a co-ordinated **Smoke-free Action Plan** focussing priority populations.[19] (EOA) (Also a SUDU activity and a Smokefree 2025 activity) 2. Support **'water-only schools'** and the development of **healthy food environments** in school settings, with a focus on low decile schools. (EOA) (Also a Healthy Food and Drink activity, and Diabetes and other long-term conditions activity) 3. Continue to support and enhance the Well Homes service, which helps families access **housing interventions** such as insulation, heating, curtain banks, beds, bedding, and carpets. (EOA)[20] 4. Address **social housing** across the district by contributing to the development of a coordinated housing approach with Hutt City Council and other social sector partners. 5. Support the **Maternal Care and Child Wellbeing Multi Agency Group**, a cross-sectoral group that identifies pregnant women who are experiencing intimate partner violence and/or child protection concerns, and works with those involved and cross-sector agencies and organisations to prevent further harm. (EOA)[21] (This is also an addressing Family Violence and Sexual Violence activity)	Q1-4 Q1-4 Q1-4 Q1-4 Q1-4	PH01: ASH[22] rates for 0–4 year olds CW02: Oral Health- Mean DMFT[23] score at school Year 8	**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
			System outcome We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

[19] Māori (particularly Māori females and mothers), Pacific peoples, Rangatahi (young people), and mental health consumers.

[20] The Well Homes service targets families at risk of housing related illnesses (such as respiratory illnesses and rheumatic fever). Māori and Pasifika families are priority populations for the Well Homes services because they have disproportionately high rates of ambulatory sensitive hospitalisation and conditions closely associated with poor housing.

[21] Māori women make up approximately 65% of the total referrals to the Maternal Care and Child Wellbeing Multi Agency Group.

[22] Ambulatory Sensitive Hospitalisation.

[23] Decayed, Missing and Filled Teeth.

Climate change

DHB activity	Milestone	Measure	Government themes:	
1. Undertake an independent audit/certification (**CEMARS**[24]) to benchmark Hutt Valley DHB's carbon emissions from various activities related to the operation of the DHB. The activities will include fuel usage, electricity consumption, waste, taxi travel, and anaesthetic gases. This will enable us to monitor our carbon footprint and measures the effectiveness of changes to reduce our emissions.	Q2	Status update report	**Improving the well-being of New Zealanders and their families** **Build a productive, sustainable and inclusive economy** (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand)	
2. Coordinate and oversee efforts to **reduce carbon emissions** and the environmental disposal of hospital and community waste products. (This is also a Waste disposal activity).	Q1		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Transition to a clean, green carbon neutral new Zealand
3. Continue to review **sustainable options around food services**, including reduction in power consumption, recycling, and composting.	Q1-4		**System outcome** We live longer in good health	
4. Continue the replacement of hospital fleet petrol vehicles with **hybrid vehicles**.	Q1-4		**System outcome** We have improved quality of life	

Waste disposal

DHB activity	Milestone	Measure	Government themes:
1. Coordinate and oversee efforts to **reduce carbon emissions** and the environmental disposal of hospital and community waste products. (This is also a Climate change activity).	Q1	Status update report	**Improving the well-being of New Zealanders and their families** **Build a productive, sustainable and inclusive economy** (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand)
2. Implement **alternative solutions for waste** to reduce environmental impact at landfill.	Q2		

[24] Certified Emissions Measurement and Reduction Scheme.

3. Support the **environmental disposal of hospital and community waste** products (including cytotoxic waste). 4. Work with Regional Public Health to ensure the appropriate **management of hazardous substances** so that adverse health effects and environmental contamination are avoided. 5. Expand the **use of steam cleaning** to non-clinical areas of the hospital, which will eliminate the use of all chemical use hospital wide.	Q1-4 Q1-4 Q1		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Transition to a clean, green carbon neutral new Zealand
			System outcome We live longer in good health	
			System outcome We have improved quality of life	

Drinking water		**This is an equitable outcomes action (EOA) focus area**		
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Meet regularly with Regional Public Health to understand and **support drinking water activities**, with an initial focus on the annual drinking water survey and compliance report. 2. Support Regional Public Health in its work with Māori communities to improve drinking water quality, including assistance to Te Rūnanganui o Taranaki Whānui Ki Te Ūpoko o te Ika ā Maui with the development and implementation of a **water safety plan** for the bore at Waiwhetu Marae. (EOA)	Q1-4 Q1-4	Status update report	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Grow and share New Zealand's prosperity more fairly
			System outcome We live longer in good health	
			System outcome We have improved quality of life	

<table>
<tr><th colspan="2">Healthy food and drink</th><th colspan="3">This is an equitable outcomes action (EOA) focus area</th></tr>
<tr><td>DHB activity</td><td>Milestone</td><td>Measure</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td>1. Align the 3DHB food and beverage guidelines with the national policy (with the exception of drinks which will remain stricter than the national policy). Finalise the implementation of the food and beverage guidelines (one phase outstanding: gifts and fundraising).</td><td>Q1-4</td><td rowspan="5">CW02: Oral Health- Mean DMFT[25] score at school Year 8</td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
<tr><td>2. Support our health provider organisations to develop a Healthy Food and Drink Policy (that aligns with the Healthy Food and Drink Policy for Organisations) covering all food and drinks sold on site/s, and provided by their organisation to clients/service users/patients, staff and visitors under their jurisdiction.</td><td>Q1-4</td><td rowspan="3">System outcome
We live longer in good health</td><td rowspan="3">Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
<tr><td>3. Support ‘water-only schools’ and the development of healthy food environments in school settings, with a focus on low decile schools. (EOA) (Also a Cross-sectoral collaboration activity, and a Diabetes and other long-term conditions activity)</td><td>Q1-4</td></tr>
<tr><td>4. Continue to fund Sport Wellington to deliver a free Active Families programme to help children and their whānau create a healthier lifestyle by becoming more active and learning about healthy eating. Māori and Pacific families are targeted. (EOA) (Also a Diabetes and other long-term conditions activity)</td><td>Q1-4</td></tr>
<tr><td>5. Work with Regional Public Health to develop processes, in partnership with other relevant agencies, for reporting in Q2 and Q4 on the number of Early Learning Settings, primary, intermediate and secondary schools that have current 1) water-only (including plain milk) policies, and 2) healthy food policies consistent with the Ministry of Health's Eating and Activity Guidelines.</td><td>Q2 and Q4</td><td>System outcome
We have improved quality of life</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
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[25] Decayed, Missing and Filled Teeth.

<table>
<tr><th colspan="2">Smokefree 2025</th><th colspan="3">This is an equitable outcomes action (EOA) focus area</th></tr>
<tr><td>DHB activity</td><td>Milestone</td><td>Measure</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td>1. Deliver a co-ordinated Smoke-free Action Plan focussing priority populations[26], which includes:
- improving the up-take of referrals to smoking cessation services
- reviewing the DHB’s smoke-free vaping policy
- supporting councils in reviews of smoke-free and vaping policies
(EOA) (Also a Cross-sectoral collaboration activity and a SUDI activity)</td><td>Q1</td><td rowspan="4">SS06: Better help for smokers to quit in public hospitals

PH04: Better help for smokers to quit (primary care)

CW09: Better help for smokers to quit (maternity)</td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
<tr><td>2. Continue to work with and support Takiri Mai Te Ata Regional Stop Smoking Service (Ministry funded wrap-around stop smoking service) and community providers on strategies to improve smoking cessation, especially in pregnant Māori women.</td><td>Q1-4</td><td>System outcome
We live longer in good health</td><td>Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
<tr><td>3. Provide training and education to new DHB staff on the importance of providing brief advice and support to patients who smoke.</td><td>Q1-4</td><td rowspan="2">System outcome
We have improved quality of life</td><td rowspan="2">Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
<tr><td>4. Develop youth appropriate smokefree messaging and communication strategies and health promoting activities</td><td>Q1-4</td></tr>
<tr><td>5. Support Healthy Families to extend their work in the community and increase smokefree environments in Upper Hutt.</td><td>Q1-4</td><td></td><td></td></tr>
</table>

[26] Māori (particularly Māori females and mothers), Pacific peoples, Rangatahi (young people), and mental health consumers.

<table>
<tr><td colspan="2">Breast Screening</td><td colspan="3">This is an equitable outcomes action (EOA) focus area</td></tr>
<tr><td>DHB activity

Hutt Valley DHB aims to achieve participation of at least 70 percent of women aged 45-69 years in the most recent 24 month period, and eliminate equity gaps for priority group Māori and Pacific women.

1. Regional Screening Services will provide six weekend breast-screening clinics and aim to screen a target of 40 women at each clinic (dependent on the magnetic resonance imaging resource). (Also a Cancer Services activity)
2. Regional Screening Service will implement a monthly evening breast-screening clinic during the working week and aim to screen a target of 15 women at each clinic.
3. To support the national (BreastScreen Aotearoa) two-year pathway to achieve the 70% screening target for Māori and Pacific women, Regional Screening Services' recruitment and retention team will aim to support an additional 50 Māori and 15 Pacific women who are overdue or unscreened to attend a breast screening clinic (EOA)
4. Regional Screening Services will use the results of a recent survey to plan for the most effective and efficient way of increasing access to breast screening services with a particular focus on improving access for Māori and Pacific women (EOA)
5. Regional Screening Services will trial same day biopsies and first specialist appointments at the breast symptomatic clinic to facilitate access and faster cancer treatments. (Also a Cancer Services activity)</td><td>Milestone

Q1-4

Q1-4

Q1-4

Q1-4

Q1-4</td><td>Measure

PV01: Improving breast screening coverage and rescreening</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families

System outcome
We have health equity for Māori and other groups

Government priority outcome
Support healthier, safer and more connected communities

System outcome
We live longer in good health

Government priority outcome
Make New Zealand the best place in the world to be a child

System outcome
We have improved quality of life

Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

Cervical Screening			**This is an equitable outcomes action (EOA) focus area**	
DHB activity Hutt Valley DHB aims to achieve at least 80 percent participation of women aged 25-69 years in the most recent 36 month period, and eliminate equity gaps for priority group women, including Māori, Pacific and Asian women.	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Regional Screening Services will provide 4 **weekend cervical screening clinics** at Hutt Hospital and aim to screen a target of 35 women at each clinic.	Q1-4	PV02: Improving Cervical Screening coverage		
2. Regional Screening Services will provide 15 **evening cervical screening clinics** at screening sites across Hutt Valley DHB and aim to screen a target of 15 women at each clinic.	Q1-4			
3. Regional Screening Services will partner with general practices with a high proportion of **overdue or unscreened women** and report the number of women who attend the 12 combined cervical and breast screening clinics for priority women.	Q1-4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
4. Regional Screening Services will use the results of a recent survey to plan for the most effective and efficient way of **increasing access to cervical screening services** with a particular focus on improving access for Māori and Pacific women. (EOA)	Q1-4		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
5. Provide 12 free **community-based cervical screening clinics** per annum in high-needs communities across the Hutt Valley district, targeting Māori, Pacific, and Asian women. (EOA) (Also a Cancer Services activity)	Q1-4			
6. Regional Screening Services will collaborate with 10 general practices in Hutt Valley DHB to use data matching reports to identify and **offer support to priority group Māori, Pacific, and Asian women** who are unscreened and under screened.	Q1-4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
7. Regional Screening Services will **promote key messages** around the importance and benefits of cervical screening and supporting women into the screening pathway on their new Facebook page, sponsorship and attendance at community events such as Te Ra o te Raukura, Pomare in the Hood, Healthy n the Hutt, Tumeke Taita, Christmas in the Nui, Pacifica Choice Festival, Waitangi Day celebrations across local Marae, linking with NCSP Māori and Pacific Support to Service Providers to follow-up 'did not attend' referrals, advertising on community social media pages, local Māori and Pacific radio and local media.	Q1-4			

2.1.4 Better population health outcomes supported by a strong and equitable public health and disability system

New Zealanders are living longer, but also spending more time in poor health.
This means we can expect strong demand for health services in the community, our hospitals, and other care settings.

Responding to this challenge will require effective and co-ordinated care in the community supported by strategic capital investment, workforce development, and joined-up service planning to maximise system resources and to improve health and increase equity.

<table>
<tr><th colspan="3">Engagement and obligations as a Treaty partner</th><th colspan="3">This is an equitable outcomes action (EOA) focus area</th></tr>
<tr><td>DHB activity

In March 2019 Hutt Valley DHB launched Te Pae Amorangi, Hutt Valley DHB's Māori Health Strategy to 2027. Te Pae Amorangi is centred on achieving Māori health equity, and advancing treaty relationships and Māori participation across the health system. It will support us to achieve Māori health equity and mauri ora (healthy individuals), whānau ora (healthy families), and wai ora (healthy environments). Progressing implementation of Te Pae Amorangi is a focus for 2019/20, including the following specific actions:

1. Develop institutional racism and bias training for Senior Medical Officers. (EOA) (Also a Workforce activity)
2. Develop and begin delivering Māori health equity and cultural safety training to DHB staff, including (EOA) (Also a Workforce activity and an Acute Demand activity)
3. Review current recruitment policies and procedures to enhance the ability to attract, appoint and retain Māori staff. (EOA) (Also a Workforce activity)
4. Establish a Kaumatua role for the DHB to focus both on supporting whānau and supporting DHB staff to provide culturally safe care. (EOA)

Māori representation is provided on Hutt Valley DHB's advisory committees and its Alliance Leadership Team. Hutt Valley DHB also established an Iwi Relationship Board in 2019 to formalise the relationship between local Iwi and the DHB, build on relationships, and share aspirations and strategic directions.</td><td>Milestone

Q3

Q4

Q4

Q1</td><td>Measure

SS12: Engagement and obligations as a Treaty partner</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td></td><td></td><td></td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
<tr><td></td><td></td><td></td><td>System outcome
We live longer in good health</td><td>Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
<tr><td></td><td></td><td></td><td>System outcome
We have improved quality of life</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

<table>
<tr><th colspan="3">Delivery of Whānau Ora</th><th colspan="3">This is an equitable outcomes action (EOA) focus area</th></tr>
<tr><td>DHB activity</td><td>Milestone</td><td>Measure</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td rowspan="4">1. Contribute to the strategic change for whānau ora approaches within the DHB systems and services, and across the district, to improve service delivery. This includes:
- Whānau Ora representation on the refreshed Alliance Leadership Team[27]
- working in partnership with local Māori health providers to meet Whānau Ora objectives
- continue working with local Māori health providers to jointly develop systems that will collect and report on agreed service outcomes that are important to the people using the services.
2. Support – including through investment – the Whānau Ora Initiative, and collaborate with its commissioning agencies and partners to identify opportunities for alignment. This includes:
- meeting with Whānau Ora collectives to investigate opportunities for alignment with the DHB’s work programme and priorities
- meeting with Te Roopu Awhina ki Porirua and Te Pou Matakana to identify possible opportunities for alignment the DHB’s work programme and priorities.
3. Undertake quality improvement actions that align with and support Healthy Lives domain of the Pasifika Futures Outcomes Framework for Prosperous Pacific Families.</td><td rowspan="4">Q2
Q4
Q4
Q4
Q4
Q1-4</td><td rowspan="4">Status update report</td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
<tr><td>System outcome
We live longer in good health</td><td>Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
<tr><td>System outcome
We have improved quality of life</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
<tr><td colspan="2"></td></tr>
</table>

[27] Hutt Valley DHB is refreshing the membership and scope of its Alliance Leadership Team to include oversight of the implementation of the Clinical Services Plan, the Wellbeing Plan and the Māori Health Strategy and to strengthen the links to other key governance groups, including our Iwi Board and our Consumer Council.

Care Capacity Demand Management (CCDM)			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Review current **recruitment policies and procedures** to enhance the ability to attract, appoint and retain Māori staff.[28] (EOA) (Also a Workforce activity and a Strong and Equitable Public Health and Disability System activity)	Q1-4	Status update report	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Establish a system to collect and collate all 23 measures needed for the **Core Data Set** (measuring patient care, work environment, and best use of health resources), and automatically feed these measures into the Capacity at a Glance screens.	Q1		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
3. Implement **Capacity at a Glance screens** in all Hutt Hospital wards to monitor current capacity (the staff) against demand (the patients in the ward), visualise the performance of the ward at a glance, and identify opportunities for improvement.	Q1		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
4. Implement the **Visual Indicator Scores** (VIS) mobile application that clinical managers will use to assess current capacity and update the Capacity at a Glance screens.	Q1			
5. Establish **Ward Quality Groups** across all Hutt Hospital wards to monitor the Core Data Set measures and implement continuous quality improvement activities.	Q4			
6. Complete the **base establishment FTE** calculations across all wards, and maintain the base-level FTEs across all wards.	Q1			
7. Re-assess the **FTE calculations annually** to feed into the budget annual process and implement the recommendations from FTE calculations.	Q2			
8. **Implement training** to keep senior staff up-to-date with changes and enhancements to TrendCare and the CCDM programme.	Q1-4			
9. Introduce **Variance Response Management** processes and tools that enable the DHB to quickly respond to workforce demands and therefore improve patient flow.	Q1-4			

[28] This activity is related to a commitment from all 20 DHB Chief Executives in June 2019 to introduce targets for DHBs to increase Māori participation in the workforce.

Disability			**This is an equitable outcomes action (EOA) focus area**	
DHB activity This activity is underpinned by the 3DHB Sub-Regional Disability Strategy 2017 – 2022 (Wairarapa, Hutt Valley and Capital & Coast District Health Boards): *Enabling Partnerships: Collaboration for effective access to health services.*	**Milestone**	**Measure** Status update report	**Government theme:** **Improving the well-being of New Zealanders and their families**	
			System outcome We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
1. **Work with Māori and Pacific** people with disabilities to determine the key goals and priorities for improving access to services. (EOA) (Also a Workforce / Health literacy activity)	Q1-4			
			System outcome We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
2. Develop and implement a **Disability Education Plan** that incorporates a rights based approach to reduce inequitable health outcomes across the disabled, Māori and Pacific communities (EOA)	Q1-2			
3. Continue quality improvement processes on the **Disability Responsiveness eLearning** module to all staff and report on the percentage of staff that have completed the training.	Q1-4			
			System outcome We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
4. Develop and complete a **Disability Survey** with our workforce to better understand the areas where capability development is required. The survey will be endorsed by the Sub Regional-Disability Advisory Group which will include Māori and Pacific input.	Q4			
5. Improve patient experiences by including information about a patient's sensory, physical, intellectual disabilities on **Disability Alerts**[29], and put in place a quality standard which is measured.	Q1-4			

Planned Care		**This is an equitable outcomes action (EOA) focus area**	
DHB activity *Quarters 1-4*	Measures - Quarter 1 Delivery of actions and improvement against Planned Care Measures expectations A plan is submitted that outlines the proposed approach to develop the Three Year Plan.	**Government theme:** **Improving the well-being of New Zealanders and their families**	
		System outcome We have improved quality of life (health maintenance and independence)	**Government priority outcome** Support healthier, safer and more connected communities
1. Continue to provide a Mobility Action Programme (MAP) to deliver a community-focused early intervention programme for people with musculoskeletal conditions in the Hutt Valley.			
2. Work with the MAP provider, Kokiri Marae, the Pacific Health Service, and Te Awakairanga Health (PHO) to increase awareness of the programme and improve the referrals of Māori and Pacific clients into the programme. (EOA)			

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

<table>
<tr>
<td rowspan="3">Quarter 1
3. Progress our Theatre Optimisation Project to improve theatre efficiency and capacity. In quarter one, we will commence roll-out of an electronic theatre booking system to replace manual processes. The electronic theatre booking features an auto-calculation of procedure times specific for each doctor. This will allow more accurate planning of operating lists and ensure that a list can be filled, maximising operating schedules and reducing waiting times. We will also assess options to improve theatre efficiency and meet the forecast demands on services. (Also an Acute Care activity)
4. Outline Hutt Valley DHB's engagement, analysis and development activities for the development a three year plan to improve planned care services.
Quarter 2
5. Progress our Theatre Optimisation Project to improve theatre efficiency and capacity. In quarter two, we will prepare a business case to implement the preferred package of options. (Also an Acute Care activity).
6. Undertake analysis of changes that can be made to our planned care services, including consultation with our Consumer Council and other key stakeholders.
Quarter 3
7. Complete a three year plan to improve planned care services at Hutt Valley DHB and submit the plan to the Ministry of Health.
Quarter 4
8. Provide the Ministry of Health with an update on actions in the three year plan to improve planned care services at Hutt Valley DHB. This will include an update on the Theatre Optimisation Project.
9. Work with Capital & Coast DHB to progress the programme of work to jointly plan and coordinate the delivery of planned care services across our network of hospitals (Wellington, Kenepuru, and Hutt Hospital) to ensure access to timely and high-quality secondary services that are both clinically and financially sustainable. [30]</td>
<td>Measures - Quarter 2
Delivery of actions and improvement against Planned Care Measures expectations
A summary report outlining the outcomes of the analysis and consultation processes to understand local health needs, priorities and preferences.</td>
<td>System outcome
We have improved health equity
(healthy populations)</td>
<td>Government priority outcome
Make New Zealand the best place in the world to be a child</td>
</tr>
<tr>
<td>Measures - Quarter 3
Delivery of actions and improvement against Planned Care Measures expectations
<u>Part two:</u>
Submission of the Three Year Plan to improve Planned Care Services.</td>
<td rowspan="2">System outcome
We live longer in good health
(prevention and early intervention)</td>
<td rowspan="2">Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td>
</tr>
<tr>
<td>Measures - Quarter 4
Delivery of actions and improvement against Planned Care Measures expectations
An update is provided on actions outlined in the Three Year Plan to improve Planned Care Services.</td>
</tr>
</table>

[30] The joint planning across our network of hospitals is a long-term project that will contribute to timely planned care services, but this work will not directly contribute to improve planned care wait times in 2019/20.

Acute Demand			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Develop a plan to implement SNOMED[31] coding in the Emergency Department, including: - assessing feasibility and the change impact to clinical workflow and systems (Q2) - liaising and consulting with sub-regional DHBs and the Ministry of Health on the findings of this assessment and the development of a coordinated approach to implementation (Q2) - developing and assessing implementation options (Q3) - developing a business case for implementation (Q4).	Q2-4	SS10: Shorter stays in Emergency Departments	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Improve patient flow by **moving some infusion therapies** from the hospital into primary care/community settings, particularly to improve equity and access for priority populations (Māori, Pacific, quintile four and five, and community service card holders).[32] (EOA)	Q2		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
3. Scope a project to **better meet the needs of Māori presenting to the Emergency Department** (leveraging off the learnings and resources developed for CCDHB's 'Equity for Maori in Wellington Emergency Department' project). (EOA)	Q4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
4. Implement **Māori health and equity training to Emergency Department staff** to grow their knowledge and practice (Tikanga) (EOA)	Q1-4			
5. Expand the **'Red2Green Initiative'** in Hutt Valley Hospital to the Older Persons and Rehabilitation Service to identify unnecessary delays in patient care and improve the patient's experience of care.[33]	Q1-4			
5. Complete a review of the **Triage and Urgent Response Service** (Te Haika) and implement the findings to improve the response to acute referrals and triage for interventions. (Also a Mental health and addictions improvement activity and an Addictions activity)	Q1-4			

[31] SNOMED is a systematically organised collection of medical terms providing codes, terms, synonyms and definitions used in clinical documentation and reporting.

[32] Getting people to access medicines in their locality is important to reduce access barriers. Identifying quintiles four and five for referrals to primary care from inpatient based clinics will be required during the triage process.

[33] Under the Red2Green Initiative, delays in patient care are actively 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.

6. Progress our **Theatre Optimisation Project** to improve theatre efficiency and capacity. The project includes the following milestones: - commence roll-out of an electronic theatre booking system to replace manual processes (Q1) - assess options to improve theatre efficiency and meet the forecast demands on services (Q1) - prepare a business case to implement the preferred package of options. (Q2) (Also a Planned Care activity) ***Improving the response to mental health patients*** To improve the wait times of patients requiring mental health and addiction services who present to Emergency Departments, MHAIDS will be trialling the placement of Rapid Assessment Mental Health Specialists in the Emergency Department at Wellington Regional Hospital. If the trial proves successful, it will be extended to the Emergency Department at Hutt Hospital. In the meantime, close monitoring of performance continues at Hutt Hospital's Emergency Department with any individual issues followed up. After-hours Mental Health managers are now in place, and this has helped streamline admissions to the Mental Health Inpatient Unit.	Q1-2 Q1-4			

Healthy Ageing			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Work with ACC, HQSC and the Ministry of Health to promote and increase enrolment in **Strength and Balance programmes** and improve osteoporosis management.	Q1-4	Strong system SS04: Delivery of actions to improve wrap around services for older people	**System outcome** We have health equity for Māori and other groups	**System outcome** We have improved quality of life (health maintenance and independence)
2. Align local DHB service specifications for **home and community support services** (HCSS) to the vision, principles, core components, measures and outcomes of the national framework for HCSS.	Q1-4			
3. Work with Sport Wellington and community partners to increase the number of Māori and Pacific older people accessing community-based strength and balance activities, to **reduce the number of falls related injuries**. (EOA) [34]	Q4		**System outcome** We live longer in good health	**System outcome** We have improved health equity (healthy populations)
4. Review quarterly referral to ED data from aged residential care providers to identify and implement workforce development and clinical learning priorities that will improve the quality of care and **reduce potentially avoidable referrals to ED**.	Q4			
5. Develop an action plan to **enhance the quality of day care services** for older people, based on consumer and provider feedback, to increase user and consumer satisfaction with services.	Q4		**System outcome** We have improved quality of life	**System outcome** We live longer in good health (prevention and early intervention)
6. Lead a multi-agency steering group to deliver projects that **promote Hutt Valley organisations to become registered Dementia Friendly**, improve early awareness of cognitive impairment leading to earlier access to support services, and projects that focus on improving dementia support to Māori and Pacific groups. (EOA)	Q1-4			
Implementation of the New Zealand Framework for Dementia Care				
7. Provide input into a regional stocktake of dementia services and related activity. (Also a Delivery of Regional Service Plan activity).	Q2			
8. Using the stocktake, work with regional colleagues to identify and develop an approach to progress priority areas for implementing the Framework. (Also a Delivery of Regional Service Plan activity).	Q4			
9. Report on work to progress the implementation of the New Zealand Framework for Dementia Care. (Also a Delivery of Regional Service Plan activity).	Q3 and Q4			

[34] Ethnicity data be collected for the Live Stronger for Longer outcome framework.

Improving Quality			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Implement the local System Level Measure Improvement Plan developed by our Alliance Leadership Team as outlined in Appendix B.	Q1-4	PH01: SLM patient experience of care SS05: ASH rates (avoidable hospitalisation) for adults	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Implement the **respiratory work programme** throughout 2019/20 to address asthma and respiratory related hospital admissions and disparities for Māori and Pacific. (EOA) **Improve patient experience**	Q1-4		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
3. Identify actions to improve staff **communication about medication side effects** to adult inpatients.[35] (Also a Health Literacy activity) **Antimicrobial Resistance**	Q1-4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
Actions planned to **address the challenge posed by antimicrobial resistance** (in alignment align with the New Zealand Antimicrobial Resistance Action Plan) include: 4. Amend patient records that incorrectly identify a penicillin allergy.[36] 5. Antimicrobial stewardship ward rounds in the hospital to optimise antimicrobial prescribing, reduce the use of unnecessary antibiotics, and educate and support junior medical staff. 6. Surveillance of antimicrobial usage, including quarterly inpatient consumption reports, biannual point prevalence studies, and review of community dispensed antibiotics following discharge after surgery. 7. Update screening and transmission-based precautions policies in line with latest evidence to make them simpler for staff to follow and easier to identify and isolate patients with multidrug resistant organisms. 8. Continue surveillance of multidrug resistant organisms and Clostridium difficile. 9. Maintain hand hygiene compliance above 80 percent across Hutt Hospital through an increased focus on education and application of standard precautions for staff to apply to all patients.	Q1-4			

[35] In November 2018, the following question scored 52% from the total respondents 'Did a member of staff tell you about medication side effects to watch for when you went home?'

[36] Only 10 percent of patients said to have a penicillin allergy actually have an allergy. Patients labelled as 'penicillin allergic' have increased usage of broad spectrum antibiotics, antimicrobial resistance, Clostridium difficile infections, increased length of stay in hospital, and increased mortality from severe infections. Penicillin allergy labels can often be removed through a careful review of the antibiotics history and in consultation with the patient.

10. Complete the rollout of a consistent cleaning method using microfiber to nurses and health care assistants across Hutt Hospital Cleaning, with cleaning effectiveness monitored through regular audit and feedback. 11. Hutt Valley DHB will continue to support residential care providers to meet the Infection Control Standard (HDS (IPC) S.2008:3.1) through a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. 12. Hutt Valley DHB will collaborate with PHOs regarding the support they provide to general practices to meet the Infection Control Standard (HDS (IPC) S.2008:3.1) through a managed environment, which minimises the risk of infection to consumers, service providers, and visitors.	Q4: Audited facilities to comply with standards			

Cancer Services			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. To improve Māori and Pacific screening rates, Regional Screening Services will continue to provide **weekend breast screening clinics and cervical screening clinics**, and **monthly evening sessions,** rotated to different sites across the sub-region. The results of a recent survey will allow us to plan the most effective and efficient way of providing our Breast and Cervical Screening services with a continued focus on improving equity. (EOA) (Also a Breast Screening activity and Cervical Screening activity)	Q1-4	SS01: Faster cancer treatment (31 days) SS11: Faster cancer treatment (62 days) PV01: Improving breast screening coverage and rescreening	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Invite and support overdue and unscreened women to **combined breast and cervical screening sessions**. (EOA)	Q1-4		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
3. Regional Screening Services will trial same **day biopsies and first specialist appointments** at the breast symptomatic clinic to facilitate access and faster cancer treatments. (Also a Breast Screening activity)	Q1-4			
4. Continue to **monitor equity** of access and timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway.[37]	Q1-4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
5. Offer **education, advice and transport** to women who have previous missed appointments to Colonoscopy Services to facilitate access and faster cancer treatments.	Q1-4			
6. Support the regional **Cancer Care Network** to develop and implement a long-term Cancer Plan for Primary and Community Care, consistent with national work on a cancer plan. This may include streamlining pathways and models of care, clinical education and	Q1-4			

[37] Hutt Valley DHB consistently achieves the 31 day and 62 FCT measures and we will continue to monitoring our performance.

training days, the development of an e-learning tool and improving access and quality of care for Māori and pacific populations. (Also a Delivery of Regional Services Plan activity) 7. Work with the Ministry of Health to develop and implement a Cancer Plan, including the delivery of local actions that support the plan. **Areas for bowel cancer service improvement** 8. Develop and implement a project to **improve engagement with Māori and Pacific peoples** in the bowel screening population, therefore increasing awareness of symptoms and early diagnosis. A Bowel Screening Project Coordinator will be established to oversee implementation of the project. Progress will be measured using our bowel screening participation rates and Māori and Pacific acute presentations to the Emergency Department who are subsequently diagnosed with bowel cancer. (EOA) (Also a Bowel Screening activity) 9. **Additional endoscopy capacity** to address a steady increase in referrals and reduce colonoscopy wait times. We will also explore other options to address the rising demand, including nurse-led triaging of referrals and use of nurse endoscopists and fellow positions. Progress will be measured by colonoscopy wait times. (Also a Bowel Screening activity)	Q1-4 Q1-4 Q1-4	PV02: Improving Cervical Screening coverage		

<table>
<tr><th colspan="3">Bowel Screening</th><th colspan="3">This is an equitable outcomes action (EOA) focus area</th></tr>
<tr><td>DHB activity

1. Develop and implement a project to improve engagement with Māori and Pacific peoples in the bowel screening population, therefore increasing awareness of symptoms and early diagnosis. A Bowel Screening Project Coordinator will be established to oversee implementation of the project. Progress will be measured using our bowel screening participation rates and Māori and Pacific acute presentations to the Emergency Department who are subsequently diagnosed with bowel cancer. (EOA) (Also a Cancer Services activity)

2. Additional endoscopy capacity to address a steady increase in referrals and reduce colonoscopy wait times. We will also explore other options to address the rising demand, including nurse-led triaging of referrals and use of nurse endoscopists and fellow positions. Progress will be measured by colonoscopy wait times. (Also a Cancer Services activity)</td><td>Milestone

Q1-4

Q1-4</td><td>Measure

SS15: Improving waiting times for Colonoscopy</td><td colspan="3">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td colspan="3"></td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
<tr><td colspan="3"></td><td>System outcome
We live longer in good health</td><td>Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
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We have improved quality of life</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

Workforce			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
Workforce priorities		Status update report	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
1. Launch the **Mauri Ora staff wellbeing programme**, including tools and resources for staff, to support a healthier and happier workplace where our wellbeing is valued.	Q1-4		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
2. Deliver the **'Speaking up Safely / Beyond Bullying' programme** to assist staff to recognise positive behaviours and address unacceptable behaviours.	Q4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
3. Collaborate with local council to provide **training sessions** around suicide prevention and supporting first symptoms of mental health (Mental Health 101) for key stakeholders, including community services and agencies, and the education sector and schools. (Also a Population Mental Health activity)	Q1-4			
4. Progress implementation of Hutt Valley DHB's five-year **nursing workforce strategy**, Nursing at its Best / Tepanikiri pai o ngaa neehi.	Q1-4			
5. Develop and implement **corporate health and safety standards and training**.	Q1-4			
6. Progress implementation of the **Care Capacity Demand Management** (CCDM) programme, with the goal of full implementation by 30 June 2021.[38]	Q1-4			
Workforce Diversity				
7. Develop and implement a **diversity recruitment policy** to help us attract and recruit a diverse mix of staff reflective of our community[39]	Q4			
8. Progress **values-based recruitment practices** across the DHB to help ensure the process aligns to our agreed values and supports an engaged workforce.[40]	Q3			
9. Review current **recruitment policies and procedures** to enhance the ability to attract, appoint and retain Māori staff. (EOA) (Also a Strong and Equitable Public Health and Disability System activity)	Q4			
10. Work towards equitable funding for professional development to doctors and nurse practitioners. This includes an additional $3000 per annum professional development				

[38] 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.

[39] 'Diversity' can relate to culture, ethnicity gender, disabilities, and age.

[40] Our core values are: *Always caring, Can do, In partnership, and Being our best.* Values-based recruitment is a methodology that enables hiring managers to incorporate scenarios and behaviourally-based questions to be included within the interview and selection processes. This is well developed for nursing roles, and will be progressed over time to include other clinical roles, senior doctors, administration, and corporate and management roles.

funding for nurse practitioners introduced into policy in 2019/20, with an intention to increase this funding incrementally every year until equity is achieved.	Q1-4			
11. Work with the Ministry of Health, regional DHB shared services, and unions to progress addressing issues around **pay equity**, the **gender pay gap**, and **the living wage**.	Q1-4			
Health Literacy				
12. Develop and begin delivering **Māori health equity and cultural safety training** to DHB staff. (EOA) (Also a Strong and Equitable Public Health and Disability System activity and an Acute Demand activity)	Q4			
13. Continue to implement a **Pacific Health Literacy programme** to improve health workforce understanding, literacy, and communication with Pacific people and whanau. (EOA)	Q1-2			
14. Identify actions to **improve staff communication** about medication side effects to adult inpatients.[41] (This is also an Improving Quality activity)	Q1-4			
15. Develop **institutional racism and bias training** for Senior Medical Officers. (EOA) (Also a Strong and Equitable Public Health and Disability System activity)	Q3			

[41] In November 2018, the following question scored 52% from the total respondents 'Did a member of staff tell you about medication side effects to watch for when you went home?'

Data and Digital			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
Improving equity through digital systems/investments				
1. Complete Business Case for multilingual versions of an electronic Patient Experience Survey.	Q3	Quarterly reports on the DHB ICT Investment Portfolio.	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Pilot Electronic Referrals from hospital services (including Emergency Department) to community providers.	Q4			
3. Make the Maori keyboard (including ability to add macrons) the standard profile.	Q1			
4. Extend free patient Wi-Fi to outpatients.	Q3		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
Leveraging approved standards and architecture				
5. Complete a Security Improvement work plan for 2019-21 based on the findings of the independent review against the Health Information Security Framework.	Q1			
6. Complete the Allied Health Activity Capture project to improve the Allied Health service's ability to meet data standards.	Q1		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
7. Work with the Ministry on developing a plan to implement SNOMED coding in the Emergency Department, including: - assessing feasibility and the change impact to clinical workflow and systems; - liaising and consulting with sub-regional DHBs and the Ministry of Health on the findings of this assessment and the development of a coordinated approach to implementation; - developing and assessing implementation options - developing a business case for implementation.	Q4			
8. Implement a FHIR (Fast Health Interoperability Resources Standard).	Q2			
Supporting new models of health care delivery through technology				
9. Extend use of Zoom to other services to support new models of care including telehealth and multi-disciplinary meetings.	Q2-4			
Leveraging Regional and National Initiatives				
10. Complete transition to the Regional Radiology Information System.	Q2			

11. Regional Clinical Portal – complete the replication of data from local Clinical Data Repositories into the Regional Clinical Data Repository.	Q2			
12. National Bowel Screening – transition onto the National Bowel Screening Platform.	Q4			
Implementing Application Portfolio Management				
13. Long Term Investment Plan – complete an Asset Management Plan for information, communications, and technology assets.	Q2			
Mobile ePatient Observations				
14. Complete Implementation Business Case for Mobile ePatient Observations.	Q1			
eMedication Management				
15. Link NZePS data to discharge documentation and improve discharge information to include medication on admission and on discharge, and record changes with reasons	Q4			
16. Implement a new ePrescribing solution for Addiction Services with connection to NZePS	Q4			
17. Complete a request for proposal of a Hospital ePrescribing and Administration system.	Q3			
18. Complete Implementation Business Case for a Hospital ePrescribing and Administration system.	Q4			

<table>
<tr><th colspan="3">Collective Improvement Programme</th><th colspan="2">This is an equitable outcomes action (EOA) focus area</th></tr>
<tr><td>DHB activity

1. Hutt Valley DHB commits to supporting a collective improvement programme.[42]</td><td>Milestone

Q1-4</td><td>Measure

Status update report</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3"></td><td>System outcome
We have health equity for Māori and other groups</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
<tr><td>System outcome
We live longer in good health</td><td>Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
<tr><td>System outcome
We have improved quality of life</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

[42] This is a national DHB Chief Executives led initiative.

Delivery of Regional Service Plan (RSP) priorities			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Collaborate with other Central Region DHBs to develop and implement an **equity framework** to monitor equity of health outcomes across our region's population and improve outcomes for Māori. (EOA)	Q1-4	SS02: Ensuring delivery of Regional Service Plans	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Collaborate with other Central Region DHBs to develop and implement a **Treaty framework** to guide and monitor achieving Māori health equity across our region. (EOA)	Q1-4		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
3. Support the regional **Cancer Care Network** to develop and implement a long-term Cancer Plan for Primary and Community Care. This may include streamlining pathways and models of care, clinical education and training days, the development of an e-learning tool and improving access and quality of care for Māori and pacific populations. (Also a Cancer Services activity)	Q1-4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
4. Support the regional work to identify people who have contracted Hepatitis C but are unaware of their condition, and refer them to Central Region's **integrated Hepatitis C service** for treatment.	Q1-4			
5. Lead a multi-agency steering group to deliver projects that **promote organisations to become registered Dementia Friendly**, improve early awareness of cognitive impairment leading to earlier access to support services, and projects that focus on improving dementia support to Māori and Pacific groups. (EOA)	Q1-4			
Implementation of the New Zealand Framework for Dementia Care				
6. Provide input into a regional stocktake of dementia services and related activity. (Also a Healthy Ageing activity)	Q2			
7. Using the stocktake, work with regional colleagues to identify and develop an approach to progress priority areas for implementing the Framework. (Also a Healthy Ageing activity)	Q4			
8. Report on work to progress the implementation of the New Zealand Framework for Dementia Care. (Also a Healthy Ageing activity)	Q3 and Q4			

2.1.5 Better population health outcomes supported by primary health care

Primary health care is a priority work programme for Government, the Ministry of Health and District Health Boards.

An affordable effective primary care system is essential to achieving the objectives of a strong public health system. Primary care is the means through which the health system can decrease use of expensive secondary health services, better manage and lower the incidence of long-term conditions, increase use of illness-preventing behaviours and treatments, and thereby increase people's ability to participate in work and education.

However, the primary health care system does not serve all people equitably. Some people are avoiding or delaying engaging with primary care services because of cost. There is also the potential for a different primary care model to better suit people's lives and better integrate across health disciplines and facilities, thereby improving health outcomes.

Primary health care integration			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
The actions below are being led by our the Acute Demand & Community Care network, which reports to Hutt Inc, Hutt Valley DHB's Alliance Leadership Team. Hutt Inc is currently made up of senior DHB managers, clinical leaders from the DHB and the community, and other experts, including representation from Pacific and Māori Health Services.		PH01: Improving system integration and SLMs	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
1. Refresh membership and scope of our Alliance Leadership Team to include oversight of the implementation of the Clinical Services Plan, the Wellbeing Plan and the Māori Health Strategy and to strengthen the links to other key governance groups, including our Iwi Board and our Consumer Council.	Q2			
2. Pilot a 'neighbourhood approach' to integrated care, including: - the establishment of a **community team** of nurses and allied health staff supporting GP practices - **streamlined pathways of care** for the frail elderly and issues facing families with complex needs - an **early-supported discharge** function - **rapid response** that can quickly react to sudden deterioration and prevent a person from having to go into hospital.	Q2		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
3. Implement **specialist support models of care** to improve primary care capacity and capability to better manage complex clients in the community - with a focus on older persons, mental health, respiratory, and palliative care services. Practices with a high proportion of Māori, Pacific and Quintile 5 patients will be targeted and an equity-focused model will be tested in those practices. (EOA)	Q4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
4. Implement additional capacity to the medical roster to enable an increase in specialist advice to primary care staff to improve **proactive management of patients** in the community.	Q1-4			
5. Continue to implement the **Health Care Home patient-centred model of care** across the Hutt Valley,[43] including support to the PHO to enhance practices' awareness of the specific needs of their populations, and designing services to meet those needs. (EOA)	Q1-4			
6. Develop and implement new **ambulatory models of care** with Wellington Free Ambulance to support GP practices and after hours care.[44]	Q1-4			

[43] The Health Care Home 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.

[44] Ambulatory models of care provide medical care to people outside of the hospital (such as diagnosis, procedures and treatment). An ambulatory model of care can include, for example, having an acute care plan in place so that the patient and ambulance and primary care staff have agreed pathways of care in the event of an acute episode.

Pharmacy			**This is an equitable outcomes action (EOA) focus area**	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
1. Support the vision of the **Pharmacy Action Plan** and the Integrated Community Pharmacy Services Agreement (ICPSA) by working with pharmacists, the public, primary care and the wider health care team to commission integrated local services that prioritise local need and support equitable health outcomes. (EOA)	Q1-4	CW05: Immunisation coverage - focus area 3: Influenza immunisation at age 65 years and over	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
2. Support the work to enable the separation of dispensing into separate ICPSA schedules (medicine and supply and clinical advice) by June 2020.	Q1-4		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
3. Develop a proposal to reconfigure the community pharmacy Long Term Conditions Service so that it integrates with primary and secondary care and better **addresses issues for complex patients** such as polypharmacy and equity of access. (EOA)	Q4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
4. Develop and implement a **flexible payment system** in community pharmacies for people on multiple medications unable to afford the up-front co-payment costs. This will reduce the risk of people with long term conditions becoming unwell because they have delayed or avoided collecting medicines due to co-payment costs. (EOA)	Q1			
5. Develop and implement local strategies that support general practice, pharmacy, and other immunisation providers to work together to **improve influenza vaccination rates** in Māori, Pacific and Asian people over 65 years of age. This includes: • developing and reporting on the local strategies by quarter three • implementing local strategies from 1 April 2020 • reporting the outcomes of these local strategies to improve influenza vaccination rates in quarter two of 2020/21.	Q3			

Diabetes and other long-term conditions			This is an equitable outcomes action (EOA) focus area	
DHB activity	**Milestone**	**Measure**	**Government theme:** **Improving the well-being of New Zealanders and their families**	
Hutt Valley DHB ensures that all the services it commissions work closely with Māori and Pacific stakeholders to ensure that their programmes and services are culturally safe and appropriate. This is achieved through working closely with our Māori and Pacific DHB advisory teams and engaging with our Māori and pacific communities. To enhance **diabetes self-management education**, we have contracted with Melon Health to deliver a digital health programme that supports self-management for people with diabetes. The programme is primarily delivered on-line through a smart phone application and includes peer support, health coaching, tracking, medication reminders, and exercise, health and symptom tracking. The programme has specific targets for ensuring that that Māori and Pacific access the programme. Outcomes are monitored through a self-efficacy rating taken before and after the 16 week programme. Hutt Valley DHB has staff dedicated to promoting **cardiovascular disease risk assessment screening**, for our Māori and Pacific males in particular. This includes working with a wide range of providers and to ensure best practice is recognised and promoted across all Hutt Valley DHB stakeholders. We have also commissioned our PHOs to deliver a concerted approach in collaboration with our Māori and Pacific communities for the screening of this target group with the expectation that best practice will be identified and supported throughout their member practices. ***Public health promotion*** 1. Support '**water-only schools**' and the development of **healthy food environments** in school settings, with a focus on low decile schools. (EOA) (Also a Cross-sectoral collaboration activity and a Healthy Food and Drink activity) 2. Continue to fund Sport Wellington to deliver a free **Active Families programme** to help children and their whānau create a healthier lifestyle. The programme is tailored to Māori and Pacific families. (EOA) (Also a Healthy Food and Drink activity) ***Managing diabetes and cardiovascular disease*** 3. PHOs to assist practices to manage diabetes and cardiovascular disease, with specific focus on Māori and Pacific patients, by: • consistently undertaking **Diabetes Annual Reviews** for patients with diabetes • utilising BMI equipment to support the awareness and monitoring of weight gain, and appropriate interventions • consistently undertaking **CVD risk assessments** for the eligible populations	Q1-4 Q1-4 Q1-4	SS13: Improved management for long term conditions FA2 Diabetes services FA3 Cardiovascular health	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
			System outcome We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
			System outcome We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

• providing strengths-based **lifestyle advice and referrals** to other healthy lifestyle programmes • improving Māori and Pacific access to the Melon Health digital tool that **supports self-management**. (EOA) 4. Undertake a **community education** programme targeting Māori and Pacific men aged 35 to 44 years to increase uptake of CVD risk assessments. (EOA) 5. Monitor PHO/practice-level data to **improve equitable service provision** and inform quality improvement. (EOA) 6. Te Awakairangi Health to provide specific **training and practical skills development** relating to equity, institutional racism and cultural safety for the general practice workforce. (EOA)	Q4 Q1-4 Q1-4			

2.2 Financial performance summary

DHB Financial Performance Summary

Hutt Valley District Health Board
Forecast Statement of Comprehensive Income
For the Year Ended 30 June

$000s	2017/18 Audited	2018/19 Forecast	2019/20 Plan	2020/21 Plan	2021/22 Plan	2022/23 Plan
Revenue						
Ministry of Health Revenue	429,340	452,502	468,766	482,933	497,537	512,591
Other Government Revenue (including other DHBs)	113,465	115,048	120,259	121,462	122,677	123,903
Other Revenue	7,640	5,158	7,042	7,113	7,184	7,256
Total Revenue	**550,445**	**572,707**	**596,067**	**611,508**	**627,397**	**643,750**
Expenditure						
Personnel	175,325	190,689	198,723	204,685	210,825	217,150
Outsourced	17,002	16,645	12,588	12,820	13,059	13,303
Clinical Supplies	27,876	25,497	26,028	26,158	26,289	26,420
Infrastructure and Non Clinical	14,171	13,678	14,142	14,209	14,276	14,343
Payments to Other DHBs	93,040	93,802	101,203	104,350	107,595	110,942
Payments to Non-DHB Providers	202,382	208,940	218,951	225,760	232,781	240,021
Depreciation and Amortisation	13,673	14,826	15,561	15,639	15,717	15,796
Interest	51	28	71	72	72	72
Capital Charge	10,092	12,070	12,720	12,783	12,847	12,912
Other Expenses	3,724	4,683	4,222	4,243	4,265	4,286
Total Expenditure	**557,336**	**580,858**	**604,209**	**620,719**	**637,726**	**655,245**
Other Comprehensive Income						
Revaluation of Land and Buildings	38,246	(0)	(0)	(0)	(0)	(0)
Total Comprehensive Income / (Deficit)	**31,355**	**(8,150)**	**(8,141)**	**(9,212)**	**(10,329)**	**(11,495)**

Hutt Valley District Health Board
Prospective Summary of Revenues and Expenses by Output Class

$000s	2019/20 Plan	2020/21 Plan	2021/22 Plan
Early Detection			
Total Revenue	158,166	162,626	167,220
Total Expenditure	162,885	167,693	172,648
Net Surplus / (Deficit)	**(4,718)**	**(5,067)**	**(5,429)**
Rehabilitation & Support			
Total Revenue	74,695	76,758	78,883
Total Expenditure	75,581	77,860	80,210
Net Surplus / (Deficit)	**(886)**	**(1,102)**	**(1,327)**
Prevention			
Total Revenue	25,570	26,042	26,525
Total Expenditure	27,164	27,768	28,389
Net Surplus / (Deficit)	**(1,593)**	**(1,726)**	**(1,864)**
Intensive Assessment & Treatment			
Total Revenue	337,693	346,140	354,830
Total Expenditure	338,636	347,457	356,539
Net Surplus / (Deficit)	**(943)**	**(1,317)**	**(1,709)**
Consolidated Surplus / (Deficit)	**(8,141)**	**(9,212)**	**(10,329)**

* Please note that the 2018/19 forecast figures exclude adjustments for year-end provisions i.e. Holidays Act, Impairments.
** Please note that these financials have not been reconciled with the details in the Statement of Service Performance.

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 2019/20.

3.2 Service Change

Service Changes 2019/20

The table below describes all active service changes that have been approved or proposed for implementation in 2019/20.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
2018 Mental Health and Addictions Reviews	In 2018, the He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction was completed. The DHB will plan for service development which aligns with the report in partnership with our stakeholders and service providers. This may result in commissioning a different range of services to that which is currently funded. It may also result in the termination of some current agreements to allow the commissioning of best practice model-of-care services that support optimal population health outcomes.	Improved, patient experience, responsiveness to Māori health, and outcomes. Strengthened clinical and operational partnership.	National & Local
Ophthalmology service	Implementation of national Age-related Macular Degeneration (AMD) and glaucoma referral guidelines	Nationally consistent acceptance criteria and timeframes for review / follow up.	National
MHAIDS Structural Review	Two consultation processes will take place in relation to the 3DHB Mental Health, Addiction and Intellectual Disability Service (MHAIDS). The first will propose to staff that MHAIDS is led on behalf of all 3 sub-regional DHBs (Wairarapa, Capital & Coast and Hutt Valley) by CCDHB. This proposal would see all MHAIDS staff being employed by CCDHB. The second consultation process will cover a fundamental review of the leadership structures and clinical governance of MHAIDS. Both consultation processes are expected to be completed by	Improved governance structures, strengthened clinical and operational partnership, and stronger locality leadership presence.	3DHB - Hutt, Capital & Coast, and Wairarapa

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	early 2019/20 with any resulting implementation complete by the end of this calendar year.		
Acute Care Continuum	A project to develop an acute care services has commenced. The aim of the project is to develop an improved model of integrated service delivery, focusing on a defined range of services which will together deliver an 'Acute Care Continuum'. The system design approach taken with this project aims to deliver best practice improvements to better meet the acute needs of services users including improved support for family / whanau. The outcome of this project will determine the investment approach for a range of linked acute services, including inpatient and NGO provided services. This may result in commissioning a different range of services than currently funded, with potential review and updating or termination of some existing contracts.	Improved integration between providers of acute care services, smother and safer care, and improved access and responsive support for at risk service users and family / whanau.	3DHB - Hutt, Capital & Coast, and Wairarapa
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 strategic assessment and single stage business case to consider facility options.	Improved patient experience, responsiveness to Māori, and improved health outcomes.	3DHB - Hutt, Capital & Coast, and Wairarapa
Acute mental health services and alcohol and other drug treatment services	The DHBs are undertaking a review of their mental health acute services and alcohol and other drug treatment services. This may result in commissioning a different range of services that what is currently funded. It may also result in the termination of some current agreements to allow the commissioning of best practice model-of-care services that support optimal population health outcomes.	Improved patient experience, better responsiveness to Māori, and improved health outcomes.	3DHB - Hutt, Capital & Coast, and Wairarapa
Sub-regional clinical services planning	As part of the sub-regional hospital network programme, CCDHB and HVDHB will be reviewing the delivery of the following services: Breast Services, Oncology services, Renal Dialysis Services, Gastroenterology/Colonoscopy, Ear, Nose and Throat, Cardiology, and Ophthalmology services.	Improved population health outcomes. Maintain the financial sustainability of the services. Better value for money.	2DHB - Hutt and Capital & Coast
Pain Services	DHBs are considering options to develop a community-based pain service for patients that are not funded by ACC (ie non-injury related).	Improved access to services, closer to home. Early intervention and self-management support. Improved health outcomes.	2DHB - Hutt and Capital & Coast
Relocating the Infant, Child, Adolescent and Family Service (ICAFS) into a Community Setting	Last year we undertook a significant review of ICAFS which significantly improved the wait times for our consumers. The remaining part of the project overseeing that was to relocate the service into a more appropriate community based setting. We anticipate doing that within the next 6 to 12 months.	Services moved closer to home, more appropriate service setting for children and youth. Removing stigma associated with mental health needs and hospital based treatment.	Local
Community Pharmacist Services	Implement HVDHB's Pharmacists Services Strategy, which includes reviewing the Long Term Condition service provided by pharmacists, and the commissioning of pharmacist services to aged residential care.	Improved integration across the primary care team. Improved access to pharmacist services and greater	Local

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
		use of pharmacists as a first point of contact within primary care. Improved support for at-risk populations.	
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. The DHB will review this change and consider further options to improve access, including targeting services on an equity basis.	Maintain the financial sustainability of the services. Better value for money. Patients appropriately managed by the right health care professional. Improved responsiveness to Māori.	Local
Community integration	A new integrated community health service model and referral system - with transdisciplinary working - is being developed. It includes the establishment of virtual locality teams by geographically aligning specialist services, DHB community services and community providers to clusters of general practices, pharmacies and local communities.	Improved responsiveness to patients and more time spent on clinical care. Improved outcomes for elderly in particular. Improved access to services, closer to home.	Local
Clinical Services Plan	Our Clinical Services Plan recommends a number of changes in how clinical services are currently configured in order for us to maintain financial and clinical sustainability. An implementation plan has been developed as part of the wider Hutt Valley work programme that identifies a number of services that require focus including paediatrics, community and theatres.	Maintain the financial sustainability of the services. Better value for money. Improved responsiveness to Māori. Improved access to services, closer to home. Smoother and safer care.	Local
Planned Care	The DHB plans to implement an enhanced skin lesion removal service in primary care, with specialist clinical oversight, to reduce secondary First Specialist Appointments. This will be subject to changes in the 'planned care' policy funding parameters.	Maintain the financial sustainability of the services. Better value for money. Improved access to services, closer to home. Smother and safer care.	Local
Children's Outpatient Services Project	The Children's Outpatient Services Project is supporting the DHB's secondary ambulatory paediatric care provision to: • ensure the service is fit for purpose and sustainable, • put the patient at the centre of service planning, • take into account the local population and project changes to this population's health care needs, and • support staff to provide the service. The Project also supports the identification and implementation of activities to further develop and expand the service so that patients, their family/whānau receive services closer to where they live through: identification of Health Pathways for development or localisation	Improved processes, procedures, efficiency, patient experience and responsiveness to Māori health, and outcomes. Supports the DHB's Clinical Services Plan and the reorientation of the paediatric service to be community facing.	Local

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	• increasing consistency in the triage process so referrers are clearer in what care they can deliver and what's appropriate for secondary care • releasing time for the Acting Charge Nurse Managers and community nurses to work at the top of their scope.		

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 2019/20 Annual Plan.

A key focus for 2019/20 is collaboration with RPH, Healthy Families, PHOs and other community providers to leverage the investment and coordinate our health promotion activities to deliver collective impact on national and local priorities. Improving equity of outcomes for Māori, Pacific, and people on low incomes is a key focus of this work.

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

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 2019/20 and out years is contained in the Financial Performance Summary section of Hutt Valley DHB's 2019/20 Statement of Performance Expectations.

Investment and asset management

In 2019/20 Hutt Valley DHB will progress work on its integrated strategic investment planning programme. This work will be guided by our strategic framework, particularly our Clinical Services Plan, which examines strategic options for service changes to achieve health improvements for our population in a clinically and financially sustainable manner.

As well as changes to our own services, we are also working closely with Central Region DHBs[45] – and Capital & Coast DHB in particular - to plan and coordinate our services across Wellington, Kenepuru and Hutt Hospital. This work is contributing to a bigger programme of work – a Long

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

Term Investment Plan – to identify the investments needed to ensure these hospitals have the assets needed in the future to manage growing demand and achieve our strategic objectives.

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 culture of continuous improvement. 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.[46] Investment will be required on the DHB infrastructure, and this will be informed by the Clinical Services Plan and the joint sub-regional service planning with Capital & Coast DHB. 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.

[46] 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.

Te Whare Ahuru (TWA), the adult mental health acute inpatient service, requires reconfiguration. TWA is the based on the Hutt Hospital campus and is the primary provider of inpatient mental health care to residents of Hutt Valley and Wairarapa DHBs. TWA operates in partnership with Te Whare O Matairangi, the Capital & Coast DHB inpatient unit based in Wellington on the regional hospital site.

A recent review of the acute model of care (including TWA) found the design of TWA is dated, not fit-for-purpose and creates clinical care and safety issues. The facility does not enable good therapeutic outcomes, and is culturally inappropriate in its ability respond to the cultural needs of Māori clients. The demand for TWA also frequently outstretches its capacity. Hutt Valley DHB has embarked on a strategic assessment and single stage business case to consider facility options.

Workforce

Hutt Valley DHB is building a workforce that is responsive to, and reflects, the populations we serve. In June 2019 all 20 DHB Chief Executives committed to introducing targets for DHBs to increase Māori participation in the workforce. To meet this commitment Hutt Valley DHB will be reviewing our current recruitment policies and procedures to enhance the ability to attract, appoint and retain Māori staff. We are also developing a diversity recruitment policy to help us attract and recruit a diverse mix of staff reflective of our community.[47]

We value cultural intelligence and are working to enhance and grow the cultural safety of our workforce. This work includes developing and delivering Māori health equity and cultural safety training to DHB staff. 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 wellbeing and engagement remains a key focus. 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 into how we work together to deliver a great service to our community.[48] We have been consulting with staff on the development of a staff wellbeing programme, Mauri Ora, which will include tools and resources for staff to support a healthier and happier workplace.

In 2018 we launched Nursing at its Best, Hutt Valley DHB's five-year nursing workforce strategy. The strategy aims to ensure that all people and their families/whanau accessing health care in the Hutt Valley, will receive excellent nursing care from a competent, culturally responsive, evidence-based and person-centred workforce. We are now progressing implementation of the strategy. Key pieces of work being progressed under the four nursing strategic priorities include:

- Nursing workforce - implementing the Care Capacity Demand Management project.[49]
- Clinical leadership - increasing senior nurse participation in the Professional Development and Recognition Programme.[50]
- Education and professional practice - implementing the Nurse Entry to Practice (NETP) Programme.[51]

[47] 'Diversity' can relate to culture, ethnicity gender, disabilities, and age.

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

[49] 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.

[50] The PDRP provides a framework that helps nurses develop their professional practice and assist them on a career pathway.

[51] The NETP programme provides graduate Registered Nurses support and professional development to facilitate their transition during their first year of practice.

- Quality, patient safety and innovation - implementing Lippincott's Nursing Procedures and Skills across the sector.[52]

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 2019/20 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.

SECTION FIVE: PERFORMANCE MEASURES

5.1 2019/20 Performance Measures

The health and disability system has been asked to focus on the following priorities:

- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention.
- Better population health outcomes supported by strong and equitable public health services
- Better population health outcomes supported by primary health care.

The DHB monitoring framework and accountability measures have been updated for 2019/20 to provide a line of sight between DHB activity and the health system priorities that will support delivery of the Government's priority goals for New Zealand and the health system vision and outcomes, within a system that has a foundation of financial, clinical and service sustainability and strong governance.

Performance measure		**Expectation**		
CW01	Children caries free at 5 years of age	Year 1	66%	
		Year 2	66%	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	0.61	
		Year 2	0.61	
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled	Year 1	>=95%
			Year 2	>=95%
		Children (0-12) not examined according to planned recall	Year 1	<=10%
			Year 2	<=10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Year 1	>=85%	
		Year 2	>=85%	
CW05	Immunisation coverage at 2 years of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month-olds olds fully immunised.		
		95% of five of two-year-olds have completed all age-appropriate immunisations due between birth and five year of age.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		

[52] Lippincott's Nursing Procedures and Skills provides real-time access to step-by-step guides for evidence-based procedures and skills in a variety of specialty settings.

CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.	
CW07	Newborn enrolment with General Practice	55% of newborns enrolled in General Practice by 6 weeks of age.	
		85% of newborns enrolled in General Practice by 3 months of age.	
CW08	Increased immunisation at two years	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years.	
CW09	Better help for smokers to quit (maternity)	90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	
CW11	Supporting child wellbeing	Provide report as per measure definition. Includes: • report actions to support providers to introduce the child protection policy requirement for funded providers • compliance reporting for the Vulnerable Children Act 2014.	
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.	
		Initiative 3: Youth Primary Mental Health.	
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.	
CW13	Reducing rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever to 1.6 per 100,000	
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Maori, other & total	Māori: 4.90% Other: 4.00% Total: 4.25%
		Age (20-64) Maori, other & total	Māori: 8.89% Other: 4.06% Total: 4.82%
		Age (65+) Maori, other & total	Māori: 2.03% Other: 2.00% Total: 2.03%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.	
		95% of audited files meet accepted good practice.	
MH03	Shorter waits for non-urgent mental health and addiction services	Mental health provider arm	80% of people seen within 3 weeks.
			95% of people seen within 8 weeks.
		Addictions (Provider Arm and NGO)	80% of people seen within 3 weeks.
			95% of people seen within 8 weeks.
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified	
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	

PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		
PV02	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.		
SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		
SS02	Ensuring delivery of Regional Service Plans	Provide reports as specified		
SS03	Ensuring delivery of Service Coverage	Provide reports as specified		
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	45-64 year olds:	Maori: 7800 per 100,000 Pacific: 7528 per 100,000 Other: 4023 per 100,000 Total: 4764 per 100,000	
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.		
SS07	Planned Care Measures	Planned Care Measure 1: *Planned Care Interventions*	Inpatient Surgical Discharges: 5,795 Minor Procedures: 2,525 Non-Surgical Interventions: 30	
		Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
			ESPI 2	0% – no patients are waiting over four months for FSA
		Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
			ESPI 5	0% - zero patients are waiting over 120 days for treatment
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool
		Planned Care Measure 3: *Diagnostics waiting times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan

				results are reported, within 6 weeks (42 days).
		Planned Care Measure 4: *Ophthalmology Follow-up Waiting Times*	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
		Planned Care Measure 6: *Acute Readmissions*	Baseline: Total: 12.0% Māori: 14.1% Pacific: 11.5%	Target: Total: 12.0% Māori: 12.0% Pacific: 12.0%
SS08	Planned care three year plan	Provide reports as specified		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (duplication) – Group B	>1% and < or equal to 3%
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	To be confirmed
		Focus Area 2: Improving the quality of data submitted to National Collections Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC, NBRS, and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than 95%
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5%
			Assessment of data reported to the NMDS	Greater than or equal to 75%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified		
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions to: Support people with LTC to self-manage and build health literacy.	
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*	

			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity
		Focus Area 3: Cardiovascular health	Provide reports as specified
		Focus Area 4: Acute heart service	**Indicator 1: Door to cath** - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram**.**
			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and **Indicator 2b:** ≥ 99% within 3 months.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - - Aspirin*, a 2nd anti-platelet agent*, statin and an ACEI/ARB (4 classes), and - LVEF<40% should also be on a beta-blocker (5-classes). ** An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.*
		Focus Area 4: Acute heart service	**Indicator 5: Device registry completion**- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device forms within 2 months of the procedure.
		Focus Area 5: Stroke services	**Indicator 1** ASU: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway
			Indicator 2 Thrombolysis: 10% of potentially eligible stroke patients thrombolysed 24/7
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation: 60 % 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.

SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.		
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.		
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.		
		95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system.		
SS16	Delivery of collective improvement plan	Deliverable still to be confirmed		
SS17	Delivery of Whānau ora	Provide reports as specified		
PH01	Delivery of actions to improve system integration and SLMs	Provide reports as specified		
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	Provide reports as specified		
PH03	Access to Care (PHO Enrolments)	Meet and/or maintain the national average enrolment rate of 90%.		
PH04	Primary health care :Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months		
Annual plan actions – status update reports		Provide reports as specified		

APPENDIX: System Level Measures Improvement Plan

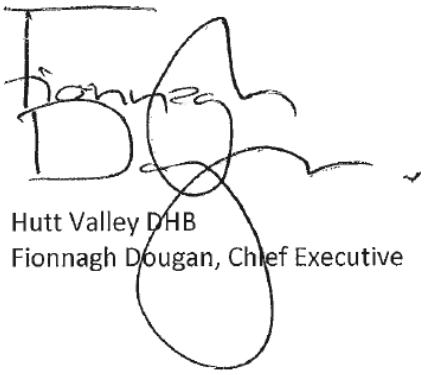
HUTT VALLEY DHB HEALTH SYSTEM LEVEL MEASURES PLAN 2019/20

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 2019/20 Annual Plan.

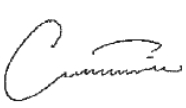
The System Level Measures are set, defined and monitored nationally. Hutt INC has locally set and agreed the improvement milestones, contributory measures and actions in our key priority areas. Each System Level Measure milestone and contributory measure in the Improvement Plan is based on analysis of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

This integration work programme is driven by the networks and sub-groups of the Alliance Leadership Team. Child Health, Mental Health, Acute Demand, Health of Older People and Youth Health are the five key areas of focus for the Alliance and the membership of these groups has been expanded in the past year to strengthen representation from across the Hutt Valley Health system. This will continue in 2019/20, aligning with the recent commitments made in the Hutt Valley DHB Clinical Services Plan, the Wellbeing Plan, the Maori Health Strategy and the soon to be updated Pacific Health Plan.



Hutt Valley DHB
Fionnagh Dougan, 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

Systems Approach

The Alliance Leadership Team acknowledge and support the following:

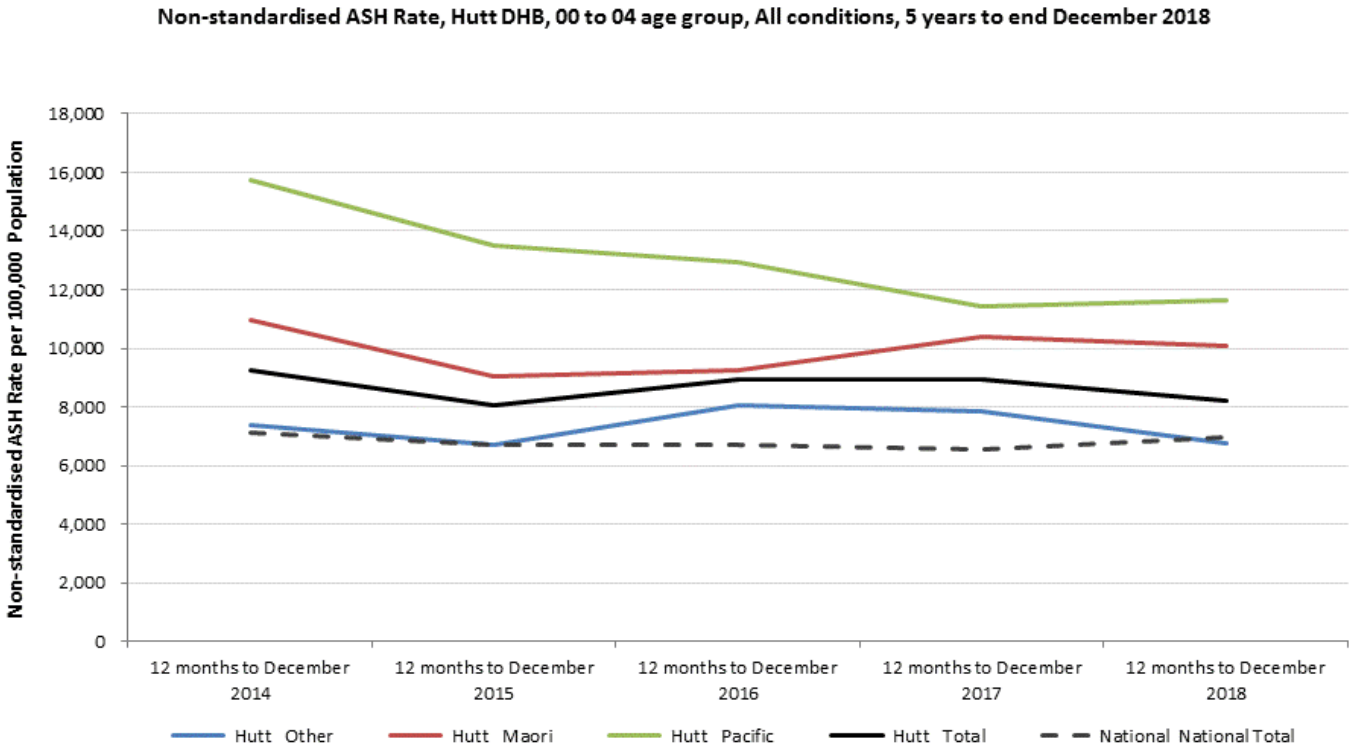
- Hutt 2020: the system-wide planning undertaken in 2014 that resulted in strategic plan for Hutt INC called Hutt 2020 (2014). This plan guided primary care actions including the development of information systems, general practice sustainability and the Long Term Conditions programme that have supported work towards integration to date.
- HVDHB Vision for Change 2017-2027. The Alliance Leadership Team will ensure the integration work programme supports the Hutt Valley strategy by aligning with the following strategic directions and enablers:
    - living well
    - closer to home
    - shorter, safer and smoother care
    - adaptable workforce
    - smart infrastructure
    - effective commissioning

The Alliance Leadership Team also support the following six key decision making principles:

- Equity – our decisions will support the elimination of health inequalities
- People-centred – our decisions will improve individuals and whānau experiences of care and address what matters most to them
- Outcomes focused – our decisions will improve health outcomes and wellbeing for individuals and whānau
- Needs-focused – our decisions will be based on where the greatest need lies
- Partnerships – our decisions will increase connections between individuals, whānau, health and social services
- Systems-thinking – our decisions will benefit the health system as a whole.

SLM 1: Ambulatory Sensitive Hospitalisations for 0-4 year olds – 'keeping children out of hospital'

Where are we now?



DHB	Ethnic Group	12 months to December 2014	12 months to December 2015	12 months to December 2016	12 months to December 2017	12 months to December 2018
Hutt	Other	7,382	6,689	8,060	7,848	6,766
Hutt	Maori	10,986	9,049	9,228	10,383	10,069
Hutt	Pacific	15,741	13,524	12,925	11,442	11,619
Hutt	Total	9,259	8,078	8,913	8,955	8,236
National	Total	7,096	6,729	6,712	6,562	6,948

Figure 1

Hutt Valley has high rates of 0-4 ASH admissions compared to the national average for Māori and Pacific populations. Between 2014 and 2017, there has been a steady decrease in the Pacific 0-4 ASH rate, with a 1.5% increase in the year to December 2018. The Māori 0-4 ASH rate remains relatively unchanged with slight fluctuations from year to year, with a 3% decrease in the year to December 2018. Our top 0-4 ASH conditions continue to be 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 11,272 for Pacific and 9,722 for Māori by the end of Q4 19/20[53], reducing the equity gap between Hutt Valley Māori and Pacific ASH rate and the New Zealand Total ASH rate by 5%.

Reducing ASH rates and disparities for Māori and Pacific remains a top priority for the Hutt Valley and our improvement plan outlines the well-established work programme in this area.

[53] *Note: target was set using baseline rate at 12 months year ending December 2018.*

The improvement activities identified in this plan have been informed by:

- Dental ambulatory sensitive hospitalisation rates disproportionally impact Māori and Pacific children in Hutt Valley, notably Pacific children.
- Respiratory, skin and gastroenteritis ambulatory sensitive hospitalisations disproportionally impact Māori and Pacific children and those living in high deprivation.

SLM	Improvement milestone by end of Q4 19/20
Hutt Valley total 0-4 years ASH rate per 100,000 children	Māori : 9,722 admissions per 100,000 children Pacific: 11,272 admissions per 100,000 children Note baseline: 12months to December 2018 HV rate total: 8,236, Māori : 10,069, Pacific: 11,619 NZ rate total: 6,948

Aim	Actions	Contributory Measures
Reduce ASH rate in 0-4 years per 100,000 to 11,272 for Pacific and 9,722 for Māori by the end of Q4 19/20.	**Respiratory:** • PHO will provide practices with details of ASH 0-4 respiratory admissions for follow up along with information about onward referral to Tū Kotahi Māori Asthma and Research Trust and Well Home Programme. • Health professionals will follow-up ASH 0-4 respiratory admissions and make onward referral and/or put management plan in place. **Dental** (Regional Child Oral Health Service)**:** • Provide training to all Well Child Tamariki Ora providers on 'lift the lip' training • Provide supervised tooth brushing and education to pre-school aged children at three selected Early Childhood Centres with high Māori and Pacific populations. • Provide 10 knee-to-knee programmes focusing on pre-school aged children enrolled in Kohanga and Early Childhood Centres in region. • Collaborate with primary- care providers to trial a project that focuses on engaging with Pacific parents and children in high need areas to increase attendance at booked appointments. • Develop systematic methods of enrolling children in Regional Dental Services (e.g. through Newborn Enrolment Service, 6 week checks or immunisations) and monitoring uptake by ethnicity and deprivation. **Skin:** • Regional Public Health / General Practice - Implement a cellulitis program (skin pack) for children for use in early childhood centres, schools and general practices to reduce morbidity and hospitalizations from skin infection.	Number of referrals to to Tū Kotahi Māori Asthma and Research Trust. Number of referrals to Well Homes for housing assessments Rate and number of respiratory related ED attendances and hospital admissions for 0-4years (Total & reduce disparity for Māori and Pacific).Number of Lift the Lip training sessions provided / Knee to Knee programmes provided Number of Maori and Pacific preschool children seen for examination Dental examination arrears rate (overdue for annual examination) for preschool children aged 0-4 (Total and reduce disparity for Māori and Pacific). Caries free at 5 years. Number of pre-school children enrolling in Regional Dental Services Number of skin-packs distributed

SLM 2 - Acute Hospital Beds days per Capita – 'using health resources effectively'

Where are we now?

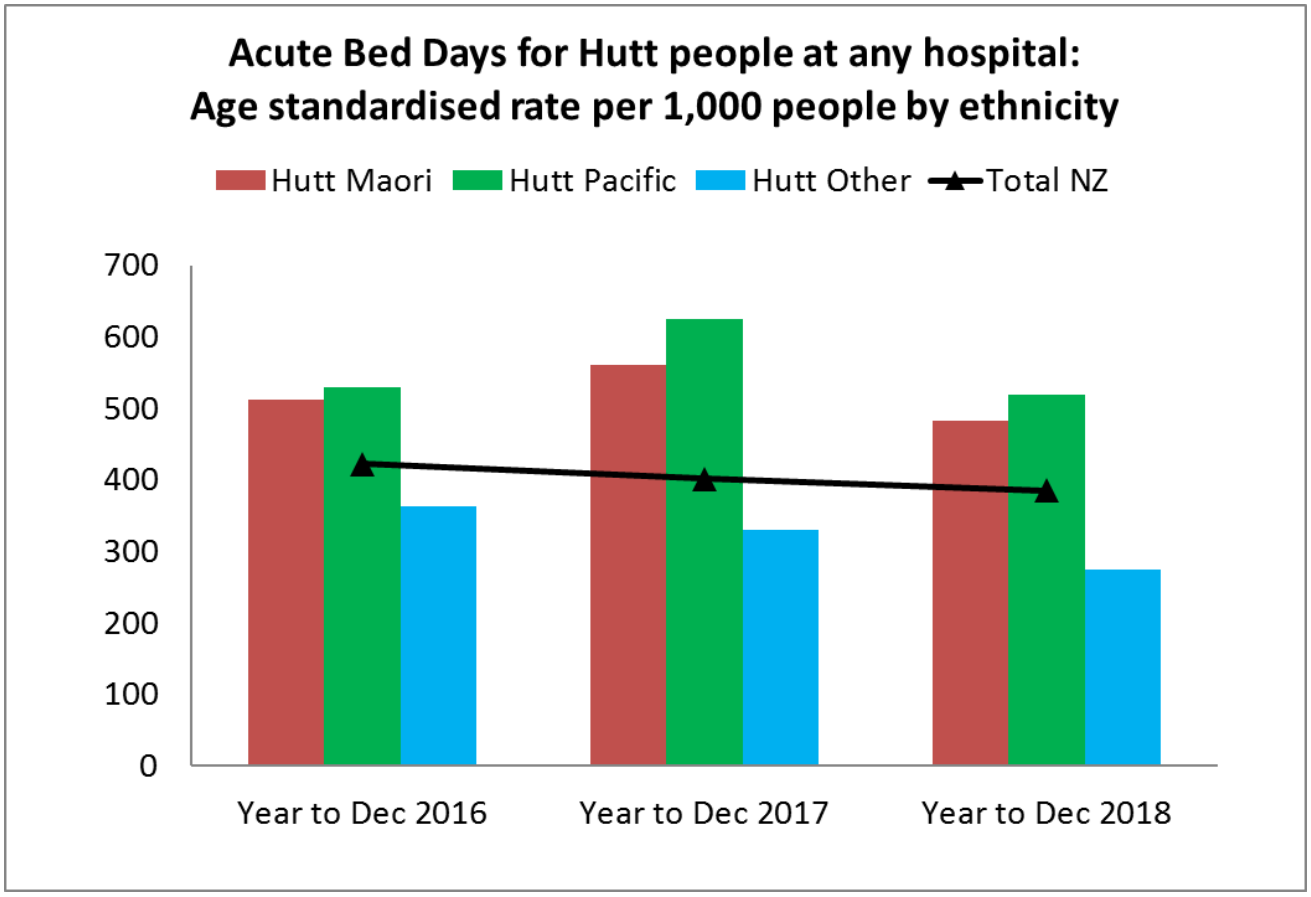


Figure 2

Hutt Valley continues to have lower rates of acute hospital beds days per capita than the national total. While the Māori and Pacific rate have both decreased significantly in the year to December 2018, the disparities for these populations remain.

The DRG clusters with the highest acute bed days are:

- Total Hutt Valley: Stroke and Other Cerebrovascular Disorders, Respiratory Infections/Inflammations, Heart Failure and Shock.
- Māori : Stroke and Other Cerebrovascular Disorders, , Respiratory Infections/Inflammations, Heart Failure and Shock
- Pacific: Cellulitis, Respiratory Infections/Inflammations, Tracheostomy, Stroke and Other Cerebrovascular Disorders, Bronchitis and Asthma.

Milestone

Our improvement plan target aims to **reduce acute hospital bed days per capita** for Māori to 463 bed days per 1,000 people and for Pacific to 501 bed days per 1,000 people by the end of Quarter 4, 2019/20.

This aims to reduce the equity gap between Hutt Valley Māori 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[54].
Hutt Valley's performance in acute bed days, Average Length of Stay and Acute Readmission continues to perform well when compared to the national average.

The improvement activities identified in this plan have been informed by the disparities between Māori, Pacific and the Total population and are focused on reducing avoidable admissions. The DHB's Community Integration Programme and Health Care Home programme remain key enablers for these activities.
Improving respiratory outcomes continue to be a focus for the Hutt Valley, especially for Pacific and Māori.

SLM	**Improvement milestone by end of Q4 19/20**
Hutt Valley total standardised ABD rate per 1,000	Māori : 463 bed days per 1,000 people Pacific: 501 bed days per 1,000 people Note baseline at Dec 2018: HV rate total: 312, Māori : 482, Pacific: 520, NZ rate: 385

Aim	**Actions**	**Contributory Measures**
Reduce Acute Hospital bed day rate per 1,000 people to 463 bed days for Māori and 501 bed days for Pacific.	**Acute Flow** • Implement Phase One of the Community Integration Programme - Trial a Neighbourhood team (comprising DHB community nursing team wrapped round clusters of GP practices) in one area of Hutt Valley • Embed Red To Green patient flow improvement process in General medicine to reduce waiting time for patient for discharge when clinically ready • DHB Specialist Support for Primary Care: Implementing a specialist support for primary care model – with a focus on older persons, mental health, cardiology, respiratory, rheumatology, palliative care service and general medicine • Falls Prevention: Implementation of the Strength & Balance programmes (Sport Wellington and DHB community) • Implement the fracture liaison protocol (PHO). **Flu Vaccinations** • Develop local strategies (to be implemented from April 2020) that support pharmacy and other immunisation providers to work together to improve influenza vaccination rates in Māori, Pacific and Asian people over 65 years of age. **Specialist Respiratory Support** • Continuation of the DHB respiratory specialist support targeted to general practice with the greatest need (linked to the Neighbourhood team, above) • Embed acute care plans and ambulance management for COPD patients to self-manage and access services in the community.	ASH rates 0-4 and 45-64 Acute hospital admissions, acute ALOS and acute readmission rate Over 65 hospital admission for falls Number of people that received in-home strength and balance retraining Number of people that received community / group strength and balance retraining Influenza vaccinations for 65 year olds and over COPD and respiratory related ED attendances and hospital admissions

[54] *Note: target was set using baseline rate at 12 months year ending December 2018.*

SLM 3 - Patient Experience of Care – 'patient-centred care'

Where are we now?

Hutt Valley National Inpatient Survey Results:

Domains (Quarter 4 data 2018)	COMMUNICATION	COORDINATION	PARTNERSHIP	PHYSICAL AND EMOTIONAL NEEDS
HV Total	8.5	8.8	8.7	8.9
HV Maori				
HV Pacific				
NZ Average	8.4	8.4	8.3	8.5

Figure 3

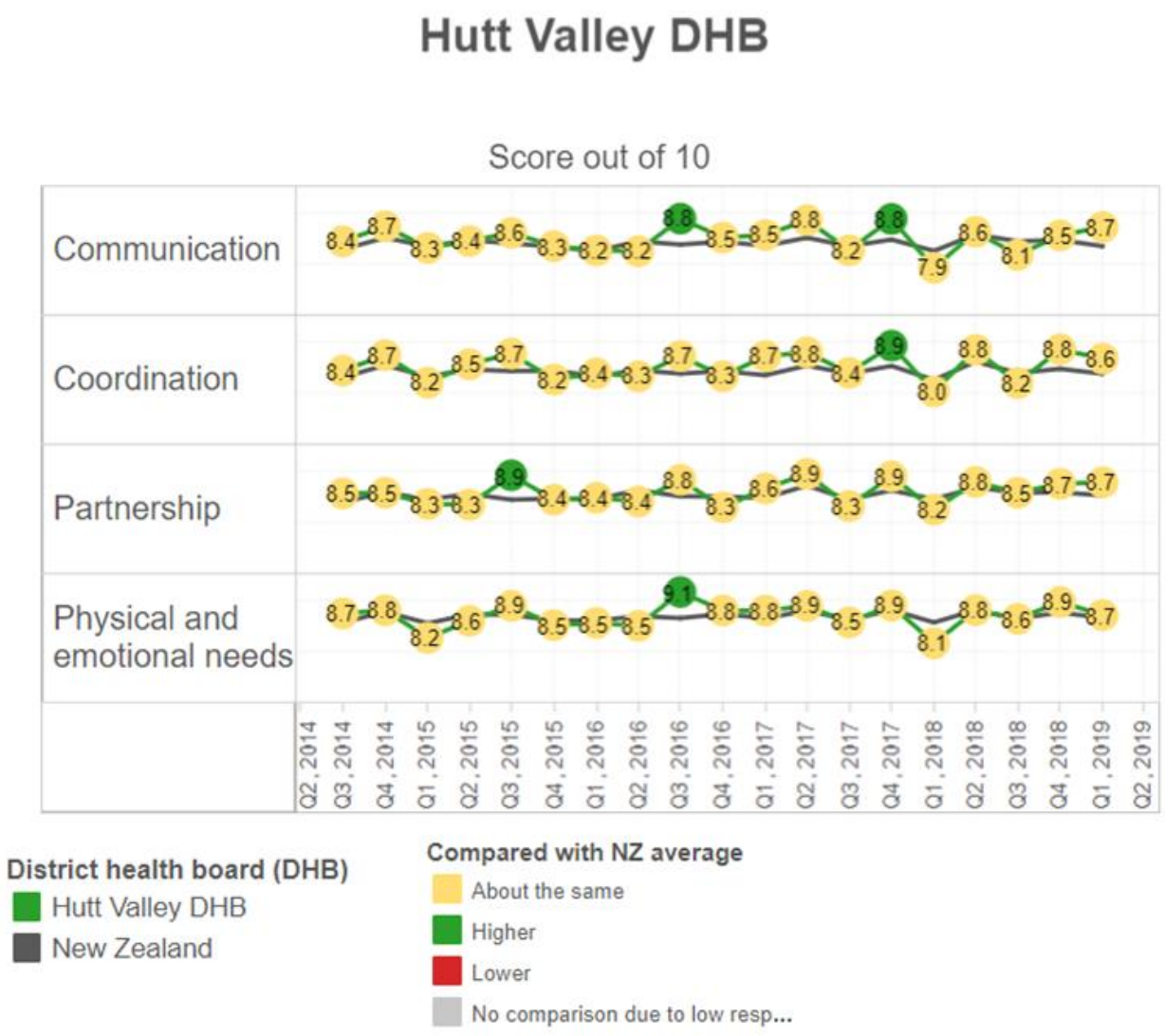


Figure 4

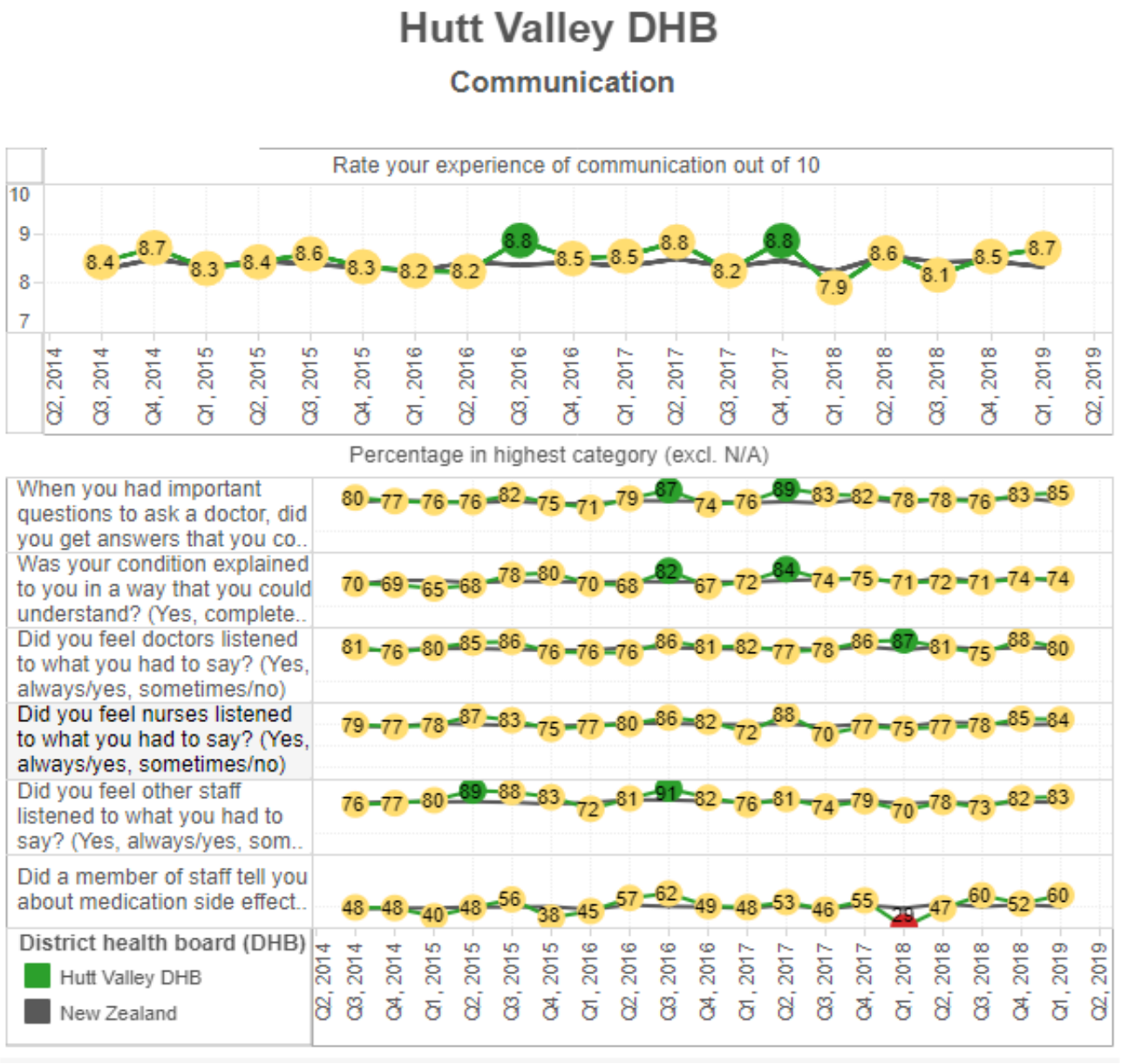


Figure 5

The Hutt Valley National Inpatient Experience Survey scores by domain fluctuate slightly each quarter but remain in line with the national average. The Hutt Valley survey response rate remains around the national average (26% in November 2018).

The Hutt Valley DHB's lowest scoring question has historically been in the communication domain (8.5) with 60% of patients answering 'yes' to "Did a member of staff tell you about medication side effects to watch for when you went home?". This is a significant improvement from Q1, 2018 where the results was 29%.

Our improvement plan actions continue to focus 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.

Hutt Valley National Primary Care Survey Results:

Domains (Data at Mar 2019)	COMMUNICATION	COORDINATION	PARTNERSHIP	PHYSICAL AND EMOTIONAL NEEDS
HV Total	8.3	8.3	7.3	7.7
HV Maori	7.5	7.7	6.4	7.4
HV Pacific	7.9	7.8	7.8	7.4
NZ Average	8.4	8.5	7.6	7.4

Figure 6

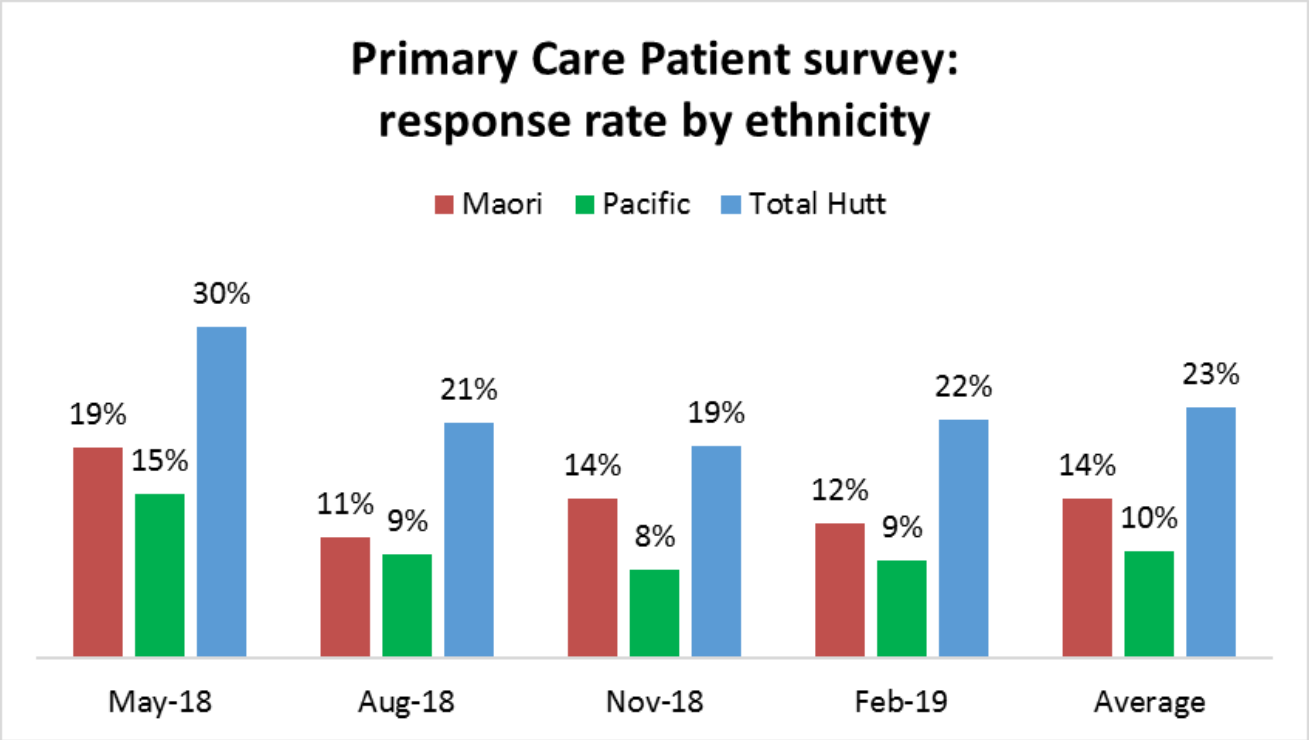


Figure 7

The primary care patient experience survey has 100% participation (20/20 general practices participating).

Hutt Valley survey results by domain are in line with the national average. The Hutt Valley response rate also remains around the national average at 25%.

The Primary Care response rate**,** as shown in Figure 8, has a lower rate for Māori (14%) and Pacific (10%) people than the total population (23%).

Our improvement plan focuses on increasing distribution and response rate, particularly for the Māori and Pacific priority populations. 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 aims to

- Primary Care Survey: **Maintain or improve the participation of Māori and Pacific in the Primary Care Survey** by Q4, 2019/20
- Inpatient Survey: **Improve the Communication domain to ≥8.5** on average for Q3 2019 – Q2 2020

Aim	Actions	Contributory Measures
• Primary Care: Maintain or improve the participation of Māori and Pacific in the Primary Care Survey	**Primary Care Patient Experience Survey:** • Continue to increase the uptake of the Patient Portal in general practice throughout 2019/20, and capture email addresses for patients as part of the process • PHO and General Practice promote the uptake of the Patient Experience Survey by Māori and Pacific patients by increasing the capture of email addresses for these patients • PHO will support practices to increase their use of PES results to identify and implement quality improvement actions relevant to their practice	Patients registered to use general practice portals Māori and Pacific Patients completing the primary care patient experience survey
• Inpatient: Improve the Communication domain to ≥8.5 on average for Q3 2019 – Q2 2020	**Adult Hospital Patient Experience Survey:** • DHB Hospital promote the uptake of the Inpatient Experience Survey by Māori and Pacific patients • Identify actions to improve staff communication about medication side effects to adult inpatients. • Develop and begin delivering Māori health equity and cultural safety training to DHB staff, including (EOA) (This is also a Workforce activity and an Acute Demand activity) • Implement a Pacific Health Literacy programme to improve health workforce communication with Pacific people and whanau. (EOA)	Response rate for Adult in-patient survey Performance in the Communication domain Number of staff trained in Māori Health Equity

SLM 4 - Amenable Mortality Rates – 'prevention and early detection'

Where are we now?

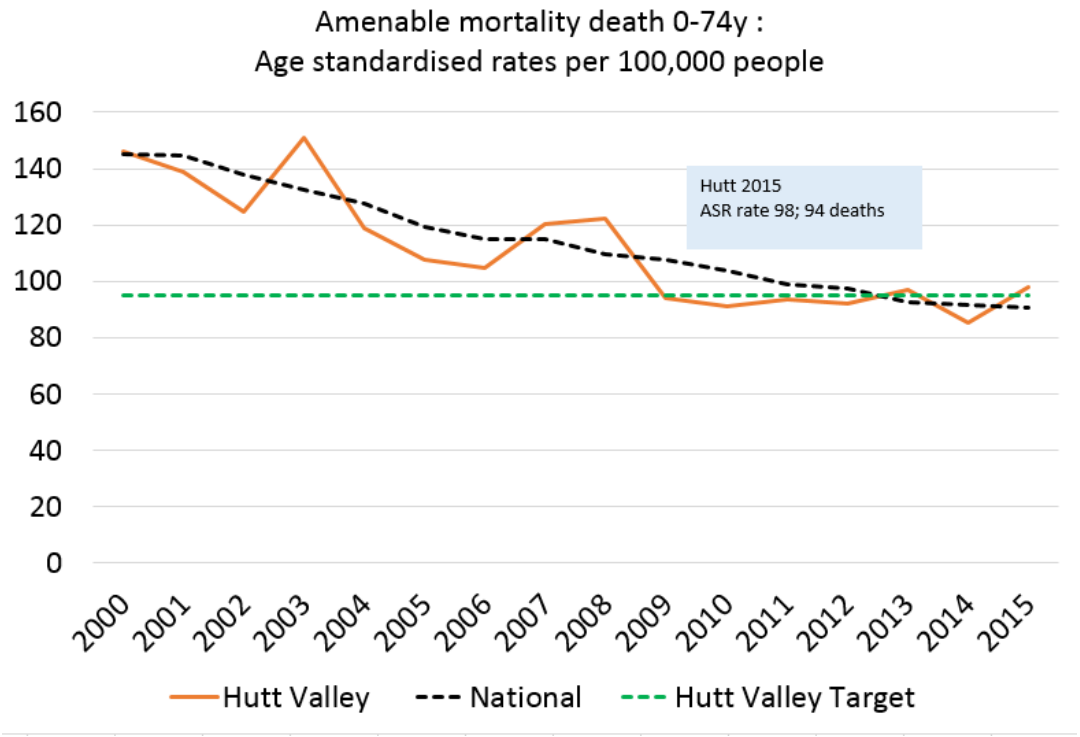


Figure 9

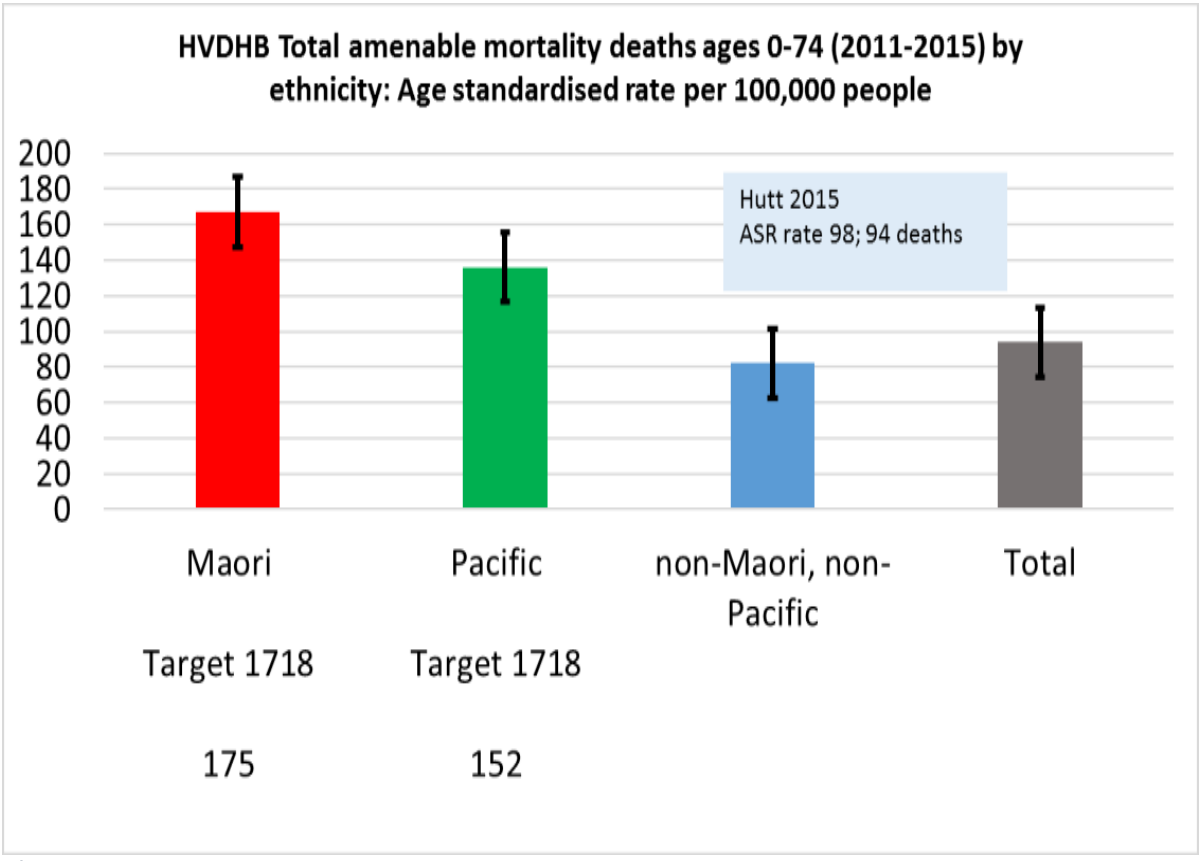


Figure 10

Amenable Mortality in the Hutt Valley is reducing over time in line with the national average. However significant disparities exist with higher rates for Māori and Pacific

The top causes of amenable mortality in the Hutt Valley are: Coronary Disease, Suicide, COPD, Rectal Cancer, and Breast Cancer.

Milestone

Influencing amenable mortality rates and reducing disparities for Māori 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.

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 Māori 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 Māori and 132 for Pacific (deaths in 2019-2023 as reported in 2025/26)[55].

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 Māori. 132 per 100,000 people aged 0-74 years for Pacific. Current Baseline rate: (deaths in 2011-2015): HV total: 94, Māori : 167, Pacific: 136, Other: 82 NZ rate: 95

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 Māori
 	
• 132 per 100,000 people aged 0-74 years for Pacific
	Tobacco
	• Develop and begin delivering a co-ordinated Smoke-free Action Plan focussing priority populations.
	
	• Continue to work with and support Takiri Mai Te Ata Regional Stop Smoking Service (Ministry funded wrap-around stop smoking service) and community providers on strategies to improve smoking cessation, especially in pregnant Māori women including:
	  • Appoint a part-time Smoke Free Coordinator role in the DHB to continue to support staff to utilise the ABC approach to smoking cessation, improve coding and referrals (quality, process and numbers)
	  • Engage with general practices to help ensure they make appropriate cessation referrals for patients post smoking brief advice
	  • Work with Hapū Māmā to improve referrals to the Hapū Māmā service
		Percentage of enrolled PHO population that currently smoke (Total and reduce disparity for Māori and Pacific).
		
		% of mothers who are smokers at time of giving birth at Hutt Hospital?
		
		Referrals to Takiri Mai Te Ata Regional Stop Smoking Service

[55] *Note: the target was set using the most recent data available (mortality data for 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.*

	CVD and Diabetes
	• Maintain uptake of CVD risk assessments for the eligible population and undertake a community education programme targeting Māori and Pacific men aged 35 to 44 years to increase uptake of CVD risk assessments.
	
	• Improve the management of patients with high CVD risk by:
	  • Giving lifestyle advice within general practice consultations
	  • Managing blood pressure
	
	• DHB or PHO provide all Primary Care providers with NHI level data on their patients with diabetes to ensure the patients are getting their Diabetes Annual Review
	
	• PHO and DHB support practices to improve the management of patients with diabetes by delivering a comprehensive diabetes quality improvement initiative (in accordance with the guidelines) and supported by a new data visibility system for practices
	
	• Improve Māori and Pacific access to resources and services to support greater self-management and behaviour change through:
	  • Increased referrals to Green Prescriptions and related programmes
	  • increased support from Healthy Family Coach services
	  • the use of relevant apps.
	
	• Support 'water-only schools' and the development of healthy food environments in school settings, with a focus on low decile schools, through RPH promoting the Water-Only Schools toolkit
	
	• DHB and PHO to collaborate with Healthy Families Hutt Valley to support Local Government in creating healthy physical and food environments through policy advice and "Turning the Tide" activities (see www.turningthetide.org.nz)
		Percentage of eligible population assessed for CVD risk in last 5 years (90% target and ensure equity for Māori and Pacific).
		
		Percentage of diabetes patients receiving Diabetes Annual Reviews (Total and for Māori and Pacific)
		
		Percentage of diabetes patients with HBA1C control <64mmol (Total and for Māori and Pacific).

	Suicide • Implement the sub-regional Piki pilot, a primary mental health initiative providing free mental health support to young people (18-25 years old) in the Hutt Valley, with additional therapists providing brief interventions; peer support; and access to self-help tools (by Te Awakairangi Health Network). • Collaborate with local council to provide training sessions for key stakeholders, community services and agencies around suicide prevention and supporting first symptoms of mental health	Number of young people 18 to 25 years receiving brief interventions (Piki pilot) Number of training sessions delivered
	Cancer • Improve access to Māori and Pacific women through evening and weekend sessions for breast and cervical screening. (EOA) • Provide 'Free Smear Clinics' in high-need communities and fund general practices to provide free smear tests to Māori, Pacific, Asian women. (EOA) • Invite overdue women who are unscreened to attend combined breast and cervical screening sessions, with personal encouragement, kai and transport to the sessions. (EOA)	Breast, cervical screening coverage to meet national targets and bowel screening rates (Total & reduce disparity for Māori and Pacific). Percentage of patients receiving their first cancer treatment within 31 days from date of decision to treat (85% and ensure equity).

	• Trial same day biopsies and first specialist appointments at the breast symptomatic clinic to facilitate access and faster cancer treatments. • Continue to monitor equity of access and timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway. • Implement and embed psychosocial support for people who have completed cancer treatment. • Implement the recommendations of the sub-regional breast services review that is due for completion in June 2019. • Offer education, advice and transport to women who have previous missed appointments to Colposcopy Services to facilitate access and faster cancer treatments.	

SLM 5 - Proportion of babies who live in a smoke free household by 6 weeks postnatal – 'healthy start'

Where are we now?

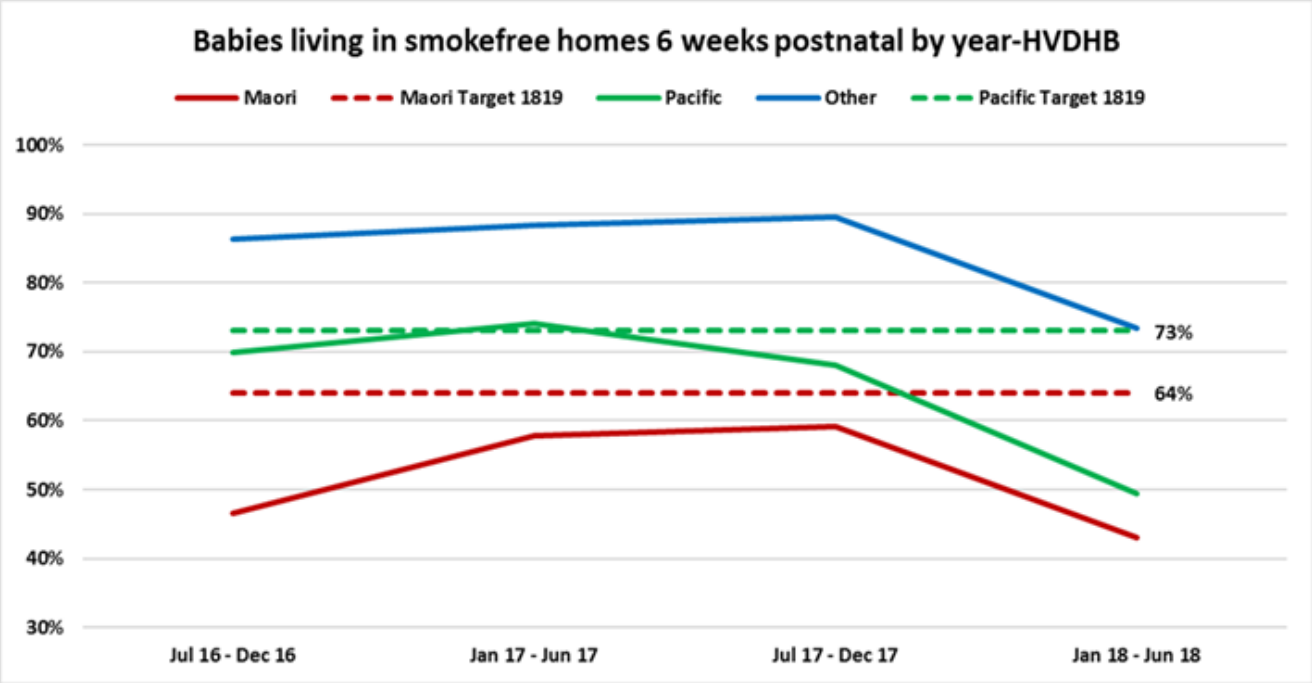


Figure 11

Note: Indicator change in Q2, 2018/19

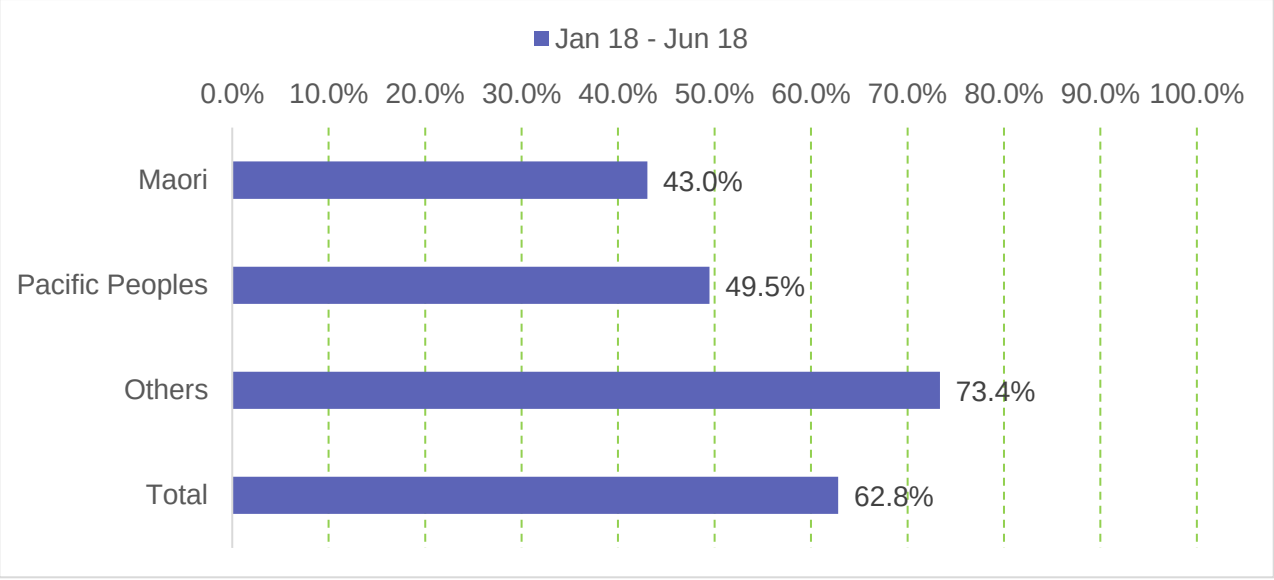


Figure 12

Data from January to June 2018, using the revised indicator definition, shows that 62.8% of Hutt Valley children live in a smokefree household at around 6 weeks old. For Māori this is 43% and for Pacific 49.5%

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 Māori to 48% and Pacific to 54% by the end of Quarter 4, 2019/20[56], reducing the equity gap by increasing the Hutt Valley Māori and Pacific rate by 5%.

The recording of smoking status of families at the six week postnatal WCTO check (core 1) needs to improve, as do interventions offered during this check.
Continuing to reduce smoking rates across the population is a key feature of the Hutt Valley Wellbeing plan and, in particular, addressing the prevalence of smoking in the population, notably among young Māori women.

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 Māori to 48% and Pacific to 54% by the end of Quarter 4, 2019/20.	See also SLM4 - **Tobacco** **Improve the measure and intervention offered at 6 weeks postnatal** Undertake a series of Plan-Do-Study-Act (PDSA) cycles with WCTO providers to assess the quality of data capture at the six week WCTO check, as well as the quality of interventions offered to families where children are exposed to smoke. **Improve access to smoking cessation programme for pregnant women and their families** Continue to work with and support Takiri Mai Te Ata Regional Stop Smoking Service (Ministry funded wrap-around stop smoking service) and community providers on strategies to improve smoking cessation, especially in pregnant Māori women **Improve newborn enrolment by implementing** An improved and seamless NBE system that enrols infants with the NIR, general practice, WCTO and oral health services (triple or quadruple enrolment) in a timely manner, i.e. within 2 weeks of the infant's birth.	s Referrals to Takiri Mai Te Ata Regional Stop Smoking Service Number of families who complete the Hapu Mama programme. Completion rates of the six week postnatal WCTO check (core 1). Better help for smokers to quit in primary care (90% target & ensure equity for Māori) and in hospital (95% and ensure equity for Māori). Establish baseline newborn enrolment information for under 6 weeks (note that this is different than the Ministry's newborn enrolment measure at 3 months postnatal).

[56] *Note: the target was set using baseline rate at 6 months ending June 2018.*

SLM 6 - Youth access to and utilisation of youth appropriate health services – 'youth are healthy, safe and supported'

Where are we now?

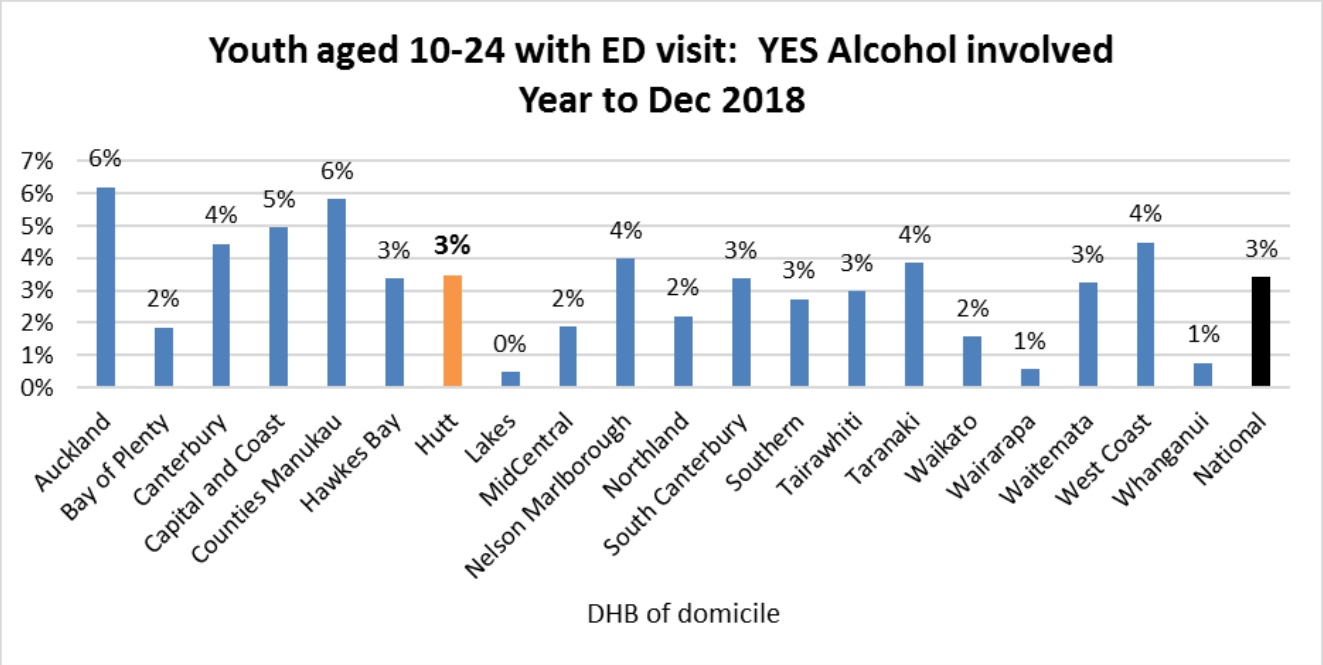


Figure 13

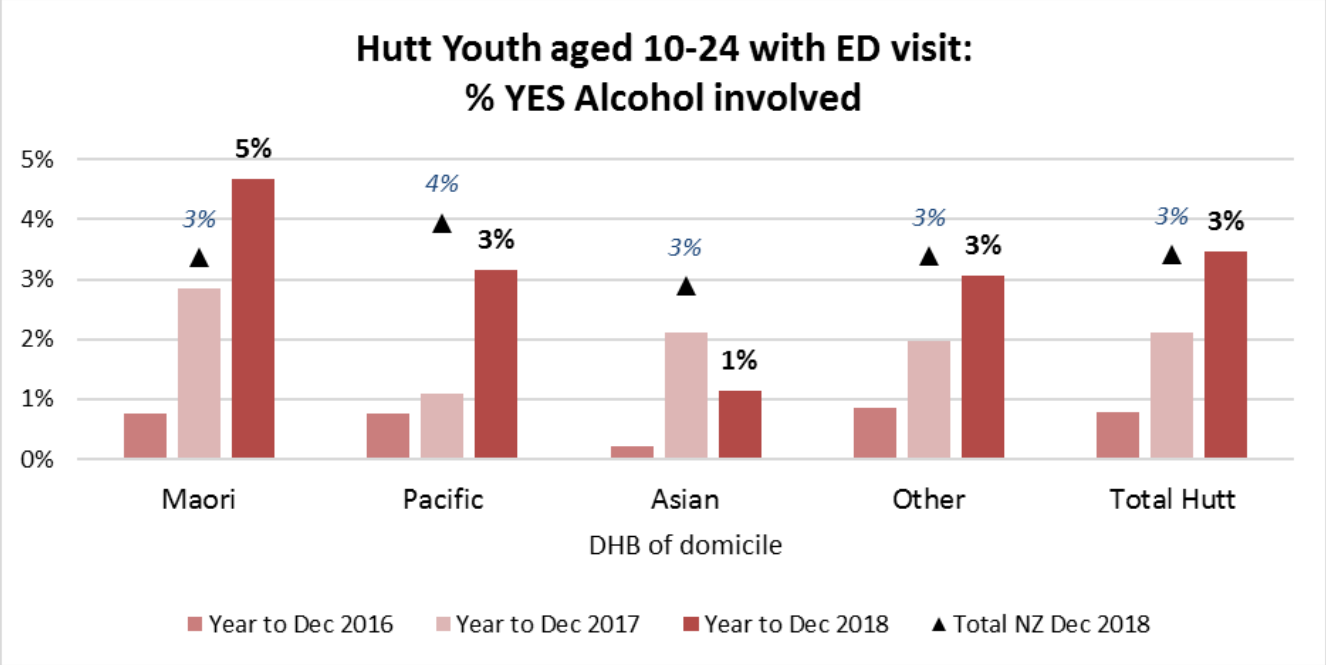


Figure 14

In the year to December 2018, the Hutt Valley rate for youth alcohol-related ED visits (3.5%) was almost the same as the national figure of 3.4%.

During 2018/19 Hutt Valley focussed on improving identification and solving data capture issues in improving the screening of youth at ED presentations. This has improved and focus on improving data quality continues for the remainder of the 2018/19 year and into 2019/20.

Activities have been identified which target the quality improvement required after identification i.e receiving appropriate and timely support. In addition to improving our screening, there will be a (3DHB) review of current alcohol and other drug (AOD) NGO services. This will give rise to improvement activities in 2020/21.

Milestone

Our improvement plan aims to reduce the Youth ED 'Alcohol involved' Rates to <=3% by the end of Q4 2019/20.

Our plan also focuses on actions to implement the recommendations of the youth health review completed in 2018. Improving health services in schools is a priority and a gap analysis and opportunities project has been initiated with the recommendations expected to inform 2019/20 activities.

Aim	Actions	Contributory Measures
Reduce the Youth ED 'Alcohol involved' Rates to <=3%	• Review of current alcohol and other drug (AOD) NGO services followed by the development of a 3DHB AOD model of care and practice pathway, which will include kaupapa Māori and Pacific therapeutic interventions. The review will address service provision to youth and adults. The intention is to commission new services in 2020/21. • Continue to improve screening and data collection on alcohol related presentation in Hutt Hospital ED. • Continue to improve access to treatment for young people with alcohol and other drugs and co-existing problems (AODCEP) through: o Expanding primary and community health services to improve access to AOD and Mental Health support in the community for young people. o A youth AOD specialist service within MHAIDs to improve access to specialist support for young people. o Providing Mental Health and AOD consult liaison and specialist support to primary and community services. • Sub-regional Piki pilot – see SLM 4	Number of 15-24year olds accessing AOD and mental health services from primary and community providers Percentage of patients 0-19 years referred to non-urgent child & adolescent mental health services and seen within 8 weeks Percentage of patients 0-19 years referred to non-urgent child & adolescent addiction services and seen within 8 weeks