Hutt Valley District Health Board 2020/21 Annual Plan

July 2020

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

The photo on the front cover was provided by a local mother who gave her permission to Hut Valley DHB to use this photo of her lovely children.

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Hon Andrew Little

Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

David Smol
Chair
Hutt Valley District Health Board
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Tēna koe David

Hutt Valley District Health Board 2020/21 Annual Plan

This letter is to advise you that I have approved and signed Hutt Valley District Health Board's (DHB's) 2020/21 Annual Plan (Plan) for one year.

I am pleased that your plan provides a strong platform to deliver on the priorities identified in the 2020/21 letter of expectation and focuses on equity, sustainability and addressing the population groups with the highest needs.

I am disappointed with your significant planned deficit position and agree to approve your DHB's Plan on the basis that it is a maximum anticipated deficit.

I expect that the DHB will:

- provide a verbal update to the Ministry of Health on the local governance and operational arrangements in place to ensure better financial performance management including financial controls, probity, compliance, reporting and scrutiny processes, at your next performance meeting
- provide a written report confirming these local assurance arrangements as part of quarter two reports due with the Ministry in January 2021.

I expect you to work with your fellow Chairs and continue discussions about how you can share skills and expertise in order to ensure that your performance is consistent with the agreed plan.

I particularly encourage you to ensure that your senior executives maintain the tight fiscal controls and implement planned service improvements that will be necessary to sustain financial performance in the out years. Good financial performance allows us to invest more in new models of care, both in hospitals and the community, improve population prevention, and to invest in better health assets.

The Ministry will have engaged with the DHB on the $18.8 million of sustainability funding for DHB led improvement projects, that has been made available by the Government. If your DHB has not done so already, I encourage you to accept offers from the Ministry to utilise this funding.

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Please note that approval of your Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health, including changes in FTE. I expect you to continue to engage with the Ministry of Health to ensure you have a strong rationale for any adjustment to planned FTE during the year. 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 does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

I am aware that an extension was provided to the requirements for finalising DHB planning documents required by the Crown Entities Act 2004 due to the impacts of COVID-19. If required, please update your published Statement of Performance expectations and Statement of Intent (if applicable) to align with your approved Plan.

Thank you for the work you and your team are doing to support equitable health outcomes for New Zealanders, during a time when our system has faced additional pressures from COVID-19.

I look forward to seeing further positive progress as you deliver your Plan.

Ngā mihi nui

Andrew Little
Minister of Health

Cc Fionnagh Dougan
Chief Executive

SECTION ONE: Overview of Strategic Priorities

1.1. Our Vision & Strategic Direction

This Annual Plan articulates Hutt Valley District Health Board's (HVDHB) commitment to meeting the Minister of Health's expectations and continue our commitment to deliver HVDHB's vision of:

Healthy People, Healthy Families,

Healthy Communities

Whānau Ora ki te Awakairangi.

To deliver on our vision, we are developing and implementing a health system that best meets the needs of our people and communities. This means applying our resources in the most effective manner to achieve equitable health outcomes and to advance improvements in health outcomes. To achieve this we are organising our system to ensure that service delivery occurs in the most appropriate setting for our people and communities.

We recognise the role of many people in our success: our communities, our families, our workforce, our provider partners, our Ministry and our social service partners. Enabling people and their whānau to take the lead in their own health and wellbeing is at the heart of this approach.

In setting the strategic priorities necessary to achieving our vision, HVDHB is guided by core legislative and governmental strategic directions including:

- Te Tiriti o Waitangi (the Treaty of Waitangi)
- the New Zealand Public Health & Disability Act 2000
- the New Zealand Health Strategy
- He Korowai Oranga – the Māori Health Strategy
- the Healthy Ageing Strategy, and
- Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018 updated with Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan.

We are also guided by the Government's commitment to the United Nations Convention on the Rights of Persons with Disabilities.

1.2. Te Tiriti o Waitangi

Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities through the founding document of Aotearoa, Te Tiriti of Waitangi. HVDHB values te Tiriti 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.

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 wellbeing, while developing partnerships with the wider social sector to support whole-of-system change.

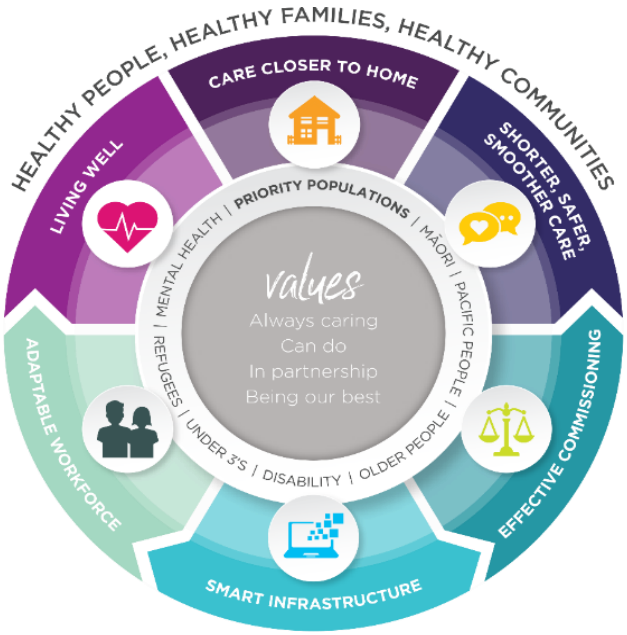
Māori representation has been provided on all advisory committees and our Alliance Leadership Team (Hutt Inc). HVDHB has a Mana Whenua Relationship Board to formalise the relationship between local Iwi and the DHB, build on relationships, and share aspirations and strategic directions.

1.3. Our Vision for Change

In 2017, we introduced *Our Vision for Change – How We Will Transform the Health System 2017-2027*.

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 home, 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 HVDHB'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.

Achieving equity is a focus throughout the Clinical Services Plan. Other areas of particular focus include:

- **Community Integration**: integrating hospital and primary care services, including the provision of specialist advice to primary care so that general practice can better support people to stay well.
- **First 1,000 Days of Life:** ensuring that our women's health, maternity, and child health services provide high-quality, safe and culturally-responsive care.
- **Acute Flow:** improving patient flow through the hospital, including efficient triage and coordination of patients when they present to the Emergency Department, improving our assessment and response to frailty, enhancing the pre-surgery assessment process and theatre productivity, and an efficient discharge planning that supports patients to transition back into primary and community care.

- 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, HVDHB'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. Te Pae Amorangi provides a clear direction and leadership across our DHB to achieve equity of health and wellbeing for Māori.

- Our Pacific Health and Wellbeing Strategic Plan aims to improve Pacific health and reduce health inequities through six priorities: child health and wellbeing, young people, adults and aging well, the health workforce and Pacific providers and NGOs, the social determinants of health, and developing a culturally responsive and integrated health system.
- Living Life Well, our 3DHB[1] Mental Health and Addictions Strategy 20 19-2015, sets the direction for mental health and addiction care to improve outcomes for our people, their whānau, and our wider communities.
- Our Sub-Regional Disability Strategy 2017-2022 provides a clear strategic direction for leaders within the health sector working with disability communities to address inequities across the population and ensure better health outcomes.

The work of implementing our strategic plans has begun. HVDHB 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 our hospital.

1.4. Health Equity

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.

Achieving equity in health and wellness is a focus for HVDHB and CCDHB. We know that we do not do as well for Māori, Pacific People, people with disabilities, those who have fewer resources available to them, and those with enduring mental illness. We can see this in our measurement of health system performance, impacts and outcomes. HVDHB is committed to improving health outcomes and achieving equity for our communities. Our focus is on improving performance, ensuring we make best use of our available resources, and achieving equity amongst our populations. Our sustainable and affordable approach to achieving equitable outcomes is to use a strategy of 'simplify and intensify' – meaning we will intensify resources and support for those who need us the most, and simplify for those who need us the least.

HVDHB has a fundamental role in enabling and facilitating the health system to achieve equitable health outcomes. Partnership is key to success in achieving equitable health outcomes. We collaborate with our Mana Whenua Relationship Board, Sub-Regional Pacific Strategic Health Group, and Sub-Regional Disability Advisory Group who provide advice on how we can achieve equitable health outcomes for the people and communities they represent. We also work closely with Central Region DHBs, particularly CCDHB and Wairarapa DHB, to coordinate our planning and development, and share learnings about innovations and interventions that achieve equitable outcomes.

In this Annual Plan, we outline our actions towards achieving equitable health outcomes particularly for Māori and Pacific people, people who are living with a disability, people who have enduring mental illness and those in our communities who have fewer resources available to them. In 2020/21, we will:

- progress implementation of Te Pae Amorangi, HVDHB's Māori Health Strategy 2018-2027
- begin implementing a newly refreshed 2DHB Pacific Action Plan
- continue to deliver Our Sub-Regional Disability Strategy 2017-2022
- continue to deliver Living Life Well – A Strategy for mental health and addiction 2019-2025.

HVDHB will contribute to equity priorities through the specific actions and milestones outlined in the section below. Equity actions are identified in the table below with code 'EOA', which means 'equitable outcome action'.

1.5. Māori health

Historical disadvantage and alienation, poverty and poor living environments lead to sustained poor health outcomes. This applies to many Māori individuals and whānau. Life expectancy for Māori males and females living in the HVDHB area continues to lag behind non-Māori, and the evidence shows that Māori continue to be over-represented in a number of health care areas.

In July 2019 HVDHB launched Te Pae Amorangi, HVDHB's Māori Health Strategy to 2027. Te Pae Amorangi is supported by this tūruapō (vision):

Tā Mātou Matakite

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

Mauri Ora – Whānau Ora – Wai Ora

Healthy People – Healthy Families – Healthy Communities

Te Pae Amorangi is centred on achieving Māori health equity, and advancing Treaty relationships and Māori participation across the health system.

Our efforts to bring about changes in Māori health outcomes are part of a broader public health plan that is most cohesively described in the Ministry of Health's He Korowai Oranga: Māori Health Strategy. This overarching framework and its underlying themes of Pae Ora (healthy futures) founded on Whānau Ora (healthy families), Mauri Ora (Healthy individuals) and Wai Ora (healthy environments) guide our activity.

Te Pae Amorangi is consistent with He Korowai Oranga and has been developed to transform our health and disability services over the next nine years to achieve Māori health equity and outcomes.

We need to be bold and implement actions that will make a significant impact towards achieving our vision. However, we also need to be flexible enough to change direction if something is not working. There is a need to work across our communities to address the underlying causes of poor health and build a health system that achieves equitable Māori health outcomes. Progressing implementation of Te Pae Amorangi is a focus for 2020/21.

1.6. Whole of system integration

HVDHB and CCDHB have entered into a joint health system planning process. This supports a consistent approach across our five communities (Upper Hutt, Lower Hutt, Kāpiti, Porirua and Wellington), three hospitals (Hutt, Kenepuru and Wellington) and two District Health Boards to achieve equity and improve health outcomes.

This approach will enable us to focus on regional and sub-regional service integration, leveraging and driving innovations and patient/consumer experience to achieve delivery of performance improvement and future sustainability. This will result in a whole of system change in the delivery of primary, secondary and tertiary health services.

Health and social outcomes are inter-related and can be improved by building strong effective partnership with community groups, providers and agencies and supports a strong focus on population health.

Regional Public Health (RPH) plays an essential role in this space. RPH is the public health unit for the 3DHB sub-region. 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 integration of RPH's activity into our commissioning function has commenced and will ensure our efforts to improve health outcomes in our communities are aligned.

Achieving equitable health outcomes for our communities requires an approach broader than the traditional boundaries of health. Partnership with local councils, government agencies, NGOs and community organisations from other sectors is required to respond to variation in the distribution of social determinants of health and the resulting inequitable health outcomes observed across the social gradient. We support these partnerships through locality-based approaches with our communities of Upper Hutt, Lower Hutt, Kāpiti, Porirua and Wellington.

1.7. Our Priorities for 2020/21

Implementing our strategies and action plans is a priority for the two DHBs. This is associated with a programme of work that transforms our health system.

We are re-organising our health system to place people and community settings at the centre of health care service delivery. We will continue to prioritise primary care development and leverage the capacity and capability of community and primary care developed through the Health Care Home model of care. We are also developing locality placed plans to improve connections with community capability.

The drivers for hospital cost growth

Cost growth is primarily a product of increasing demand and differences between the cost of service provision and price.

Demand is being driven by the impacts of ageing, the combination of multiple co-morbidities increasing patient complexity and non-communicable diseases.

We have also had to fund the response to unforeseen events. The Whakaari / White Island natural disaster placed additional demand on our Plastics and Burns Unit, and COVID-19 had a significant impact on the wider DHB.

Managing the clinical risk and patient safety created by demand and capacity mismatch is driving cost growth in the hospitals. Some of the current major clinical risks for HVDHB include:

- Symptomatic Colonoscopy – high demand for colonoscopies has at times outreached capacity resulting in delayed cancer diagnosis.
- Emergency Department Security – following an incident where staff were injured from an aggressive patient, investment is needed to ensure the security and safety of staff and patients.
- Maternity – investment is needed to address the recommendations from an external review that found quality and safety deficiencies in maternity care at Hutt Hospital
- Operating theatres – investment in additional after-hours theatre access is required to avoid delays in patient care and the potential for harm
- Specialty access – other risks that have been identified through clinical governance structures are: outdated clinical spaces that are no longer fit-for-purpose, radiologist and radiographer shortages leading to delays in imaging, constrained plastic surgery capacity, lack of a 'step down' area post ICU care, and no ability to provide dialysis in the Hutt Valley.

HVDHB Performance Improvements

HVDHB has already delivered a range of projects to alleviate some of the pressure on provider services, including:

- Specialist support to GPs – so they can access advice for their patients and potentially avoid hospitalisation
- Improved theatre efficiency and safety – the introduction of electronic waitlist management software has improved the tracking/tracing of patients through their elective surgery journey
- Improved flow of acute (unplanned emergency) patients – the introduction of capacity planner software has enabled us to track and predict daily acute demand, and better match expected demand with staff capacity (nursing rosters)
- Digital dental has been introduced at Bee Healthy dental sites – which means children can now have a single appointment for examination, x-rays, diagnosis and prevention
- The Medical Service Improvement Project has enabled a new roster guaranteeing specialist availability to ED and GPs. Patients receive faster access to senior decision makers.
- Community Nursing: Delays accessing District & Specialist Nursing – efficiency gains resulting in fewer patients waiting for care, and increased responsiveness to ward discharges.
- Ophthalmology - Alternative model of care has been introduced to deliver services closer to home and reducing patient travel.
- Maternity - programme to support mothers with higher needs, ward enhancements with safety benefits, and enhanced clinical governance arrangements.
- Health Care Home (HCH) – the HCH patient-centred model of care has been implemented in fifteen general practices, representing 85 percent of Hutt Valley DHB's 'enrolled population' (those enrolled with a general practice).

Even though these projects have alleviated some of the pressure, additional work is required.

Achieving Sustainability while meeting our obligations

We are committed to achieving sustainability while meeting our obligations. This means that in providing and commissioning health services we are:

- Achieving equity for Māori and others
- Reducing avoidable hospital demand
- Optimising cost structure; and
- Delivering a COVID-19 recovery plan.

Achieving equity for Māori and others in our communities

Overall, our residents are living longer and experiencing better health. However, inequities remain a significant challenge with Māori and Pacific Peoples, people with disabilities, as well as those who have low socio-economic status or an enduring mental illness and/or addiction, and refugees, experiencing the greatest burden of poor health. Inequity also drives avoidable utilisation of health services. Intensifying support to these populations improves health outcomes, and keeps people healthy and well in their community.

We remain focused on achieving equity that is sustainable over time. Key equity priority areas for 2020/21 include:

- Maternal, Child and Youth, including the 2DHB Maternal and Neonatal Health System Plan
- Mental Health and Addictions, including community mental health

- Workforce, including workforce development for staff to build understanding of Māori health and equity.

Reducing avoidable hospital demand

There is overwhelming evidence and agreement that investment in drivers of equity, prevention and early intervention across the life course will reduce the burden of preventable and avoidable disease and poor health and improve the health of the community. This is partnered with an expectation that demand for acute care will be mitigated and enable health system sustainability and affordability.

The question is often raised as to why we do not invest more in equity, prevention and early intervention, and in the early years. The answer is in two parts: (1) that existing services must serve Māori and other people who experience inequity as well, so that we reduce all forms of inequity (why we invest in pro-equity); (2) that disinvesting in specialty and hospital services will cause direct harm to the communities we serve.

It is therefore safer and more effective to purposefully direct resources to reduce the proportional spend on specialty and hospital services through following approaches:

- Implementing pro-equity commissioning for all current and new investment to ensure that Māori, and other groups that experience inequity, receive care that meets their needs and redresses inequities in health outcomes;
- Managing specialty and hospital services provider performance to ensure it is as efficient and productive as safely possible;
- Implementing integrated models of care that provide care in lower cost settings achieving equity, and the same or better health outcomes using less resources;
- Investing in community and primary care services to increase greater capacity and capability to provide health services;
- Investing in prevention and early intervention within integrated models of care to reduce the burden of preventable and avoidable disease.

Optimising Cost Structure

To ensure that we are optimising cost structure we need to ensure that:

- Our services are safe and risk is managed
- Funding for specialty services is fair and does not detract from community investment
- Our hospital and specialty providers are efficient and we are using resources well, and
- Our 2DHB hospital network provides significant economies of scale whilst improving safety and access.

The purpose of the 2DHB Hospital Network Programme is to provide the approach to design and implement the future personal health system across our five communities (Upper Hutt, Lower Hutt, Kāpiti, Porirua and Wellington), three hospitals (Hutt, Kenepuru and Wellington) and two District Health Boards to achieve equity and improve health outcomes.

Three streams of work have been established to plan and deliver this programme:

1. Infrastructure Planning (best use of Hospital Sites/Enabling Infrastructure)
2. Clinical Services Planning
3. Health System design and implementation

The objectives of the programme are:

- Create service delivery models that improve equity and health outcomes
- Support great places to work
- Make effective use of resources
- Make effective use of workforce teams
- Avoid unnecessary duplication and maximise co-location
- Create clinically sustainable services
- Improve financial sustainability of services for both DHBs.

The aim is to provide services that are as local as possible and as specialised as necessary.

COVID-19 Recovery

COVID-19 had a significant impact on the delivery of health care services across the region. During the pandemic:

- a significant number of planned care procedures were deferred, and
- fewer people presented to primary care, accident & medical centres, and emergency departments.

This resulted in an influx of patients requiring care post COVID-19.

Implementing our COVID-19 recovery plan is a focus for 2020/21. For RPH, which is the lead public health agency in a pandemic response, this includes implementing national system changes to improve our capacity for contact tracking. For DHBs, the recovering plan includes embedding new ways of working that developed during COVID-19, such as greater use of telehealth and increasing the availability of specialist support and advice to primary care; working across agencies to look after our most vulnerable populations, including homeless people; and supporting our Māori and Pacific community providers to work alongside whānau and achieve equitable outcomes for our priority populations.

New ways of integrated working are also being explored to mitigate the growth of demand on hospital services. While such changes will help address the backlog of patients whose treatment was deferred during COVID-19, additional capacity will also be needed to clear the backlog through the use of private providers.

The recovery plan also includes a programme of work to support infection control practices across our wider community network, and update and strengthen our pandemic and emergency preparedness plans. We are capturing the learnings from COVID-19 so that we are even better prepared for future pandemics and other emergencies. Finally, we are prioritising the psychosocial response for our workforce and our communities to help mitigate the economic fallout from COVID-19. This is reflected in many of the activities throughout this Annual Plan, particularly under the Improving Mental Wellbeing section.

1.8. Message from the Chair and Chief Executive

It is our privilege to introduce the Hutt Valley DHB Annual Plan for 2020/21, which articulates our ongoing commitment to the HVDHB vision: "Healthy People – Healthy Families – Healthy Communities".

2020 has been an extraordinary year to date and will have a far reaching impact on the way we deliver services and work with our people and communities.

We have been working to bring our partnership as a 2DHB organisation to fruition, beginning with a joint CE, and the recruitment of a number of 2DHB Executive Leadership Team positions, along with the appointment of a joint Chair and the alignment of the two boards.

The release of the Health and Disability System Review, commonly known as the Simpson Review, has signalled change for DHBs. Our strategic approach is aligned with the direction articulated in the recommendations. Hutt Valley and Capital & Coast DHBs are working as one, where possible, across our hospital services and workforce to gain efficiencies and to improve sustainability, safety and quality.

Our staff responded extraordinarily well to the Whakaari / White Island natural disaster, which placed additional demand on our Plastics and Burns Unit at Hutt Hospital. The DHBs in our region also led a strong regional health response to COVID-19 through all alert levels. People rose to the challenge to find new ways of working together in hospitals and with community providers. It has been a time of collaboration across multiple agencies, and of recognising what is important and what stands in our way. We are proud of how our team of many thousands stood strong and supported New Zealand's team of five million to eliminate COVID-19 from community transmission. We continue to maintain our readiness to respond should anything change, and our learning and experience has put us in good stead to lead the health response for the managed isolation facilities across the greater Wellington region.

Embedding the new ways of working that developed during COVID-19 includes greater use of telehealth and increasing the availability of specialist support and advice to primary care. It means working across agencies to look after our priority populations, including homeless people, and supporting our Māori and Pacific community providers to work alongside whānau and achieve equitable outcomes for our priority populations. We continue to explore new ways of integrated working to mitigate the growing demand on hospital services. We are capturing what we have learned from COVID-19 so that we are even better prepared for future pandemics and other emergencies, particularly with regard to the psychosocial wellbeing of our workforce and the population they serve.

People and place are at the heart of all we do and our two key drivers. We are committed to ensuring all of our people have equitable access to health care and, in particular, can access care where they need it. We are committed to the beliefs and values of te Tiriti o Waitangi, and to creating an accessible environment for people with disabilities.

What we can be sure of, is that new territory is opening up for us all the time. We have seen that it is possible to be more agile and responsive. We have an amazing team of people at our DHBs who we know are ready to meet the challenges before us. None of what we do would be possible without our hardworking and dedicated staff who are going to extraordinary lengths to make a difference in the lives of thousands of people every day.

We value all of our partnerships throughout our hospitals and our communities, and we are committed to delivering the health system the people of our region are asking us for.

Fionnagh Dougan
Joint Chief Executive
Hutt Valley and Capital & Coast DHBs

David Smol
Joint Chair
Hutt Valley and Capital & Coast DHBs

1.9. Message from the Chair, Mana Whenua Relationship Board

Māori in the Hutt Valley make considerable contributions to the health and social sector, and often contribute their own resources and time to support health and social sector service provision. Māori health and social sector organisations often lead the way in whānau-centred innovative approaches, from a holistic view that recognises the many determinants that impact on whanau and whanau wellbeing.

Māori health professionals are critical to our health system's success. Rongoā Māori supports wellbeing for many whānau Māori and individuals.

Hutt Valley DHB still have work to do. Our health and wellbeing statistics, and our whānau experiences of services, tell us that we need to be doing things differently. We need use the strengths inherent in our community and work with our Māori health and social sector providers to support the development and approaches that are Māori owned and driven and focus on achieving their own aspirations . We will focus our efforts and resources into the areas of greatest need and work with Maori across the Hutt Valley and beyond, in a manner that is supportive and collaborative. While there is good will and knowledge within our DHB around achieving equity and improving Māori health, we also recognise that Maori will have their own solutions and our challenge is supporting the solutions to practice. Action to make an impact, transform the system, and achieve Māori health equity.

Last year we developed Te Pae Amorangi, Hutt Valley DHB's Māori Health Strategy, to support a transformation of the DHB over the next nine years. Te Pae Amorangi is centred on achieving Māori health equity and supporting Māori participation across the health system. As a DHB, we want to inspire and lead change across our health system to ensure we meet the health needs and aspirations of Māori as tāngata whenua of Aotearoa.

This year we are focussed on progressing implementation of Te Pae Amorangi. This is reflected in many of the actions included in this annual plan. We want to accelerate our treaty relationships and work across our communities to build a health system that is equitable, fair, transparent and accountable in achieving Māori health and equity.

Kuini Puketapu
Chair
Mana Whenua Relationship Board

1.10. Signature Page

Agreement for the HVDHB 2020/21 Annual Plan

between

David Smol
Chair
HVDHB
Date: 29/7/20

Deputy Chair
HVDHB
Date: 04/08/2020

Hon Andrew Little
Minister of Health
Date: 18 December 2020

Fionnagh Dougan
Chief Executive
Hutt Valley and Capital & Coast DHBs
Date: 5/8/20

SECTION TWO: Delivering on Priorities

This section outlines HVDHB's commitment to deliver on the Minister's Letter of Expectations and key activities and milestones to deliver on the Planning Priorities. More information on the Ministry's performance measures is provided in Section 5: Performance Measures.

2.1 Government Planning Priorities

Give practical effect to He Korowai Oranga – the Māori Health Strategy

Engagement and obligations as a Treaty partner		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
In March 2019 Hutt Valley DHB launched Te Pae Amorangi, our 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 will be a focus for 2020/21.		SS12 Status Update Report
1. Our Board, CEO, and Executive Leadership Team will increase their knowledge of, and continue to build relationships with, our local Māori communities, mana whenua.	Q1, Q2, Q3 and Q4	
2. Enhance the partnership with local Iwi by working closely with the Mana Whenua Relationship Board on the development and implementation of planning and strategic documents. (EOA)	Q1, Q2, Q3 and Q4	
3. Create a Rangatahi Māori governance position, with the support of mana whenua and local Māori communities, as a co-opted member of our board to grow our future leadership.	Q4	
4. Māori health equity will be a standing agenda item for each board meeting. (EOA)	Q1	
5. Continue to support and grow Māori representation on Hutt Valley DHB's advisory committees and its Alliance Leadership Team. (EOA)	Q1, Q2, Q3 and Q4	

Māori Health Action Plan – Accelerate the spread and delivery of Kaupapa Māori services		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
1. Implement Te Pae Amorangi equity principles for decision making for commissioning services, so that equity and health outcomes for Māori underpin all new commissioning investments across our DHB. (EOA)	Q1	Status Update Report
2. Review all funded services against our developed equity framework and where possible redirect resources to achieve Māori health and equity outcomes. (EOA)	Q2	
3. Advance our Treaty relationships through active and regular contact with mana whenua, iwi and Māori, and by working in partnership to shift care closer to home and into communities. (EOA)	Q1, Q2, Q3 and Q4	
4. Increase our funding investments in Māori for Māori health services to achieve equity and improve outcomes. (EOA)	Stocktake: Q2; Develop Plan: Q4	
5. Develop and implement a Māori mental health and addictions team within our DHB, and increase our investments in Māori for Māori mental health and addiction services to meet the holistic needs of whānau. (EOA)	Q1, Q2, Q3 and Q4	

6. Partner with local communities to support their development of Māori suicide prevention approaches that fit their community needs, aspirations and realities. (EOA) (This is also a Mental Health and Addiction System Transformation action)	Q1, Q2, Q3 and Q4	

Māori Health Action Plan – Shifting cultural and social norms

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Senior Medical Officers will undertake institutional racism and bias training.[2] (EOA)	Q1, Q2, Q3 and Q4	Status Update Report
2. Deliver Māori health equity and cultural safety training and development to DHB staff. (EOA)	Q1, Q2, Q3 and Q4	
3. Adapt our recruitment policies and procedures to better attract, appoint and retain Māori staff. (EOA)	Stocktake: Q1. Adapt policies: Q4	
4. Actively incorporate Māori perspectives, traditional knowledge, and worldviews into health assessments, treatment protocols, measures of outcomes and frameworks for analysis. (EOA)	Q1, Q2, Q3 and Q4	

Māori Health Action Plan – Reducing health inequities- the burden of disease for Māori

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Implement Whakapumautia te Aroha Māori mentoring programme across our DHB. (EOA)	Q4	Status Update Report
2. Develop and implement recruitment policies to attract, appoint and retain Māori in our DHB. (EOA)	Q1	
3. Develop a proactive recruitment positon for Māori Senior Leadership across all DHB positions.	Q2	
4. Our Executive Leadership Team will champion career development and leadership progression for Māori employed by our DHB, including mentoring and leadership programmes for Māori staff.	Q1, Q2, Q3 and Q4	

Māori Health Action Plan – Strengthening system settings

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Our Board, CEO and Executive Leadership Team will develop and agree specific performance indicators used to monitor equitable health outcomes for Māori.	Q3	Status Update Report
2. Develop robust ethnicity data collection measures and report these to our community transparently to ensure we are accountable for our work.	Q4	
3. Incorporate 'achieving Māori health equity' into everything we do, including our policies, practices, norms and organisational culture.	Q1, Q2, Q3 and Q4	

[2] Te Pumaomao is a nationhood building Wānanga that focuses on Aotearoa, Te Tiriti o Waitangi, and Māori. It is two full days and those enrolled attend the full Wānanga hosted by one of our local marae. Other professional groups of staff at Hutt Valley DHB are exploring this as a viable option for their areas.

4. Commission the development of an equity think piece for our DHB to support the organisation to further develop and advance equity actions.	Q4	

Improving sustainability

Improved out year planning processes

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
Part One: Financial		Status Update Report
1. 2DHB Provider Hospital Network Planning: (a) Strategic Infrastructure Brief (b) Site-wide Master Site Planning (c) Clinical Services Planning Implemented (services to be prioritised)	(a) Q1 (b) Q2 (c) Q3	
2. More Affordable Models of Care: (a) Expansion of ESD (early supportive discharge) (b) Implementation of Planned Care Plan (see Planned Care planning priority below)	(a) Q2 (b) Q4	
Part Two: Workforce (2DHB)		
3. Align People, Culture and Capability services and activities across Hutt Valley and Capital & Coast DHBs, including: a) Develop and refine proposed future state b) Consult on proposed future state and undertake formal change process c) Confirm and implement future state proposal d) Embed future state.	(a): Q1 (b): Q2 (c): Q3 (d): Q4	
4. Implement 2DHB Quality and Safety Framework (patient and staff safety, developed in 2019-2020 year), including: a) Implement prevention of bullying harassment, victimisation and discrimination policy 3DHB. b) Establish a 2DHB wellbeing vision and objectives, leading to a work programme. c) Align staff safety frameworks across the two DHBs (HVDHB and CCDHB)	(a): Q1 (b): Q3 (c): Q4	
5. Identify effective people management systems to support increased data analytics and planning, including: a) Exit interview reporting. b) Refine the dashboard of people data. c) People metrics to support business partners.	(a): Q1 (b): Q3 (c): Q4	

Savings plans – in-year gains

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Estimated Saving	Measure
1. Patient Flow reducing demand on emergency and hospital so our communities only using the hospital when they really need to, and getting people home sooner. The objective is to manage ED occupancy. (a) Convert medical assessment unit to general assessment unit (b) Roll out early supported discharge, enabled by Advanced Wellness at Home Initiative (AWHI)	Q2 & Q4	$0.5m	Status Update Report

(c) Reducing avoidable bed days - focus on patients with length of stay >10 days and increase proportion dischargers earlier in the day (d) Increase specialist rounding at weekends (e) Daily acute physician clinics (f) Specialist support for primary care			
2. Provider performance improved through enhanced production planning and efficient operating room utilisation. Objectives are to ensure service delivery to plan, and efficient use of resources. Production planning activities include: (a) Joint 2DHB plan to deliver local volumes and manage through peak occupancies (b) Robust outsourcing (c) Embedding virtual outpatient assessments and virtual advice to GPs Operating room utilisation activities include: (d) Developing improved access for acute surgery – second acute theatre (a) Development of procedure rooms for those non-theatre procedures currently done in theatre.	Q2 & Q4	$2.4m	
3. Financial; control expenditure and manage costs. The objectives are: (a) Rationalise contracts across the 2DHBs, including standardise performance monitoring and review. (b) Manage the cost of clinical and non-clinical consumables (c) Effective Use of Workforce (d) Early implementation of data and digital strategy	Q2 & Q4		
4. Community performance improved to help reduce admissions to Hutt Hospital. Activities include: (a) Improving the management of frailty and avoidable hospitalisation by implementing a 'neighbourhood approach' to integrated care, which includes a community team of nurses and allied health staff supporting GP practices. (b) Community activities to increase the uptake of flu vaccinations the 2021 season, reduce the spread of influenza in the community, reduce staff sick leave, and reduce acute hospital admissions. There is an opportunity to apply the learnings from the 2020 flu season and COVID-19. The following activities are planned to increase the uptake of flu vaccinations: (i) General practice teams will pro-actively contact high priority people to offer flu vaccine in clinics (ii) Implement the Māori Provider Influenza Vaccine Support Project (eg outreach, marae clinics, and incentives) (iii) Increase the number of services providing influenza vaccine in the 2021 flu season. (iv) Facilitate the provision of influenza vaccine to over 65s through marae and Pacific church settings. (v) Promote and encourage DHB staff to be vaccinated.	Q2 & Q4		

Savings plans – out year gains; and

Consideration of innovative models of care and the scope of practice of the workforce to support system sustainability

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Estimated Saving	Measure
Part One: Savings plans – out year gains		$4.6m	Status Update Report
1. **Infrastructure and Support Services.** Activities include: (a) Transport and Supply; centralise transport and supply functions across 2 DHBs (b) Communications; develop integrated call centre across 2 DHBs (c) Transcription services; transition to working from home; and integrated medical typing pool across 2DHBs	Q4		
2. **Vision for Change Implementation – improving community care options.** Activities include: (a) Operating a single health service commissioner in high needs areas of Hutt Valley (b) Implementing integrated service delivery models for communities	Q4		
3. **2DHB Hospital Network Implementation.** Activities include: (a) Early movers for clinical services planning include: Cardiology, Tertiary Surgery, ENT, and Ophthalmology	Q4		
4. **3DHB MHAIDS Implementation.** Activities include: (a) Established commissioning Board (b) Implementation of Living Life Well Strategy improving community service delivery. (c) Implementation of He Ara Oranga Strategy and expansion of community and primary mental health.	Q4		
Part Two: Workforce activities to support system sustainability			
1. Workforce capability developed to support inter-professional working. Activities include: a) Development of an Interprofessional strategy - inclusive of the student learning experience, utilisation of kaiawhina workforce, new graduate practice and development of interprofessional practice within clinical practice for qualified staff (Q2) b) Extend the Early Supported Discharge service to include AHS&T staff (alongside current Nursing allocation) (Q1) c) Introduce AHS&T new graduate programme at Hutt Valley DHB (Q1) d) Ensure key workforce data accuracy and workforce dashboards are available to support decision making (Q2) e) Develop and implement a Kaiawhina workforce plan that supports growing capability and increased inter-professional practice of this workforce (Q3) f) Provide capability programmes that build inter-professional competencies for organisational projects and for clinical practice (Q4) Organisational surveillance developed to identify priority workforce vulnerabilities and action plan agreed (Q4)	Q1-Q4 Narrative Report		
2. Build Māori and Pacific leadership networks. Activities include: a) Seek and apply privacy approval for all staff to upgrade ethnicity data and for it to be used to target activities to support Māori and Pacific staff (Q1) b) Support and grow Whakapumautia te Aroha Māori mentorship programme (Q1) c) Māori and Pacific leadership networks set up and supported. (Q2-4) (EOA) g) Review Whakapumautia te Aroha outcomes with Māori Health Team and link to leadership networks as appropriate. (Q2-4)	Q1-Q4 Narrative Report		

3. All vacancies reviewed for appropriate skill mix/profession to ensure position is configured for top of scope practice. Activities include: a) Analyse recruitment and selection practices (Q1) b) Enhanced recruitment reporting established (Q2) d) Refine recruitment processes to improve quality of hiring decisions and skill match to role requirements (Q3-4)	Q1-Q4 Narrative Report		

Working with sector partners to support sustainable system improvements		
Government theme: Improving the wellbeing 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		
Activity	**Milestone**	**Measure**
1. **Planned Care:** Work with Te Awakairangi Health[3] to roll out the Health Care Home patient-centred model of care across the Hutt Valley to every willing practice, achieving the aim of maximum coverage of the enrolled population. We aim to roll out the model to all willing practices by the end of 2020/21 – as close to 100% coverage as possible. (This is also a Planned Care activity)	Q1-Q4	Status Update Report
2. **Maternity:** Co-design innovative models of care with Māori and Pacific women in order to improve outcomes. This will include exploring midwifery practice continuity models that fit the cultural context for Māori women and Pacific women, and examining the feasibility resourcing (including financial) of potential new case loading models of care, and the impacts on Lead Maternity Carers of different case loading model approaches. (EOA) (This is also a Maternity and Early Years activity) (2DHB)	Q4	
3. **Mental Health and Addictions:** Support and contribute to the development of a collaborative between the Māori and Pacific service providers across Capital & Coast and Hutt Valley DHBs. The collaborative will develop and implement culturally appropriate and community-based models of care. The goal of the collaborative is to work together to support service development and delivery, share information, build service resilience, and improve the sustainability of services. (This is also a Mental Health and Addiction System Transformation activity) (2DHB)	Q4	
4. **Family Violence Prevention:** Work in partnership with Māori, HVDHB, and community providers to co-design and develop a joint 2DHB Family Violence Prevention Action Plan for our communities, with a particular focus on at-risk population groups. This approach will include a range of prevention, early intervention and specific interventions to enhance safety for families and whanau. Q1- confirm scope project; Q2 – complete interviews, research, and analysis; Q3 - co-design and draft plan; Q4 - test, refine and approve plan. (EOA) (2DHB) (This is also a 'Family violence and sexual violence' activity)	Q1-4	

Improving Child Wellbeing - improving maternal, child and youth wellbeing

Maternity and Midwifery workforce		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Make New Zealand the best place in the world to be a child		
Activity	**Milestone**	**Measure**
5. Addressing specific population needs through focused maternity care across the region in partnership with Māori: a) Participate in the joint sub-regional Maternity Quality Safety programme (MQSP), which will develop an action to reduce pre-term births. The action will be informed by retrospective data collection and research undertaken in 2019/20 on reducing the preterm birth rate for Māori women over a 5-year period. (2DHB) (EOA)	a): Develop action: Q1 Implement action: Q2-4 b): Q1-4	Status Update Report

[3] 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.

b) Implement the recommendations from a recently completed breast feeding review aimed at improving breast feeding rates for Māori and Pacific women. This builds on the work done in 2019/20 around data collection, mapping of current supports, consumer hui and engagement in service design, and use of the Health Equity Assessment Tool to determine the responses needed. (2DHB) (EOA)		
6. Deliver integrated Midwifery workforce planning against the 2019-2023 DHB midwifery workforce strategies (CCDHB/HVDHB) to achieve a sustainable future in the provision of safe maternity care and match our midwifery staffing to meet maternity demand for mothers/ mama and babies/pepe. Key actions below are some of the deliverables we will undertake in 2020-2021: a) Work with CCDHB and local education providers to ensure that undergraduates are placed in clinical settings that align with undergraduate workforce planning and support optimal learning. Provide appropriate practice settings for learning to support, encourage, and prepare new midwives for practice in New Zealand. (2DHB) b) Work with CCDHB to finalise a shared MOU to agree a joined up application process for new graduate placements across the region. This will include sharing education resource, joint education sessions and advertisement, and streamlining the appointment and recruitment process to reduce competition and help us attract midwives to the region to meet our current and future clinical need. (2DHB) c) Co-design innovative models of care with Māori and Pacific women in order to improve outcomes, and explore midwifery practice continuity models that fit the cultural context for Māori women and Pacific women. (EOA) (2DHB) (This is also a Maternity and Early Years activity) d) Forecasting in advance of seasonal Lead Maternity Carer shortfalls and planning around this to ensure antenatal, intrapartum and postnatal care is optimal.	a): Q1-4 b): Finalise MOU: Q1 Evaluate effectiveness of MOU: Q4 c): Q4 d): Q1-2	

Maternity and early years

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

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

Activity	Milestone	Measure
1. CCDHB and HVDHB to work together to develop and implement a reformed 2DHB maternal and neonatal health system plan that will deliver equitable outcomes for all women, babies and families living in Wellington, Porirua, Kāpiti, Lower Hutt and Upper Hutt. This work will consider the clinical and social risk factors (including mental health) impacting the way people access services. (EOA) (2DHB)	Q4	Status Update Report
2. Co-design innovative models of care with Māori and Pacific women in order to improve outcomes. (EOA) This will include: (a) Exploring midwifery practice continuity models that fit the cultural context for Māori Women and Pacific women (b) Explore options to improve access to ultrasound scanning (c) Examining the feasibility resourcing (including financial) of potential new case loading models of care, and (d) The impacts on Lead Maternity Carers of different case loading model approaches (EOA) (This is also a Maternity and Midwifery Workforce activity, and a Working with Sector Partners activity) (2DHB)	Q2 & Q3	Status Update Report
3. Implement the recommendations of the Women's Health Service Review to deliver sustainable, high-quality and safe care to our local women in a culturally-responsive way.	Q1-Q4	Status Update Report
4. Facilitate development of an action plan to improve the wellbeing of children and young people in the Hutt Valley. The plan will include short-term activities focussed on addressing urgent needs, as well as starting the work on longer-term changes needed to transform systems and services. The plan will include actions to reduce inequity of access to ultrasound scanning, pregnancy and parenting education and Well Child	Q2	Status Update Report

Tamariki Ora services. Development of the plan will draw on evidence about what works from Hutt Valley DHB's First 1000 Days Partnership Project and Data Matching project, as well as the National Child and Youth Wellbeing Strategy.		PH01: ASH[4] rates for 0–4 year olds
5. Strengthen the function of Hutt Hospital's Children's Outpatient Service, including improved triage and prioritisation of referrals into the service, and streamlining care pathways with improved service coordination with primary care.	Q1-Q4	
SUDI Prevention Hutt Valley DHB will 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.		Referrals to the Hapu Mama programme at Kokiri Marae.
6. We will work with community providers on strategies to improve smoking cessation programmes and safe sleep messages to hāpu wāhine, including the possibility of group smoking cessation sessions for hāpu wāhine. (EOA)	Q4	CW09 - Better help for smokers to quit (maternity)

Immunisation

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
Hutt Valley DHB is working to improve the delivery and uptake of immunisation from infancy to age 5 years, with a particular focus on achieving equity and improving Māori and Pacific uptake and outcomes. Oversight of Māori and Pacific focused work is provided through the Executive Leadership Team at Hutt Valley DHB, which includes the Director of Māori Health and the Director of Pacific People's Health. We are conscious of the groups within our population that may find accessing childhood immunisations harder as a result of COVID-19. The activities below are planned so that we continue to immunise children on time in light of the COVID-19 pandemic.		CW05 – Immunisation coverage (8 months, 5 year old, HPV coverage) CW08 – Increased immunisation (at 2 years)
1. Pacific Health Unit staff will implement visits to all new Pacific mothers in the maternity ward following birth of their babies. Immunisation will be discussed as part of a wider discussion about the health and wellbeing needs of mother, baby and their wider family. Pacific Health Unit staff will be provided with immunisation training, annually, to enable culturally meaningful immunisation conversations. (EOA)	Q1	
2. Explore collective strategies with Te Awakairangi Health, Regional Public Health (RPH) and outreach immunisation providers to work with people who are not well engaged with their general practice and may find accessing childhood immunisations harder as a result of COVID-19. (EOA)	Q3	
3. Roll out community flu vaccination clinics following successful community pilots conducted in 2019/2020	Q2	
4. Review the Immunisation Pre/Re-Call Protocol for general practices to ensure a consistent best-practice approach is adopted to increase equity of uptake. (EOA)	Q1	
5. Increase the number of pharmacies providing influenza vaccine in the 2021 flu season. (Also a Pharmacy activity)	Q1	CW05 – Immunisation coverage (Influenza immunisation at age 65 years and over)
6. Implement the Māori Provider Influenza Vaccine Improvement Project – through marae and outreach-based services. (EOA) (Also a Pharmacy activity)	Q1	
7. Facilitate flu-vax clinics to eligible people through Pacific churches and Asian places of worship to increase flu vax coverage. (EOA) (Also a Pharmacy activity)	Q1	

[4] Ambulatory Sensitive Hospitalisation.

School-Based Health Services

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have improved quality of life

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
Hutt Valley DHB's Youth Health Steering Group (our equivalent to a 'Youth Service Level Alliance Team') has the following actions planned for 2020/21 to improve the health of the DHB's youth population:		Child wellbeing CW12: Youth mental health initiatives HVDHB will provide quarterly qualitative reports on the actions of the Youth Health Steering Group.
1. Undertake ongoing implementation of recommendations from the Health in Schools: Gap Analysis and Opportunities for Improvement review, focusing on services for young people 10-15 years of age.[1]	Q1-Q4	
2. Undertake a distinct project looking at how a model of care may be developed that best suits the needs of young people. This will have a focus on periods of transition in a young person's life, in particular transitioning from primary school to intermediate and again from intermediate to secondary school. Evidence shows that this is a time of anxiety for young people. The outcome will be a 'proof of concept' pilot that could be trialled within a community setting. The trial would have a strong equity focus and build strong relationships with our key partners in the community.	Q1-Q4	
3. Align primary mental health youth services in the Hutt Valley with the Ministry of Health Piki Pilot to ensure consistent primary mental health services for young people in the Hutt Valley.[3]	Q1-Q4	
4. The DHB will utilise the SBHS funding to increase the level of FTE in a decile 4 school to recognise the increase in enrolled pupils and ensure that the ratio of 1:700 is met. The school transition project (refer to 2 above) will also be supported via the SHBS funding.	Q1-Q4	

Family violence and sexual violence

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have improved quality of life

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Advance Treaty relationships and partnerships with Kaupapa Māori family violence providers within the Hutt Valley. We will draw on their expertise, knowledge and connections in the community to engage effectively with Māori whanau experiencing family violence.	Q1-Q4	A qualitative status update report will be provided for all activities.
2. Look to extend the Violence Advisory Group to kaupapa Māori family violence providers to ensure greater connection and collaboration across the community.	Q4	
3. Develop Service Level Agreements (SLA) between DHB and family violence services with regards to referrals and how on-site services will be provided.	Develop SLA by Q4	
4. Work in partnership with Māori, CCDHB, and community providers to co-design and develop a joint 2DHB Family Violence Prevention Action Plan for our communities, with a particular focus on at-risk population groups. This approach will include a range of prevention, early intervention, and specific interventions to enhance safety for families and whanau. Q1- confirm scope project; Q2 – complete interviews, research, and analysis; Q3 - co-design and draft plan; Q4 - test, refine and approve plan. (EOA) (2DHB) (This is also a 'Working with sector partners' activity)	Q1-4	
5. Host mult-iagency case reviews each year (one for Intimate Partner Violence and one for Child Abuse and Neglect) to evaluate health actions within family violence response. This will include a review of a Māori woman who presented to our Emergency Department following violence and injury by an intimate partner. The review will consider whether the response to the presentation was culturally safe and aligned with best practice. (EOA)	Q1-Q4	

[1] The review identified that there are very limited services available to refer young people to when required.

[3] Piki is 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). Piki empowers and supports Rangatahi towards better health and wellbeing.

6. Contribute to Safe Hutt Valley, the regional World Health Organisation's Safe City programme. A family violence work stream has been included in the Safe Hutt Valley programme, supporting networking among agencies such as Te Ahuru Mowai o Te Awakairangi, local Whānau Ora programmes, Naku Enei Tamariki and others. There is a communication pathway between the Safe Hutt Valley Governance Group, the Hutt Valley DHB Executive Leadership Team, and the VIP team (includes VIP sponsor, VIP manager(s) and coordinators). The Safe Hutt Valley Governance Group includes at least one Māori representative from HVDHB.	Q1-Q4	
7. Work with sector partners to strengthen the established Maternity Care and Child Wellbeing Multi-Agency Group with a focus on prevention and early intervention, the sharing of information, and active referrals for services to support the safety of pregnant women and unborn tamariki and their whānau. The Maternity Care and Child Wellbeing Multi-Agency Group includes representatives from Hutt Valley DHB, Oranga Tamariki, New Zealand Police, Te Awakairangi Birthing Centre, Pacific Health Services, Well Child/Tamariki Ora providers, Naku Enei Tamariki (Family Start provider), Kokiri Whanau Ora Social Support Services, and VIBE Youth Health Services.	Q1-Q4	

Improving mental wellbeing

Mental Health And Addiction System Transformation		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
Placing people at the centre of all service planning, implementation and monitoring programmes		MH01: Improving the health status of people with severe mental illness through improved access
1. Work with co-design principles to ensure lived experience from service users and family / whānau is incorporated into planning and development, and seek regular input into key strategic and transformational projects from the 3DHB Lived Experience Advisory Group (LEAG).[5] The LEAG membership is diverse and includes members who represent Māori, Pacific, youth and rainbow communities. In addition to providing feedback into key pieces of work the Co- chairs have agreed to add a recruitment function (for key roles) to their work programme for 20/21. We will strengthen the link between LEAG and provider arm clinical services consumer advisor roles with a specific goal of supporting greater service user leadership in monitoring consumer rights in clinical services. (3DHB)	Q1-Q4	
2. Develop and implement a Māori mental health and addictions team within our DHB, and increase our investments in Māori for Māori mental health and addiction services to meet the holistic needs of whānau. (EOA)	Q1-Q4	
3. Expand Hutt Valley DHB's mental health and AOD provider forum, which includes primary care and NGO mainstream and kaupapa Māori services, to also include inter-sectoral representation. The forum will become a wider cross-sector network that can better address the underlying causes of poor mental health through coordinated cross-sector activity and intersectoral service linkages across the continuum. (EOA)	Q4	
4. Develop a proposal to support implementation of Real Time Feedback (RTF) with NGO providers and work with the secondary specialist clinical services to implement RTF in MHAIDs clinical services.	Q4	
5. We will provide further support for additional workforce placement by increasing resource in local workforce readiness programmes with local NGO providers, and by integrating the current employment programme with CCDHB. This integration will support improved efficiency and greater access to a wider range of options for employment.	Q1-4	

[5] Projects include the 3DHB Acute Care Continuum project, the reconfiguration of Te Whare Ahuru Acute Inpatient Unit, and the 3DHB AOD model of care project.

Embedding a wellbeing and equity focus		
6. Support and contribute to the development of a collaborative between the Māori and Pacific service providers across Capital & Coast and Hutt Valley DHBs. The collaborative will develop and implement culturally appropriate and community-based models of care. The goal of the collaborative is to work together to support service development and delivery, share information, build service resilience, and improve the sustainability of services. (This is also a Working with Sector Partners activity) (EOA) (2DHB)	Q4	
7. Collaborate with local councils to provide training sessions around suicide prevention and supporting first symptoms of mental health (Mental Health 101) for key community stakeholders. The aim of the training programme is to increase overall community resilience by providing education, building links and sharing resources across a range of community services and groups. Target community groups include community services and agencies providing services to vulnerable groups in areas of high deprivation, such as LGBT, refugee, and Muslim communities.	Q1-Q4	
8. We will partner with our Public Health Promotion and Education partners to investigate mental health wellbeing and equity, and public health and promotion activity which will address mental health needs, across our system. We will plan to identify mental health needs and how they will be met through implementation of our Wellbeing Plan. Key areas of focus in the implementation of the Wellbeing Plan will include: • Healthy Active Learning and physical activity • reducing the impact of alcohol and drug use in our population • improving maternal mental health • providing stop smoking services to people using our mental health services • supporting healthy families and developing a 2DHB Family Violence Prevention Action Plan • support healthy housing and eliminating homelessness. We will create improved access to physical activity programmes through increased use of green prescriptions for mental health clients who are vulnerable to developing or are affected by metabolic syndrome. We will partner with MHAIDS, Regional Public Health, Healthy Families, Māori and Pacific providers, and PHOs to investigate and incorporate a specific focus on mental health wellbeing and equity into our public health activities and health promotion and education campaigns.	Q2-4	
9. Develop COPMIA (Children of Parents with Mental Illness or Addictions) services and, subject to investment, expand these services into Upper Hutt, Wainuiomata, and Naenae.	Q1-Q4	
10. Improve support to families dealing with acute mental health issues by strengthening links between acute mental health and COPMIA services, and increasing the referrals from Te Whare Ahuru, the acute mental health inpatient service, to COPMIA services.	Q2	
Increasing access and choice of sustainable, quality, integrated services across the continuum		
11. Support and participate in the recently established 3DHB Greater Wellington Regional Collaborative (GWRC) established to support the implementation of the integrated primary mental health and addictions service (Te Tumu Waiora model). The model aims to improve access into general practice services. General practices with high Māori, Pacific, youth and rural populations will be prioritised in the first tranche. (3DHB)	Q2-Q4	
12. Invest in a Hutt Valley DHB general practice / primary care liaison service (subject to funding) to grow capability and capacity in the relationship between community mental health and primary care. (This is also a Mental Health improvement activity)	Q1-Q4	
13. Develop an integrated community mental health and wellbeing service, based on the hub-model of service delivery, which will provide a timely local-level service to improve our response to people in distress and crisis who present with acute issues.	Q2-Q4	
14. 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 for responding to Māori mental health needs. Implementation of the model of care will address legacy barriers to NGO services meeting acute needs such as setting pricing to afford better levels and types of resource, and improved sustainability through improved volumes of clustered services. (3DHB)	Q4	

Suicide prevention		
15. Develop and begin implementation of a 3DHB suicide prevention and postvention plan. This plan and subsequent actions will incorporate goals from the national suicide prevention strategic plan 'Every Life Matters', and will focus on population groups at higher risk of suicide. (EOA) (3DHB)	Q1-Q4	
16. Streamline and improve data collection and reporting on suicide numbers/self-harm presentations across the 3DHBs. This will include standardising documentation and electronic data capture to reflect sector standards. (3DHB)	Q1-Q4	
17. Collaborate with local council to provide training sessions around suicide prevention and supporting first symptoms of mental health (Mental Health 101) for key community stakeholders. The aim of the training programme is to increase overall community resilience by providing education, building links and sharing resources across a range of community services and groups. Target community groups include community services and agencies providing services to vulnerable groups in areas of high deprivation, such as LGBT, refugee, Muslim communities.	Q2-Q4	
Workforce		
18. Undertake workforce planning in partnership with NGO providers, including the development of a collective workforce development plan that will consider opportunities for investment. The plan will also include support for NZQA recognised peer support training, and links with training institutions. The collective NGO workforce group will engage with workforce centres, including the Central Agency (Central TAS) to plan for our future workforce and include the 'Let's Get Real' framework. Plans will focus on retention, recruitment and training, and the health and wellbeing of our workforce. (2DHB)	Q1-Q4	
Forensics		
19. Work with the Ministry to improve and expand the capacity of forensic responses from Budget 2020.	Q1-Q4	
20. Contribute, where appropriate, to the Forensic Framework project.	Q1-Q4	
Commitment to demonstrating quality services and positive outcomes		
21. Support and contribute to the National KPI Programme, established to focus on improvements in specific Key performance indicators. Whanau Engagement - Adult services are focusing on improving whanau engagement across the services by establishing practise standards, auditing against those standards, and using data to inform improvement work.	Q2-Q4	
22. Undertake a Connecting Care project, which focuses on service transitions and the coordinated transfer of care between one health care or social service provider and another. The project aims to ensure that mental health and addiction service consumers receive continuous quality care between providers. (2DHB)	Q2-Q4	
23. Implement a Creating Safety Through Practice project to improve the way we learn from adverse events. This project will engage all stakeholders and improve the experience of consumers, family and whānau and staff involved in an adverse event, as well as supporting DHBs to define a consistent approach to responding to events which result in harm or have the potential to. The focus is on improving the review process to ensure we review events appropriately and in a timely way. We will also be looking at how we action any resulting recommendations. (2DHB)	Q2-Q4	
24. The Strategy Planning and Outcomes (SPO) team will jointly work with the Ministry of Health in planning for a psychosocial recovery programme, and increasing the focus on wellbeing across services with an initial focus on the primary care investments. The HVDHB SPO team is increasing local suicide prevention and postvention resources in 2020-21 by dedicating funded resource to HVDHB areas aligned with regional public health programmes.	Q2-4	

Mental health and addictions improvement activities		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**

1. Invest in a Hutt Valley DHB general practice / primary care liaison service (subject to funding) to grow capability and capacity in the relationship between community mental health and primary care. This is aimed to improve the smooth transition of care from specialist services to primary care, and provide consult and liaison input to the primary care teams targeting the moderate group of need. This initiative will better align secondary specialist services with the additional newly-funded mental health and addictions services in primary care (Piki, Te Tumu Waiora) and existing services such as Te Awakairangi Health Network's Wellbeing Service). (This is also a Mental Health and Addiction System Transformation activity)	Q2-Q4	MH02 – Improving the health status of people with severe mental illness through improved access MH05 – Reduce the rate of Māori under the Mental Health Act Status Update Report
2. Implement a quality improvement plan with NGO partners. The plan will focus on common access to accurate and validated data, improvements in PRIMHD data collection and analysis, and quality auditing and monitoring cycles of activity. The quality auditing processes have a focus on meeting the National Health and Disability Standards. The monitoring audits will specifically include requests to identify evidence of leadership in promoting respect for and observance of the Code of Health and Disability Services Consumers' Rights.	Q4	
3. Toward Zero Seclusion (TZS) Complete TZS the National collaborative between District health board (DHB) teams, mental health and addiction service consumers, the Health Quality & Safety Commission and Te Pou o te Whakaaro Nui (Te Pou), towards the elimination of seclusion by 2020 (3DHB – MHAIDS)	Q1-Q4	
4. Improving Māori and Pacific Health Workforce: Grow the Māori and Pacific workforce by increasing the number of scholarships offered to support workers and administrators to engage in the Bachelor of Nursing Programme. Increase the number of New Entrant to Specialist MH positions in Mental Health and Addictions and target Māori and Pacific graduates. (EOA) (3DHB – MHAIDS)	Q2 & Q4	
5. Marama RTF: Complete implementation of the Marama Real Time Feedback project to collect client and whanau experience of the service in real time. Data collected will inform service performance and improvements. (3DHB – MHAIDS)	Q2	
6. Client Pathway: Continue to develop and implement quality improvements for the He Ara Oranga (client pathway), ensuring best practise standards and high quality care for clients while providing visibility of digital client records that are accessible to GPs (3DHB – MHAIDS)	Q3	
7. ICT Implementation of the MH digital and data Intelligence projects, advancing and enabling an integrated system across the three DHBs, improved visibility, monitoring, and reporting through technology. (3DHB – MHAIDS)	Q2	
8. Learning from Adverse Events Creating safety through practice – improving the way we learn from adverse events. This project will engage all stakeholders and improve the experience of the people involved in an adverse event, as well as supporting DHBs to develop a consistent approach to responding to such events. The focus is on improving the review process to ensure we review events appropriately and in a timely way. We will also be looking at how we action any resulting recommendations. (3DHB – MHAIDS)	Q4	
9. Talking Therapies A project to increase the skills of current staff to deliver strong evidence-based talking therapies and to improve access for clients to those therapies (3DHB – MHAIDS)	Q2 & Q4	
10. Supporting Parents Healthy Children: A project that aims to support MHAIDS to develop a workforce that is confident and competent to have conversations with people about their parenting and their children; knows about the SPHC resources and links to local parenting and community supports and services; is able to recognise and respond to the needs of children and their family and whanau (3DHB – MHAIDS)	Q2 & Q4	
11. DNA – Younger Persons services are focusing on reducing the number of Did Not Attend (DNA) (3DHB – MHAIDS)	Q2 & Q4	

Addiction		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**

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.		MH03
1. Increase investment in AOD services to ensure the sustainability of AOD services, following a review and investment bid in 2019/20. The investment in services will be implemented along with a jointly organised update of service specifications and contracts.	Q1 & Q2	
2. Establish the AOD Collaborative Network to ensure key stakeholders remain engaged and participate in the co design and implementation of the Model of care. (3DHB – MHAIDS)	Q4	
3. Complete the 3DHB Model of care and priority pathways for Māori, Pasifika, Youth, Rural and Remote areas, and Severe AOD. (EOA) (3DHB – MHAIDS)	Q3	

Maternal mental health services		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
HVDHB funds the following community-based primary maternal mental health services: a) 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. b) Lower Hutt Women's Centre provides community-based primary mental health services, targeted to Māori, Pacific, and low income women c) General practice provides primary mental health services for low income Māori or Pacific people age 12 years and over. In 2020/21, we will develop and expand existing maternal mental health services through the following activities:		Status update report
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) Equity of outcomes expectations will be embedded in the plan to develop options. Nāku Ēnei Tamariki is part of a wider collective that has strong links with other providers. Whānau input to the implementation of the programme will be sought as implementation is planned and through the wider network of other providers. Access to maternal mental health services will include a section on links to infant mental health and particularly early parenting support programmes.	Q1-Q4	
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-Q4	
3. CCDHB and HVDHB to work together to develop and implement a reformed 2DHB maternal and neonatal health system plan that will deliver equitable outcomes for all women, babies and families living in Wellington, Porirua, Kāpiti, Lower Hutt and Upper Hutt. This work will consider the clinical and social risk factors (including mental health) impacting the way people access services. (EOA) (2DHB) (This is also Maternity and Early Years'' activity)	Q4	

Improving wellbeing through prevention

Environmental sustainability		
Government theme: Improving the wellbeing of New Zealanders and their families; Build a productive, sustainable and inclusive economy **System outcome:** We live longer in good health **Government priority outcome:** Make New Zealand the best place in the world to be a child		
Activity	**Milestone**	**Measure**

1. Transition 70% fleet cars from petrol to Hybrid by July 2021.	Q4	Status update report using Environmental and Border Health report template
2. Review all food waste policies (Q2) and implement guidelines for waste reduction and disposal (Q3-4).	Q2-Q4	
3. Eliminate 80% of the plastic food and drink containers within the food service department by July 2021.	Q4	
4. Review power consumption within food services, with a particular focus on refrigeration, and implement a replacement programme where all new equipment will have a 5 star power efficiency rating.	Q3-Q4	
5. Introduce environmentally sustainable pest control measures by replacing harmful chemicals and aluminum lights with LED lights	Q1-Q2	
6. A requirement to provide sustainable service delivery will be included in all tenders for house management services.	Q1-Q4	

Antimicrobial Resistance (AMR)

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
Actions planned to address the challenge posed by antimicrobial resistance (in alignment align with the New Zealand Antimicrobial Resistance Action Plan) include:		Status Update report
1. Amend patient records that incorrectly identify a penicillin allergy.[6]	Q1-Q4	
2. Antimicrobial stewardship ward rounds in the hospital to optimise antimicrobial prescribing, reduce the use of unnecessary antibiotics, and educate and support junior medical staff.	Q1-Q4	
3. Surveillance of antimicrobial usage, including quarterly inpatient consumption reports, biannual point prevalence studies, and review of community dispensed antibiotics following discharge after surgery. For multi-drug resistant organisms (MDROS), we do continued surveillance of: ESBL Klebsiella, MRSA, CPE, VRE, and C. difficile. WSCL microbiology laboratory provides an annual antibiogram of our local susceptibility patterns.	Q1-Q4	
4. 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.	Q1-Q4	
5. Continue surveillance of multidrug resistant organisms and Clostridium difficile.	Q1-Q4	
6. 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-Q4	
7. 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.	Q1-Q4	
Equitable Outcomes Actions Our local data shows that Gram-negative resistance does not currently disproportionately affect Māori and Pacific groups, however we are concerned about the impact on these groups if this changed. The most effective way to protect Māori and Pacific population groups is to have a strong and broad community infection prevention and control (IPC) and antimicrobial resistance (AMR) programme to reduce the rate of transmission of Gram-negative resistance in the community. To support a strong and broad community IPC AMR programme, HVDHB will:		
8. Provide an information session on Infection Prevention and Control to general practitioners under the Continuing Medical Education programme.	Q1-Q4	
9. Provide a session on sterilisation to primary care staff and an Infection Prevention and Control study day that general practice staff and rest home nurses can attend.	Q1-Q4	

[6] 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.

Māori and Pacific are disproportionately affected by Methicillin-resistant Staphylococcus aureus (MRSA) infections and we have identified that the Hutt Valley has a high rate of skin Infections and use of anti-staphylococcal antibiotics compared to the national average.		
10. To help address this, Hutt Valley DHB will pilot skin infection clinics run from general practices in high need areas. These clinics will be led by an Infectious Diseases SMO and supported by Community Nurses. They will focus on the prevention of skin infections for patients and their whānau. The clinics will also serve as an opportunity to support and strengthen general practice. (EOA)	Q1-Q4	

Drinking water

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Provide a drinking water programme as per the Environmental and Border Health Exemplar for Public Health Units. (RPH - core function: health protection) (3DHB)	Q2 & Q4	Status update report (Environmental and Border Health reporting template)
2. Use public health risk assessment to identify and target vulnerable populations (including communities with high Māori and Pacific Peoples populations. (RPH - core function: health protection) (3DHB) (EOA)	Q2 & Q4	

Environmental and Border Health

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Undertake activities as per the Environmental and Border Health Exemplar for Public Health Units including hazardous substances; border health; emergency planning and response; resource management, regulatory environments and sanitary works; and other regulatory issues. (Also refer to the drinking water section). (RPH -core function: health protection) (3DHB)	Q2 & Q4	Status update report (Environmental and Border Health reporting template)
2. Use public health risk assessment to identify and target vulnerable populations (including communities with high Māori and Pacific populations. (RPH - core function: health protection) (EOA) (3DHB)	Q2 & Q4	

Healthy food and drink

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Ensure the DHB Food and Beverage Guidelines align with National Healthy Food and Drink Policy (drinks will remain stricter than the national policy). (3DHB)	Q2	Status update report CW02 – Oral Health mean DMFT[7] score at
2. Develop a standard clause stipulating an expectation that service providers have a Healthy Food and Drink Policy covering all food and drinks sold on site/s and provided by their organisation to clients/service users/patients, staff and visitors.	Q1	
3. Include the standard clause in all relevant contracts and licences to occupy, as and when these contracts are agreed or renewed.	Q1-Q4	
4. Work with food service providers operating on site at Hutt Valley DHB to ensure that they are 100% compliant with the updated Food and Beverage Guidelines by Q4.	Q1-Q4	

[7] Decayed, Missing, Filled Teeth.

5. Work in partnership with Sport Wellington and the Ministry of Education to provide the Healthy Active Learning programme to schools and early learning services, with a continued emphasis on (a) water-only and (b) low decile schools with higher numbers of Māori and Pacific students. We will report on the number of Early Learning Services, primary, intermediate and secondary schools that have current water-only (including plain milk) policies and healthy food policies (that are consistent with the Ministry of Health's Eating and Activity Guidelines. (RPH - core function: health promotion) (3DHB) (EOA)	Q1-Q4: Implement Healthy Active Learning Q4: Water-only polices and food policies consistent with guidelines	school Year 8

Smokefree 2025

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Undertake compliance and enforcement activities relating to the Smokefree Environments Act 1990. (3DHB and RPH - core function: health promotion)	Q2 & Q4	SS06 – Better help for smokers to quit in public hospitals PH04 - Better help for smokers to quit in primary care CW09 - Better help for smokers to quit (maternity)
2. Co-ordinate the delivery of the Hutt Valley Smokefree Action Plan (collectively developed with and delivered by partners in tobacco control) focusing on priority populations. Delivery of the plan includes: a) working with Upper Hutt Council to help implement a new Smokefree Outdoor Public Places Policy and increase smokefree environments (3DHB and RPH - core function: health promotion) b) promoting access to stop smoking services, particularly for priority populations (3DHB and RPH - core function: health promotion) c) working with Takiri Mai te Ata Regional Stop Smoking Service and community providers on strategies to improve smoking cessation, especially hāpu wāhine and other Māori women. To achieve this objective, we will: - establish regular meetings with Takiri Mai Te Ata Regional Stop Smoking service to collaborate on innovations, review service gaps, and develop actions together to improve the service for priority populations - collaborate with the Hapu Mama service provider to identify and implement opportunities to promote Hapu Mama services within and across the DHB. (3DHB and RPH - core function: health promotion) (EOA) d) delivering health promotion campaigns focusing on our priority populations (3DHB and RPH - core function: health promotion) e) developing resources and improved training for hospital staff to improve brief advice discussions, support of patients who smoke, and referrals (3DHB and RPH - core function: health promotion)	Q2 & Q4	

Breast Screening

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

HVDHB continues to work with the Regional Screening Services to achieve the 70% screening target for Māori and Pacific women.

Activity	Milestone	Measure
1. Regional Screening Services will provide six weekend breast-screening clinics at each of the DHBs and aim to screen a target of 40 women at each clinic (dependent on medical imaging technologist resource). (Also a Cancer Services activity) (2DHB)	Q1-Q4	Status update provided Q2 & Q4 PV01 – Improving breast
2. Regional Screening Service will implement more regular monthly evening breast-screening clinics during the working week and aim to screen a target of 15-20 women at each clinic (dependent on medical imaging technologist resource). (2DHB)	Q1-Q4	
3. To support the national (BreastScreen Aotearoa) two-year pathway to achieve the 70% screening target for Māori and Pacific women, Regional Screening Services'	Q1-Q4	

recruitment and retention team will aim to support as many additional Māori and Pacific women as possible who are overdue or unscreened to attend a breast screening clinic. (EOA) (2DHB)		screening coverage and rescreening Breast screening and DNA rates by ethnicity.
4. Regional Screening Services will use the results of the BreastScreen Central Mammography Project to inform changes to provide 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. The project will look at additional fixed sites and/or a replacement mobile unit. (EOA) (2DHB)	Q1-Q4	
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 depending on surgeon and radiologist resource. (Also a Cancer Services activity) (2DHB)	Q1-Q4	
6. Regional Screening Services will work in partnership with local Māori and Pacific health providers, PHOs, and primary care and community health services, including multidisciplinary meetings and teleconferences, use of local clinics, and organising education and health promotional events.	Q1-4	

Cervical Screening

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
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.		Q2 & Q4: Status update PV02 – Improving cervical screening coverage Cervical screening and DNA rates by ethnicity.
1. Regional Screening Services will continue to promote the key messages around the importance and benefits of cervical screening by attending events where priority populations gather, and educating and supporting women into the screening pathway.	Q1-Q4	
2. Invite and support overdue and unscreened women to combined breast and cervical screening sessions. We will work in partnership with clients and find appointment days and times that best suit them. (EOA) (Also a Cervical Screening activity and a Cancer Services activity)	Q1-Q4	
Free cervical screening clinics		
3. To improve Māori and Pacific screening rates, Regional Screening will continue to provide weekend free cervical screening clinics, four per annum at Hutt Hospital and aim to screen 35 women at each clinic. These clinics will be combined with breast screening where possible. (EOA)	Q1-Q4	
4. Regional Screening Services will provide approximately 15 free community-based cervical screening clinics per annum in high-needs communities across the Hutt Valley region targeting Māori, Pacific, and Asian women. (EOA) (Also a Cancer Services activity)	Q1-Q4	
Primary Care		
5. Regional Screening Services will increase linkages with general practices in the Hutt Valley region and will work with them using data matching reports to identify and offer support to priority group Māori, Pacific, and Asian women who are unscreened and under screened. (EOA) (Also a Cancer Services activity)	Q1-Q4	

Reducing alcohol related harm

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. RPH continues to develop and improve our local knowledge of how alcohol adversely affects local communities, including using hospital and emergency department data. (RPH - core function: health assessment and surveillance) (3DHB)	Q1-Q4	Q2 & Q4: Status update

2. Provide health protection activities relating to the Sale and Supply of Alcohol Act 2012. (RPH - core function: health protection) (3DHB)	Q1-Q4	(Reducing Alcohol Related Harm: Health Protection Planning/ Reporting template)
3. Influence policies related to reducing alcohol related harm, e.g. Councils' local alcohol policies. (RPH - core function: health promotion) (3DHB)	Q1-Q4	
4. Support communities to have a voice in local alcohol licensing decisions, alcohol and drug policy and legislation development. We engage with the iwi and local community leaders to support them to advocate with their communities from their own lived experiences (RPH -core function: health promotion) (3DHB) (EOA)	Q1-Q4	

Sexual health

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Provide information and advice to communities and health providers for sexually transmitted infections (STIs) outbreaks. (RPH - core function: health promotion) (3DHB)	Q1-Q4	Q2 & Q4: Status update
2. Lead collaboration with relevant sexual health services and stakeholders to support the sexual health workforce to be able to respond to the sexual health issues identified by Māori and Pacific populations. (RPH - core function: health promotion) (3DHB) EOA)	Q1-Q4	
3. Support stakeholders to respond to sexual health issues identified by Māori and Pacific populations by providing advice, information and linking with relevant agencies and experts. (RPH - core function: health promotion) (3DHB) (EOA)	Q1-Q4	
4. Implement the National Syphilis Action Plan. (3DHB)	Q1-Q4	
5. Provide contact tracing/partner notification. (RPH - core functions: health assessment & surveillance) (3DHB)	Q1-Q4	

Communicable Diseases

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Provide a notifiable communicable disease programme to prevent, identify and respond to exiting/emerging communicable diseases including prompt follow up of notifiable communicable diseases; detect and control of outbreaks; facilitate TB drug regimens completion; and promote infection prevention, control and immunisation in community and healthcare settings. (RPH - core functions: health promotion, health protection, health assessment & surveillance, public health capacity development and preventive interventions) (3DHB)	Q1-Q4	Q2 & Q4: Status update
2. Improve access to infectious disease related services for Māori and Pacific Peoples (RPH -core function: health promotion) (EOA) (3DHB)	Q1-Q4	
3. Provide BCG vaccination to children (to prevent tuberculosis) according to the Ministry of Health's eligibility criteria and vaccine availability. (RPH - core function: early intervention) (2DHB)	Q1-Q4	

Cross Sectoral Collaboration including Health in All Policies

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Co-plan and implement healthy housing activities as a member of the Wellington Regional Healthy Housing Group. (RPH - core function: health promotion) (3DHB)	Q1-Q4	Q2 & Q4: A qualitative

2. Provide the 'Health in All Policies Programme' focusing on influencing Councils' spatial planning and district plan reviews. (RPH - core function: health promotion) (3DHB) (EOA)	Q1-Q4	status update report will be provided on the progress of all activities.
3. Coordinate, co-deliver and enhance the Well Homes service in partnership with Tu Kotahi Māori Asthma Trust, He Kāinga Oranga (Otago University) and the Sustainability Trust; including assessments, intervention planning and delivery for families at risk of housing related illnesses (e.g. respiratory diseases and rheumatic fever) with priority to Māori and Pacific families. (RPH - core function: health promotion) (2DHB) (EOA)	Q1-Q4	
4. Contribute to implementing the Hutt City Council Homelessness Strategy, along with other social sector partners; including advocacy to central government to ensure motels/hotels used for emergency accommodation are fit for purpose.	Q1-Q4	
5. Continue to implement the HVDHB Wellbeing Plan, which includes providing information and advice to the Hutt Valley Governance Group. (Links with actions under the Smokefree 2025 and Healthy Food and Drink sections)	Q1-Q4	

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

Delivery of Whānau Ora		
Government theme: Improving the wellbeing 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		
Activity	**Milestone**	**Measure**
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: a) Whānau Ora representation on the refreshed Alliance Leadership Team[8] b) working in partnership with local Māori health providers to meet Whānau Ora objectives c) 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.	a): Q1 b): Q1-Q4 c): Q1-Q4	SS17 – Delivery of Whānau Ora Status update report
2. Support – including through investment – the Whānau Ora Initiative, and collaborate with its commissioning agencies and partners to identify opportunities for alignment. This includes: a) meeting with Whānau Ora collectives to investigate opportunities for alignment with the DHB's work programme and priorities b) meeting with Taeaomanino Trust and Te Pou Matakana to identify possible opportunities for alignment with the DHB's work programme and priorities.	a): Q1 b): Q1	
3. Undertake quality improvement actions that align with and support Healthy Lives domain of the Pasifika Futures Outcomes Framework for Prosperous Pacific Families.	Q1-Q4	

Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan		
Government theme: Improving the wellbeing 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		
Activity	**Milestone**	**Measure**
8. Hutt Valley DHB commits to supporting delivery of the new Pacific health plan - Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan. (EOA)	Q4	Status update

[8] 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)

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Ensure everyone who is able to, is earning, learning, caring or volunteering

Activity	Milestone	Measure
General		Status update report
1. Complete the annual CCDM work plan (year 3 of the three year plan) with the intent to have full implementation of CCDM by 31 June 2021.	Q1-Q4	
Governance		
2. Continue monthly CCDM Council meetings with stakeholders working in partnership to progress implementation of CCDM at Hutt.	Q1-Q4	
3. Complete the Standards Assessment and quarterly milestone reports for National Governance.	Q1-Q4	
4. Continue communications to all stakeholders regarding progress of CCDM implementation at the Hutt Hospital with monthly newsletters and staffing updates on the DHB Intranet.	Q1-Q4	
Validated Patient Acuity		
5. Implement TrendCare updates within 3 months of release	Q1-Q4	
6. Complete the annual Inter Rater Reliability (IRR) testing and for all new staff within 6 weeks of employment	Q1-Q4	
7. Work towards attainment of 100% accuracy with the input of information into TrendCare.	Q1-Q4	
Core Data Set		
8. Continue to develop the remaining measures for the Core Data Set (3 out of 23 still to be developed)	Q1-Q4	
9. Progress the Core Data Set dashboards for directorate and organisational reporting measures being used for monitoring, reporting and continuous quality improvement	Q1-Q4	
Ward Quality Groups (WQGs)		
10. Establish Ward Quality Groups in the remaining areas	Q1-Q4	
11. Implement and monitor continuous quality improvement activities that arise in WQGs through effective use of the Core Data Set.	Q1-Q4	
Staffing Methodology		
12. All ward/units new roster models and other recommendations from the 2019/2020 FTE calculations will be implemented.	Q1-Q4	
13. FTE calculations to inform the 2021/2022 budget (based on 2020/2021 data) will commence June 2020.	Q1-Q4	
Variance Response Management		
14. Develop reporting from the Visual Indicator Score mobile application and implement continuous improvement activities to improve reporting	Q1-Q4	

Disability Action Plan

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Ensure everyone who is able to, is earning, learning, caring or volunteering

Activity	Milestone	Measure
There is a 3DHB Strategy that is in place 2017-2022		Status Update Report
1. Extend data governance working group.	Q1	
2. Source and secure Data points across the 3 DHBs and external partners.	Q2	
3. Redesign information requirements of referrals ensuring disability is detailed and appropriate to inform a data strategy for the purpose of improving health outcomes.	Q4	

4. Education processes to enhance data capture are developed and actioned across the DHBs.	Q4	
5. Encourage stakeholders to work in partnerships to address challenges experienced by Pacific disabled people and their families by ensuring representation of Pacifica on the Sub Regional Disability Advisory Group, and ensuring data planning includes Pacific disabled people. (EOA - Faiva Ora Outcome)	Q2	

Disability

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Ensure everyone who is able to, is earning, learning, caring or volunteering

Activity	Milestone	Measure
1. Provide a human rights-based staff training framework, one that promotes equity and barrier free engagement with health services by disabled people. This will result in significant attitudinal change across the DHB's. Core disability responsive education will comprise of an initial e-learning programme of three modules that all staff must complete. This programme will ensure that all staff have foundational knowledge about disability, the rights based approach, the importance of attitude and how to make reasonable accommodations. Once this core learning has been completed additional modules can be provided that gradually build on knowledge and information as required - this can be taken to advanced levels.	Q2	Status Update Report
2. Deployment of effective disability alert system that is evident on all patient records. This will include a launch and education program for the workforce.	Q4	
3. Collaborate with the Ministry on targeted engagement by DHBs with disabled people in each region.	Q2	
4. Health information is to be accessible for disabled people in ways that promote their independence and dignity. The DHB is committed to working progressively to ensure all information intended for the public is accessible to everyone and that everyone can interact with services in a way that meets the individual need to promote their independence and dignity. New Zealand Sign Language (NZSL) will be used to convey public alerts across the DHB.	Q4	
5. Finalise the revised hard copy Health Passport and launch with education programme for public and staff across the 3 DHBs: (a) Agree version of prototype e-version of Health Passport.	Q3; (a) Q4	

Planned Care

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
Improve understanding of local health needs		Status Update Report SS07 – Planned Care Measures
1. Progress the 2DHB Hospital Network Programme with Capital & Coast DHB to ensure our services are clinically and financially sustainable. This includes analysing and modelling different configurations of services that could operate at Wellington, Kenepuru and Hutt Hospitals – and assessing their future impact in terms of cost, equity, and health outcomes. (2DHB)	Q4	
Balance national consistency and the local context		
2. Undertake joint 2DHB planning with CCDHB to ensure our services are clinically and financially sustainable.	Q1-Q4	
Simplify pathways for service users		
3. DHB staff from the Pacific Health Unit will visit and offer support and advice to all new pacific mothers in the maternity ward following birth of their babies. The staff will help facilitate access to any other health or social services needed by the new mother or her whānau. (EOA)	Q1-Q4	
Optimise sector capacity and capability		

4. Implement the Patient Observation Platform at Hutt Hospital to improve efficiency and optimise the use of our nursing, midwifery and medical workforce. This enables nurses and midwives to digitally collect observations and assessments about patients on mobile devices, and alert clinicians to deterioration in a patient's health. (Also a Data and Digital activity)	Q2 roll out starts at Hutt Hospital	
5. Establish an integrated community health service model that brings the separate Allied Health disciplines across the DHB into a single team, with a central referral system that will co-ordinate internal and external referrals processes feeding into a transdisciplinary and patient-centred model of care. As part of this new model, we will also extend the Early Supported Discharge programme to include Allied Health staff.	Q1-Q4	
Systems are sustainable and fit for the future		
6. Pilot a 'neighbourhood approach' to integrated care through the establishment of a community team of nurses and allied health staff supporting GP practices wrapped round the Naenae / Taita / Stokes Valley neighbourhoods.	Pilot operational by Q2	
7. Work with Sport Wellington to improve the availability of, and access to, strength and balance activities and programmes to Māori and Pacific older peoples. (Also a Healthy Ageing activity) (EOA)	Q1-Q4	
8. Hutt Valley DHB is committed to meeting national planned care service delivery and waiting time expectations.	Q1-Q4	

Acute Demand

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
Acute data capturing		Status Update Report
1. Implement SNOMED in the Emergency Department, including both triage codes and discharge codes.	Q1	
Acute Demand		
2. Our Emergency Department will work with the PHOs to explore and support opportunities for increased management of patients in the community and to build relationships with primary health care.	Q1-Q4	
3. Implement a project to improve equity of access and outcomes for Māori, including: a) Project planning with ED and the Māori Health Team. b) Establish a Māori Acute Demand Interest Group with consumer and community representation. c) Identify project actions and begin implementation. (EOA)	(a): Q1 (b): Q1 (c): Q2-Q4	
4. Investigate the feasibility of an Infectious Diseases Physician supporting primary care to effectively manage skin infections in high-need communities.	Q4	
5. Produce a Summer and Winter plan for the Medical Ward to improve patient flow. This may also include a Discharge Lounge, particularly during Winter months, and a focus on time of discharge.	Q1-4	
6. Arrange for General Medical Physicians to work in the community with general practices in assigned neighbourhoods to meet, greet and listen; respond to requests for information; and, attend practice-based multi-disciplinary team meetings.	Q1	

Healthy Ageing

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Work with our two Home and Community Support Services (HCSS) providers to ensure consistent delivery of service across Hutt Valley and Capital & Coast DHBs, in line with the national service specifications and the National Framework	Q1-Q4	SSO4: Implementing

	(following a transition from one to two HCSS providers during 2019, and a shared contract between HVDHB and CCDHB). (2DHB)		the Healthy Ageing Strategy
2.	Work with Primary Care and Sport Wellington on the collection of data relating to older persons identified as requiring osteoporosis management, and those identified as at risk of falls, to develop sustainable strength and balance programmes in partnership with community groups.	Q1-Q4	
3.	Work with Sport Wellington to improve the availability of, and access to, strength and balance activities and programmes to Māori and Pacific older peoples. (EOA) (Also a Planned Care activity)	Q1-Q4	
4.	Explore systems for consistently assessing and recording the risk of falls within the Hutt Valley region, through coding data from ED presentations, to inform the development of initiatives to reduce falls.	Q1-Q4	
6.	Ensure HQSC Frailty Care Guides are referenced in the localised Health Pathway for 'Frail but Stable Older People' (2DHB)	Q1	
7.	We will survey ARC providers to identify their current use of the HQSC Frailty Care Guides. This will help to raise awareness of the guides and identify if any further promotion/training is needed. (3DHB)	Q2	
8.	Participate in a Regional Equity forum, using dementia as the area of focus, and identify future equity actions arising from this forum and the findings of the National Dementia Stock-take. (2DHB)	Q2-3	

Improving Quality

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. **Improving equity** Asthma: Implement the next phase of Respiratory Work Programme throughout 2020/21 to address asthma and respiratory related hospital admissions and disparities for Māori and Pacifica. This includes implementing the specialist respiratory support model for primary care, consistent respiratory self-management plans across primary, secondary and community, and proactive planning for LTC and high user patients aligning with Proactive Care activities in Year 2 of Health Care Home model in primary care. (EOA) (This is also a Long Term Conditions including Diabetes activity)	Q1-Q4	COPD and respiratory related ED attendances and hospital admissions, by ethnicity.
2. **Improving consumer engagement** *Working within SURE (Supporting, Understanding, Responding, Evaluating) Framework.* *The aim of this framework is measure how District Health Boards are listening, responding to and partnering with consumers, and how they honour Te Tiriti o Waitangi in their consumer engagement planning and activities.* *In addition to the SURE Framework, Hutt Valley DHB aims to:* • *simplify how patient/consumer feedback is received* • *provide transparency of outcomes (acceptable resolution reached or next steps)* • *retain data integrity and the paramountcy of patient confidentiality.* a) Supporting: Establish a Hutt Valley DHB oversight group for the Health Quality & Safety Commission (HQSC) Health Quality Safety Marker (QSM). The oversight group membership will reflect the priority populations (Māori, Pacific Peoples and People living with a disability) and include consumer presentation. (EOA) b) Understanding: Review and improve consumer data collection and entry in the feedback system (SQUARE) with an emphasis on improving the quality of the data, in particular ethnicity and disability data. Specific patient- and service-focussed initiatives will ensure patient-experience information is collected, analysed and reported by ethnicity. c) Responding: review the pathway for patient/consumer communication to ensure it is patient-centred, meaning it is simple for patients to provide feedback and the response is timely and respectful. The review will also consider how the DHB records whether the consumer who raised an issue is satisfied with the outcome.	a): Q4 b): Q1-Q4 c): Q1-Q4	Status update report

3. **Spreading hand hygiene practice** a) Hutt Valley DHB has 14 clinical areas planned for hand hygiene audit in 2020/21. Audits are reported quarterly and results come out in February, June and October. Progress will be discussed at monthly Infection Prevention and Control meetings, and learnings from areas that excel or require development will be discussed and actions undertaken for improvement as indicated. We have the capacity and expertise to undertake audits across all 14 clinical areas. Our auditors receive re-training twice a year. b) We will work with ACC to develop aseptic guidance to support the application of the five moments for hand hygiene to all aseptic techniques. c) Educational support on hand hygiene will be delivered during staff clinical orientation, through ward-based education sessions, and at any opportunistic times across the clinical areas.	a): Q1-3 b): Q3 c): Q1-3	Status update report

New Zealand Cancer Action Plan 2019 – 2029		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
1. Regional Screening Services will continue to provide six weekend breast-screening clinics at each of the DHBs and aim to screen a target of 40 women at each clinic (dependent on medical imaging technologist resource). (Also a Breast Screening activity) (2DHB)	Q1-Q4	SS11 – Faster cancer treatment Status update report
2. Regional Screening Services will continue to trial same day biopsies and first specialist appointments at the breast symptomatic clinic to facilitate access and faster cancer treatments to out of district women, depending on surgeon and radiologist resource. (Also a Breast Screening activity) (2DHB)	Q1-Q4	
3. To improve Māori and Pacific screening rates and achieve at least 70% coverage, 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. (Also a Breast Screening activity and Cervical Screening activity) (2DHB)	Q1-Q4	
4. We will invite and support overdue and unscreened women to combined breast and cervical screening sessions. We will work in partnership with clients and find appointment days and times that best suit them. (EOA)	Q1-Q4	
5. Continue to monitor equity of access and timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway. (2DHB)	Q1-Q4	
6. Offer education, advice and transport to clients who have previous missed appointments to Breast, Cervical or Colonoscopy Services to facilitate access and faster cancer treatments. (2DHB)	Q1-Q4	
7. Continue to support combined breast, cervical and bowel health promotion activities at regional events (working with CCDHB around the bowel screening promotion activities). (2DHB)	Q1-Q4	
8. Implement a project to improve engagement with Māori and Pacific peoples in the bowel screening programme to facilitate their access to timely screening and early treatment of cancers. (This is also a Bowel Screening activity) (2DHB)	Q1-Q4	
9. Seeking additional endoscopy capacity to address a steady increase in referrals, address the backlog and reduce colonoscopy wait times.	Q1-Q4	
10. Establish a genetics clinic in Breast screening to support management of patients with a family history of breast cancer.	Q1-Q4	
11. Regional Screening Services will work in partnership with local Māori and Pacific health providers, PHOs, and primary care and community health services, including multidisciplinary meetings and teleconferences, use of local clinics, and organising education and health promotional events.	Q1-4	

Bowel Screening and colonoscopy wait times

Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
Colonoscopy Wait Times		SS15 – Improving wait times for Colonoscopy Status Update Report
1. Finalise draft Production Plan to ensure greater understanding and planning for capacity and demand.	Q2	
2. Business Case approval for additional FTE to support demand for colonoscopy – could be in the form of a Nurse Endoscopist.	Q2	
Bowel Screening Programme		
3. Implement a Bowel Screening Outreach Programme to improve engagement with Māori and Pacific peoples and facilitate their access to timely screening and early treatment of cancers. The programme is about reaching out to Māori and Pacific peoples who have been sent (or are due to receive) the FIT kit to talk to them about the benefits and talk them through the process. Our Māori and Pacific healthcare providers will be contracted to deliver the programme, which also includes bowel screening promotion and education in the community.	Q1-Q4	

Workforce

Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
HVDHB Workforce Priorities		
1. **Workplace culture:** Creating a workplace culture that aligns with our strategy, keeps our values at the heart of everything we do and drives high performance. Milestones include: (a) Values embedded into people systems and processes (e.g. role descriptions, recruitment processes); (b) Mechanisms in place to empower people to enact values (c) Areas where values conflict identified and strategies for resolution identified (d) Values embedded into high performance system.	(a) Q1; (b) Q2; (c) Q3; and (d) Q4	Status Update Report
2. **System Capability**: Ensuring that our people are supported by robust data, that the skills and capabilities of our leaders and our people reflect the clinical and operational needs of our health system. Milestones include: (a) Leadership framework defined (b) Coaching for leaders as agents and examples of values engagement and culture in place (c) Networks, forums and development plans to support Māori and Pasifika leaders established (d) Mechanisms to strengthen our ability to identify talent and create a leadership talent pipeline in place.	(a) Q1; (b) Q2; (c) Q3; and (d) Q4	
3. **Equity**: Supporting our workforce to achieve increased equity outcomes, particularly for Māori, Pacific and people with disabilities. (EOA) Milestones include: (a) Te Reo used in job titles (b) Workforce understanding of Māori health and equity increased (c) Workforce development focussed on cultural leadership, safety and competency embedded.	(a) Q1; (b) Q1-Q2; and (c) Q3	
4. **Employee experience**: Enhancing our employee experience by valuing wellbeing, delivering practical, easy to navigate people systems and processes, and ensuring our people have clear roles and accountabilities. Milestones include: (a) 2DHB high performance and development framework defined (b) Framework piloted	(a) Q1-Q2; and (b) Q3-Q4	
Workforce Diversity: The diversity of our workforce needs to reflect the communities we serve. Specific strategies to attract, recruit and retain our Māori, Pacific and disability workforce are key priorities.		

5. We will build our understanding of our workforce through better use of workforce data, and ongoing use of survey tools. We will develop our ability to integrate workforce intelligence and utilise forecasting tools. Milestones include: (a) Include high quality diversity data in all our recruitment data collection and reporting (b) Upgrade existing workforce diversity data to enable enhanced accuracy of diversity data reporting. (c) Integrate the recruitment data into our payroll data base, which will involve upgrading our payroll system	(a) Q1; (b) Q2; and (c) Q3	
6. We will continue to build the capability of our new graduates through our commitment to workforce initiatives and high quality training for groups such as; RMO Postgraduate Year 1 and 2 (PGY 1s and 2s), our New Entry to Specialist Practice programme for nursing, nurse practitioner talent mapping, and Community Based Assignments for medical trainees. Activities include: (a) Work with clinical leads to provide structured new entry to practice programmes for nursing, medical and allied health graduates. (b) In consultation with clinical leads and tertiary providers monitor the effectiveness of the transition between training and workplace to ensure a positive experience for all trainees.	Q2 & Q4	
Health Literacy: To achieve gains in equity of outcomes, a focus on health literacy will be important. This includes our workforce having effective understanding of responsibilities under Te Tiriti O Waitangi and ability to enact Te Tiriti.		
7. Taking a planned approach to embedding and extending programmes already initiated will be important in the coming year. Activities include: (a) Extend uptake of health literacy eLearning across workforce. (b) Embed health literacy focus into on boarding for all new staff.	Q2 & Q4	
Cultural Safety		
8. Focus this year will be to enact the intentions outlined in the Māori Health strategy (2019) and Central Region Equity Framework. This will include a focus on increasing the cultural intelligence and safety of our workforce, with a particular emphasis on understanding and challenging bias. Activities include: (a) Extend uptake of equity eLearning across workforce. (b) Embed equity focus into onboarding for all new staff. (c) Commence the education of our workforce about recognising and addressing unconscious bias using eLearning modules.	(a) Q2 & Q4; (b); Q3 & Q4; and (c) Q4	
9. This also includes ensuring that our attraction and recruitment processes are culturally safe. In the first instance, this means being able to provide accurate ethnicity data from our people systems. Activities include: (a) All job titles expressed in Te Reo and English. (b) Project to revise attraction, recruitment and onboarding to ensure cultural safety and to attract Māori workers.	(a) Q1; and (b) Q2	
Leadership		
10. Leadership activities in the coming year will focus on adapting our current approach of developing individual leaders to strengthening leadership as a core capability and an enabler for achieving organisational priorities. Milestones include: (a) Leadership framework designed; (b) Leadership framework piloted implementation; (c) Leadership framework implementation commences.	(a) Q1; (b) Q3; and (c) Q4	
11. We will put support mechanisms in place for our senior leaders to role model and to actively develop leadership capability in their leaders and across the DHBs. Milestone includes: (a) Design a leadership pipeline that includes an approach that will support us to identify future leaders and manage this talent.	(a) Q2	
12. Work with Māori, Pacific and people with disabilities to identify how to enhance mana to empower full participation in leadership and governance within the DHBs. Milestones include: (a) Reference group of Māori and Pasifika leaders established to provide guidance on the development of leadership initiatives. (b) Networks to support Māori and Pasifika leaders established.	(a) Q1; (b) Q2	

Pandemic Preparedness		
13. A 2DHB health system Workforce Office was set up to support coordinated workforce planning and deployment for COVID-19 during the response. A 'virtual' workforce office continues to monitor requests and can be stood up if required. The virtual office continues to hold a database of staff who may be available for redeployment during any future response. Milestones include: (a) Review carried out (b) Systems and processes used by the Office are documented so they can be retrieved and used.	(a) Q1; (b) Q2	
14. HVDHB and CCDHB have developed an Aged Residential Care (ARC) Contingency Plan as part of the COVID-19 Response. The Plan sets out how the HVDHB and CCDHB will support the management of a COVID-19 outbreak in an Aged Residential Care (ARC) facility (including workforce considerations).	Q1: Plan finalised	
15. A 20DHBs Emergency Response Function was established to support coordinated workforce response for COVID-19. The structure and operating model were identified and stood up during the response. This function remains on standby, to enable rapid response for future pandemic events.	Q1: Function enabled for standby status.	

Data and Digital

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity[9]	**Milestone**	**Measure**
1. **Achieving stability of critical systems - Concerto clinical portal consolidation:** This 3DHB initiative will bring Concerto back into support, provide consistent features and enable sharing of patient information across the three DHBs. This will reduce long run costs of the clinical portal, and enable migration to regional infrastructure. This will also ensure that there is consistent clinical service experience for Māori and other groups across the three DHBs. The software component of this project is an enabler for electronic referrals. (EOA)	Q4	Status Update Report
2. **Significant improvement to operational efficiency and patient care – Mobile Electronic Patient Observations:** This project is delivering the implementation of a platform for Patient Observations, Early Warning Score Management and Nursing Documentation across our three DHBs. First deployment into the CCDHB children's ward by Q4.	Q4	
3. **Transforming services to be fully digital - Digital Workplace** The goal of this programme of work is to minimise digital boundaries so staff can securely connect to DHB information anywhere, anytime, anyway. This will transform how our people operate enabling more effective and efficient service delivery. The work is a multi-year change programme based on digital workplace tools such as Information Management, Microsoft Teams, increasing mobility of our workforce, and providing a single interface where a person can access everything they need to do their job. Activities include: first iteration of modern desktop Q2; First delivery of communication tools (i.e. exchange online) Q2; Implemented knowledge management framework Q3.	Q3	
4. **Mandated outcome - Fax end of life** The Ministry of Health have mandated phasing out the use of analogue fax by health sector agencies by December 2020. The MOH mandate is to support secure digital communication within the NZ health and disability sector. First use case made fax free September 2020. Many fax use cases have work arounds or is on new technology by Q4.	Q4	
Submit quarterly reports on the DHB ICT Investment Portfolio to the Ministry of Health	Q1-Q4	

[9] Please also see strategic intentions of the 3DHB ICT services outlined in Section 4: Stewardship.

Implementing the New Zealand Health Research Strategy		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
1. Implementation of New Zealand Health Research Strategy, including: a. Develop 2DHB Research Strategy that aligns with the national New Zealand Health Research Strategy. b. Collaborate with National Research Managers group to engage and provide support to the successful HRC grant applicants (Health Delivery Grant and other DHB specific grants as part of the Health Research Strategy)	a): Q2 b): Q1-Q4	Research Strategy developed and approved by the ELT and the Board in Q2.
2. Work regionally to further develop research and analytics networks, including: a. Attend monthly regional research collaboration meetings b. Work with our regional research collaborators and partners to create research networks, and support and further develop existing research networks. c. Support and develop research leaders who prioritise collaborative team science—aligning basic, clinical and health services research with a shared aspirational vision of a healthier region d. Support new researchers to build capacity and to be more proactive about succession planning. e. Build symbiotic relationships with local universities and health partners.	Q1-Q4	Provide monthly stat clinics to 2DHB staff as part of the analytical support and collaboration with Victoria University of Wellington.
3. Policy and procedure development, including: a. undertake background research b. update the 2DHB's research policy in line with new HDEC guidelines 2020 and other regulatory bodies as required	Q1-Q4	Provide a status update report outlining progress
4. Produce an Annual Research Report and Summary Report.	Q4	Completed Annual Research Report and Summary Report by Q4

Delivery of Regional Service Plan (RSP) priorities and relevant national service plans		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
Hutt Valley DHB will support the region to deliver the RSP, including:		Status Update Report
1. Work on our region's identified priority areas (Cancer, Cardiac, Radiology, and Regional Care Arrangements)	Q1-Q4	
2. Work in the region to encourage optimal Hepatitis C virus care in general practice, including encouraging primary health staff to request more Hepatitis C tests, and implementing and publicising the new regional pathways for Hepatitis C.	Q1-Q4	

Better population health outcomes supported by primary health care

Primary health care integration		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
1. Implement the local System Level Measure Improvement Plan developed by our Alliance Leadership Team, as outlined in the Appendix.	Q1-4	

2. Roll out the Health Care Home patient-centred model of care across the Hutt Valley to every willing practice, achieving the aim of maximum coverage of the enrolled population. We aim to roll out the model to all willing practices by the end of 2020/21 – as close to 100% coverage as possible.	Q1-Q4	PH01 – improving system integration and SLMs
3. Pilot a 'neighbourhood approach' to integrated care through the establishment of a community team of nurses and allied health staff working closely with a cluster of general practices wrapped round the Naenae / Taita / Stokes Valley (high deprivation) neighbourhoods.	Pilot operational by Q2	
4. Review the current delivery and performance of our Cardiovascular Disease Risk Assessment programmes, and explore different models of care and/or alternative programme delivery options, including potential partnerships with Māori/Pacific providers.	Q1: Review; Q2-Q4: Explore alternatives	

Emergency Ambulance Services

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. HVDHB remains committed to the 10 year plan to achieve a high functioning and integrated National Air Ambulance service and will participate through the National Ambulance Collaborative to achieve this. HVDHB will support the implementation of changed Governance arrangements to include DHBs to effect improved partnership with MOH and ACC in all elements of leadership of the NASO work programme, and supports the development of a robust national process to scope the requirements of a national tasking service.	Q4	Status Update Report

Pharmacy

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
In accordance with Future Pharmacist Services 2018–2023, our five year strategy for pharmacist services, and in recognition of COVID-19, HVDHB will:		Status Update Report
1. Survey community pharmacies on the impact of COVID-19 to identify the opportunity for service development and DHB support in the post-COVID-19 period. Consider the survey findings, the needs of service users, and the needs of other stakeholders and undertake the highest priority actions.	Q2: Survey completed Q1-Q4	
2. Complete a review and trial a replacement for the community pharmacist long term conditions service that is more effective at meeting the needs of all people with long term conditions by: a) including a clinical pharmacist service b) providing for a range of interventions, including a polypharmacy focus c) allocating resources on an equity basis d) reducing compliance costs.	Q2-Q4 LTC Review completed Dec 2020	
3. Extend funded provision of the Emergency Contraception Pill from under 25s to under 30s.	Q1	Contracts in place for all pharmacies currently contracted by 30 September 2020.
4. Increase the number of pharmacies providing influenza vaccine in the 2021 flu season. (Also an Immunisation activity)	Q1	More than 21 pharmacies providing flu-vax in 2021. Flu-vax provision by community pharmacies in 2021 exceeds the 361
5. Implement the Māori Provider Influenza Vaccine Improvement Project – through marae and outreach-based services. (EOA) (Also an Immunisation activity)	Q1	

6. Facilitate flu-vax clinics to eligible people through Pacific churches and Asian places of worship to increase flu vax coverage. (EOA) (Also an Immunisation activity)	Q1	provided to Maori and 215 provided to Pacific in 2020. CW05 – Immunisation coverage: Focus Area 4 (Influenza immunisation at age 65 years and over)

Long-term conditions including diabetes

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Te Awakairangi Health Network will undertake a review of the Long Term Conditions programme to ensure alignment with Health Care Home (HCH) 'Year of Care' planning, as HCH continues to be rolled out to general practice.[10]	Q1-Q4	SS13 Status Update Report
2. Assess the success of the education session pilot delivered by Clinical Nurse Specialist (Cardiac, Respiratory and Diabetes) in primary care (2019/20) with the expectation that these sessions will be expanded further in 2020/2021.	Q1: Assess Q2-Q4: Expansion (if applicable)	
3. Review the Diabetes Self-Management education service provided by Melon Health post year 1 implementation. The review will determine if the programme has met the objective of reaching Māori and Pacific and they were successfully able to access the programme.	Q1-Q2	
4. Implement any changes identified in the review of the Diabetes Self-Management education service to ensure equal access to self-management education for Māori and Pacifica is achieved. (EOA)	Q3-Q4	
5. In addition to the diabetes annual reviews, Hutt Valley PHOs will include the following activities within their diabetes management programmes, using the existing contracts and funding: a. System level measure for diabetes moving to an outcome measure for diabetes management b. Working with Tu Ora Compass to provide retinal screening lists to practices on their electronic portal to ensure all people with diabetes are getting the biennial retinal screening c. Multi-disciplinary team (MDT) approach including use of health coaches, and warm handovers to discuss nutrition and lifestyle medicine as funding allows d. Exploring shared medical appointments for delivering diabetes education to groups of patients e. Continued targeting of diabetes related services (foot checks, community podiatry and referral to hospital podiatry) dependent on the level of risk of foot disease	Q1-Q4	
6. Review the current delivery and performance of our Cardiovascular Disease Risk Assessment programmes, and explore different models of care and/or alternative programme delivery options, including potential partnerships with Māori/Pacific providers.	Q1: Review; Q2-Q4: Explore alternatives	
7. Undertake implementation of the next phase of the Respiratory Work Programme throughout 2020/21 to address asthma and respiratory related hospital admissions and disparities for Maori and Pacifica. This includes implementing the specialist respiratory support model for primary care, consistent respiratory self-management plans across primary, secondary and community , proactive planning for LTC and high user patients, and aligning with Year 2 of Health Care Home model in primary care. (Also an Improving Quality activity)	Q1-Q4	

[10] The aim is to better align general practice LTC plans with the Health Care Home 'Year of Care' planning programme, which involves comprehensive health planning with a patient to ensure that everyone providing care to him or her is working from one plan. This is a proactive, interdisciplinary team approach in which the team schedules in a patient's appointments, reviews, specialist care and social care over six to twelve months.

2.3 Financial performance summary

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

$000s	2018/19 Audited	2019/20 Forecast	2020/21 Plan	2021/22 Plan	2022/23 Plan	2023/24 Plan
Revenue						
Ministry of Health Revenue	453,977	474,094	503,800	513,875	524,153	534,636
Other Government Revenue (including other DHBs)	116,086	114,327	123,030	125,306	131,274	135,310
Other Revenue	4,822	4,998	4,877	4,881	4,884	4,888
Total Revenue	**574,886**	**593,420**	**631,707**	**644,062**	**660,311**	**674,833**
Expenditure						
Personnel	190,558	204,366	213,888	216,201	218,165	220,462
Outsourced	16,478	18,385	15,479	15,642	15,808	15,975
Clinical Supplies	24,879	27,169	28,663	29,259	29,698	30,144
Infrastructure and Non Clinical	23,213	15,380	14,140	14,396	14,595	14,796
Payments to Other DHBs	95,136	101,298	109,807	112,003	114,243	116,528
Payments to Non-DHB Providers	211,618	218,583	227,536	232,088	236,730	241,465
Depreciation and Amortisation	16,334	14,917	16,022	16,342	16,669	17,003
Interest	23	12	71	72	79	80
Capital Charge	12,022	10,257	12,423	12,486	13,797	13,866
Other Expenses	4,500	4,504	4,326	4,409	4,462	4,516
Total Expenditure	**594,761**	**614,872**	**642,354**	**652,898**	**664,246**	**674,833**
Other Comprehensive Income						
Revaluation of Land and Buildings	(7,175)	19,866	-	-	-	(0)
Total Comprehensive Income / (Deficit)	**(27,051)**	**(1,585)**	**(10,647)**	**(8,836)**	**(3,935)**	**0**

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

$000s	2020\21 Plan	2021\22 Plan	2022\23 Plan
Intensive Assessment & Treatment			
Total Revenue	327,889	334,198	344,274
Total Expenditure	336,242	341,355	347,119
Net Surplus / (Deficit)	**(8,353)**	**(7,157)**	**(2,845)**
Prevention	-39%	-45%	-79%
Total Revenue	55,249	56,339	57,450
Total Expenditure	56,914	57,727	58,552
Net Surplus / (Deficit)	**(1,665)**	**(1,389)**	**(1,102)**
Early Detection & Management	-1%	-14%	-29%
Total Revenue	174,242	177,725	181,277
Total Expenditure	175,793	179,020	182,376
Net Surplus / (Deficit)	**(1,551)**	**(1,296)**	**(1,099)**
Rehabilitation & Support	-57%	-67%	-74%
Total Revenue	74,380	75,856	77,361
Total Expenditure	73,456	74,845	76,250
Net Surplus / (Deficit)	**924**	**1,010**	**1,111**
	-115%	-116%	-117%
Consolidated Surplus / (Deficit)	**(10,645)**	**(8,832)**	**(3,935)**

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, which 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. HVDHB 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 HVDHB is not seeking any formal exemptions to the Service Coverage Schedule in 2020/21.

3.2 Service Change

Service Changes 2020/21

The table below describes all active service changes that have been approved or proposed for implementation in 2020/21.

Summary of Service Changes for 2020/21:

Change	Description of Change/Initiatives	Benefits of Change	Change for local, regional or national reasons
Patient Flow: Managing Acute Flow at Wellington regional and Kenepuru Hospital	Convert medical assessment unit to general assessment unit Roll out early supported discharge, enabled by Advanced Wellness at Home Initiative (AWHI) Reducing avoidable bed days - focus on patients with length of stay >10 days and increase proportion dischargers earlier in the day Increase specialist rounding at weekends Daily acute physician clinics Specialist support for primary care	Avoid need to open additional beds at Wellington Regional Hospital and ensure ongoing length of stay management across CCDHB and HVDHB Reduced avoidable readmissions and ensure people are well supported in the community reducing overall bed days especially for older people. Improved patient flow through ED and reduce nursing demand based on need.	Sub regional
Hospital Provider Performance	Production Planning: CCDHB and HVDHB have created a single approach to Planned Care delivery; • Joint 2DHB plan to deliver local volumes and manage through peak occupancies • Robust outsourcing including price management • Electronic referrals management programme	Improved control of planned care contributing to maximisation of planned care revenue Optimising use of outsourcing to deliver planned care efficiently. Improved productivity of surgical and procedure delivery optimising cost of service delivery.	Sub-regional

Change	Description of Change/Initiatives	Benefits of Change	Change for local, regional or national reasons
	• Embedding virtual outpatient assessments and virtual advice to GPs Operating Room Utilisation: • Maximise use of Kenepuru hospital operating rooms – focus on day stay • Develop further capacity in one current underutilised theatre on Wellington site (OR13)		
MHAIDS Structural Review	Following multiple consultation processes, decisions have been taken to introduce a Tier 2 Clinical Partnership Model within MHAIDS. This will see the leadership of MHAIDS being jointly delivered by an Executive Clinical Director and an Executive Operations Director. Both positions will sit on the DHBs Executive Leadership Teams and report to the joint Chief Executive of CCDHB and HVDHB. Once these positions are in place there will be further work undertaken to determine what if any further changes are required to strengthen local leadership, improve equity outcomes and embed clinical and operational partnership throughout the service. The three sub-regional Boards have also agreed that the MHAIDS service should be delivered by CCDHB on their behalf. Therefore all MHAIDS staff, including Wairarapa and Hutt Valley based people, will become CCDHB employees. This will significantly simplify operations and ensure maximum efficiency.	Improved governance structures, strengthened clinical and operational partnership, and stronger locality leadership presence.	3DHB - Hutt, Capital & Coast, and Wairarapa
Health System Plan Implementation: improving community care options	Operating a single health service commissioner in high needs areas of Hutt Valley Implementing integrated service delivery models for communities	Reduced avoidable use of hospitals including better ASH rates.	Sub-regional

Service Changes as a Result of COVID-19

The table below describes all active service changes as a result of our response to COVID-19 that will continue into 2020/21.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Pandemic Plans	The Health Emergency Plan and the Pandemic Plans (both hospital and community) have been reviewed across the three DHBs to incorporate learnings from the COVID-19 response, with a draft 3DHB Health Emergency Plan developed.	These reviews will inform our planning and response to any public health need, such as COVID-19	3DHB - Hutt, Capital & Coast, and Wairarapa

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Telehealth	The effectiveness of telehealth during the COVID-19 period for both clinicians and patients will be evaluated.		2DHB - Hutt and Capital & Coast
Patient, Visitor and Staff Survey	2DHB are developing a patient, visitor and staff survey on the impact of the changes that were implemented due to COVID-19.		2DHB - Hutt and Capital & Coast
Two acute theatres	Traditionally theatres have been scheduled as: 1 acute theatre, and 7 planned care elective theatres during the weekday. The electives were constantly being interrupted or cancelled for additional acute procedures that could not be accommodated in the one acute theatre. During COVID-19 we ran two acute theatres. We will trial this model until the end of 2020 and review its effectiveness.	Less acute interruptions/ cancellations will mean that we still do a similar amount of work as before, and improve patient outcomes and staff and patient satisfaction.	Local - HVDHB
Changes to the Medical Assessment Planning Unit (MAPU)	During COVID-19, if patients were not needing an assessment, they were either admitted for treatment or discharged as required. If they needed an assessment they came to MAPU and were expected to stay for only 6-12 hours, before either being transferred to execute their care plan, or discharged with home support/referrals. They also expanded their intake from only being a medical unit, and began accepting general surgical (GSG) patients, and gynaecological patients for assessment. Before this change, patients would be admitted to a ward, stay in a bed in ED waiting for their assessment to take place, or be taken to MAPU where they could stay for a number of nights before discharge or transfer. We will trial this new model for 6 months and review its effectiveness.	Improve patient flow. Improve outcomes and patient and staff satisfaction.	Local - HVDHB

FTE Reconciliation

The maintenance of safe service delivery has required investment, including in service delivery. These FTE are detailed below and relate directly to safe service delivery.

	2019/20	2020/21	
Full Time Equivalent (FTE)	**Plan**	**Plan**	**Change**
Medical Personnel	280	289	9
Nursing Personnel	792	838	46
Allied Health Personnel	408	418	10
Support Personnel	135	137	2
Management/Administration Personnel	383	388	5
Total FTE	**1998**	**2070**	**72**

SECTION FOUR: Stewardship

4.1 Managing our Business

2DHB ELT Structural Change

Following the appointment in 2019 of the Capital & Coast and Hutt Valley District Health Boards' (CCDHB and HVDHB) single Chief Executive, to lead both DHBs, three key priorities were identified as a first step in strengthening executive leadership in the region and driving better population health outcomes for the region's families, whānau and communities:

1. Improving organisational performance and delivery of services at and across both DHBs;
2. Planning for, and implementing, sustainability plans to ensure the best possible use of every dollar of public funding that we receive; and
3. Taking every opportunity to pro-actively integrate our services in as timely a manner as possible across sub-regional patient-centred pathways.

To give effect to these priorities, a new 2DHB Executive Leadership Team (ELT) structure was created to support the development and recruitment of a core group of executive leaders whose roles would mirror and support the dual accountabilities of the 2DHB CEO. A number of appointments were made throughout 2019 to these ELT positions. Recruitment will conclude in 2020, with the appointment of a new 2DHB CFO in August.

Organisational performance management

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

Funding and financial management

HVDHB'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 HVDHB'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 HVDHB's planned financial position for 2020/21 and out years is contained in the Financial Performance Summary section of HVDHB's 2020/21 Statement of Performance Expectations.

Investment and asset management

HVDHB is committed to a sustainability pathway that emphasises cross-organisation and system governance of financial and service delivery performance. It is supported by an Investment Approach that considers all investments across the health system, and determines their impact on the optimisation of the system. Part of the work programme is the development of whole of system investment plans, capital investment, infrastructure development and service investment strategies.

HVDHB and CCDHB have entered into a joint sub-regional clinical planning process. The 2DHB Provider Network Programme is an input into joint long-term investment planning, which will inform 'what' investments are needed across the two DHBs to implement the strategic vision and associated strategies of both DHBs. These investments have to deliver on ensuring the safety and quality of our services, the impact on equity and outcomes amongst our populations and the sustainability of our health system.

Shared service arrangements and ownership interests

HVDHB 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

HVDHB has a formal risk management and reporting system, with monthly reporting to the HVDHB Finance, Risk and Audit Committee via the Executive Leadership Team. HVDHB 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

HVDHB'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.

HVDHB'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.

HVDHB 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.

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 HVDHB. 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.

A key focus for 2020/21 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.

4.2 Building Capability

Capital and infrastructure development

This year the Government announced $300 million of capital investment in health sector infrastructure across New Zealand (the Health Infrastructure Package). As part of this commitment, approximately $25 million has been earmarked for the reconfiguration of Te Whare Ahuru (TWA), the adult mental health acute inpatient service. 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 CCDHB 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 requires an upgrade and reconfiguration.

The Health Infrastructure Package also includes $9.47 million to upgrade the Maternity Assessment Unit, the Special Care Baby Unit, and other maternity facilities at Hutt Hospital.

Other strategic capital investments continue to be IT related. 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. HVDHB is also improving the effectiveness and efficiency of human resources, and work is underway to upgrade and streamline our recruitment, induction, and performance management processes and systems across the DHB.

Workforce

Our vision: A caring, connected and responsive team where excellence thrives, which works to enhance the health and wellbeing of our communities.

The Quadruple aim guides us to focus on ensuring that we have a workforce that can deliver improved patient safety and experience, improved health equity of outcomes and best value for health resources. In order to achieve this a key priority is improving staff safety and experience to support health system sustainability and a strong and equitable health and disability system.

Nationally, the People Force 2025 developed by the Workforce Strategy group continues to guide investment in workforce development and to

promote a strategic approach to people activities (e.g. MECA negotiations providing a setting for a wider conversation about workforce development).

We work collaboratively with our Central Region partners to deliver regional workforce priorities and to identify potential efficiencies through closer alignment.

HVDHB as an employer

HVDHB is a good employer and aims to ensure that our employment practices attract and retain top health professionals and support staff, who embody our values and culture. Hutt Valley DHB employs over 2600 staff, making us the largest single employer in the Hutt Valley (Te Awakairangi).

Workforce priorities for 2020/21:

1. Workplace culture: Creating a workplace culture that aligns with our strategy, keeps our values at the heart of everything we do and drives high performance.
2. System Capability: Ensuring that our people are supported by robust data, that the skills and capabilities of our leaders and our people reflect the clinical and operational needs of our health system.
3. Equity: Supporting our workforce to achieve increased equity outcomes, particularly for Māori, Pacifica and people with disabilities.
4. Employee experience: Enhancing our employee experience by valuing wellbeing, delivering practical, easy to navigate people systems and processes, and ensuring our people have clear roles and accountabilities.
5. Workforce Agility: Developing our capability to be flexible and agile in response to the changing nature and context of work, and the resultant changing workforce profiles and requirements.

Information technology and communications systems

3DHB ICT is developing a new digital and data strategy that will describe the five key core digital and data themes that we will use to prioritise our portfolio of work across the 3DHBs. These themes will support the achievement of the CCDHB, HVDHB, and Wairarapa DHB priorities. The draft themes of our strategy are:

1. Place-based and virtual health options in our communities
2. Empowering people as partners in their own care.
3. Seamless collaboration across our GW sub-region and wider health ecosystem.
4. Equity of access and health outcomes, including for Māori, Pacific peoples and people with disabilities
5. Empowering our workforce to deliver high quality, efficient specialist care

These five themes inform our operating model change towards a modern ICT business unit that lifts portfolio management, a move to product & service management, and an effective support model of operation. This business change journey commenced in 2019 and is not planned to be completed until 2021.

We have legacy technology debt to overcome as we shift towards enabling better health care for our region. This means improving the resiliency of our supporting infrastructure in the advent of a disaster, shifting away obsolete voice technology towards unified communications, addressing gaps in cyber security to protect our systems and information as well as increasing awareness of cyber security risks.

Activities for 2020/21

3DHB ICT has selected its four critical initiatives for inclusion into the 2020/21 annual plan (see *Data and Digital*). These initiatives are focused on achieving stability of existing critical clinical and corporate systems, bringing significant improvements to operational efficiency, improving patient care, and transforming services to be fully digital.

Co-operative developments

HVDHB 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 HVDHB's Annual Plan.

SECTION FIVE: Performance Measures

5.1 2020/21 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 2020/21 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	65%	
		Year 2	65%	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	< 0.59	
		Year 2	< 0.59	
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 eight months 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-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.		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with General Practice	The DHB has reached the 'Total population' target for children enrolled with a general practice by 6 weeks of age and by 3 months of age and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets. Measure 1: 55% of newborns enrolled in General Practice by 6 weeks of age. Measure 2: 85% of newborns enrolled in General Practice by 3 months of age. Achieved significant progress for the Māori population group, and the Pacific population group, for both targets.		
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.	
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile one to four (and decile five after January 2020) 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.	
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.	
MH07 (tbc)	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	(expectation to be confirmed)	
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)	Target rate for Hutt total is 4340 Improvement on 12 months to Dec 2019 (baseline). As at Dec 2019, Hutt Total was 4533 or 117% of NZ total. Target is based on reducing ratio to NZ Total by 5%		
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.		Only applies to specified DHBs
SS07	Planned Care Measures	Planned Care Measure 1 (PCM 1): *Planned Care Interventions*		TBC
		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
			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*	Target: Hutt Valley total target: 11.8%. Baseline as at Dec 2019: HV 11.9%. National: 12.2%.	
		Planned Care Measure 7: Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)	Note: There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year.	
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 (causing duplication)	>1% and <=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	Still to be confirmed
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than95 %
			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.*
			Count of enrolled people aged 15-74 in the PHO who have completed a DAR in the previous 12 months.
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity Diabetes Annual Review: Target >90% 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 - 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*, and an statin (3 classes) - ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), - Beta-blocker if LVEF<40% (5-classes). • * An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.
			Indicator 5: Device registry completion ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure.
			Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.

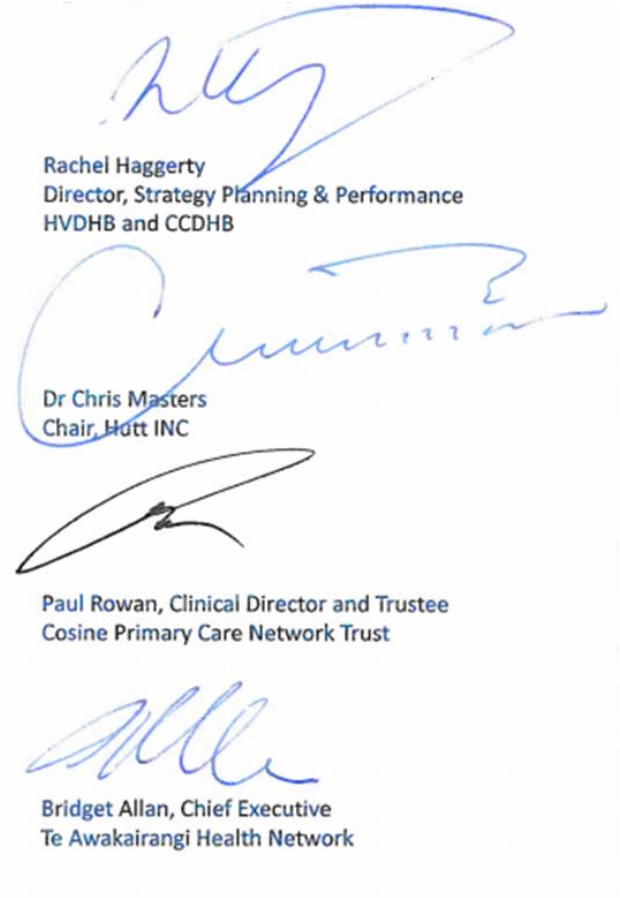
		Focus Area 5: Stroke services	**Indicator 1** ASU: 80% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital
			Indicator 2 Reperfusion Thrombolysis /Stroke Clot Retrieval: 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile (Service provision 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.	
SS17	Delivery of Whānau ora	Appropriate progress identified in all areas of the measure deliverable.	
SS18	Financial out-year planning & savings plan	Provide reports as specified	
SS19	Workforce out-year planning	Provide reports as specified	
PH01	Delivery of actions to improve SLMs	Provide reports as specified	
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90 percent.	
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95 percent or above	
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

System Level Measures Improvement Plan 2020/21

2 July 2020

Signatories for the 2020/21 HVDHB SLM Plan



Rachel Haggerty
Director, Strategy Planning & Performance
HVDHB and CCDHB

Dr Chris Masters
Chair, Hutt INC

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

Bridget Allan, Chief Executive
Te Awakairangi Health Network

The development of this System Level Measures Improvement Plan (SLM Plan) has been guided by the following key principles from Hutt Valley DHB's Vision for Change 2017-2027:

- **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.

The SLM Plan is the culmination of integration and improvement work undertaken across the Hutt Valley Health System through our Alliance Leadership Team, Hutt Inc. The SLM Plan has been developed to drive the implementation of the Ministry of Health's System Level Measures Framework, and it will be submitted to the Ministry of Health as an Appendix to Hutt Valley DHB's 2020/21 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 SLM Plan is based on analysis of local trends to appropriately address the needs and priorities of our population. All measures, including contributory measures, will be broken down by ethnicity so that we can monitor equity on a population basis.

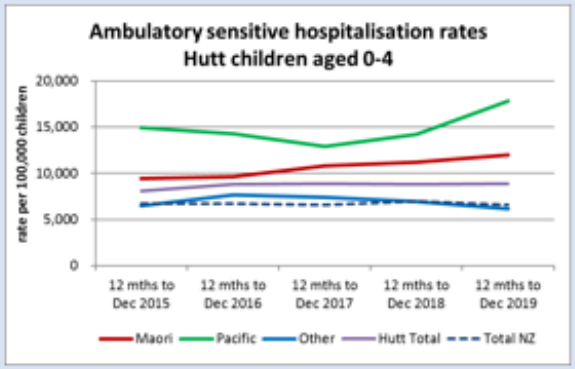
This integration work programme is driven by the networks and sub-groups of the Alliance Leadership Team. Child Health, Mental Health, Acute Demand, Health of Older People and Youth Health are the five key areas of focus for the Alliance. The membership of Hutt Inc includes representation from across the Hutt Valley Health system and includes the two PHOs that operate in Hutt Valley DHB: Cosine Primary Care Network Trust and Te Awakairangi Health Network. We have plans to update and expand representation in 2020/21, aligning with the recent commitments made in Te Pae Amorangi (our Māori Health Strategy) and the 2020/21 annual plan.

huttinc
integrated network of care

Keeping children out of hospital

System Level Measure: ASH rates per 100,000 for 0-4 years.

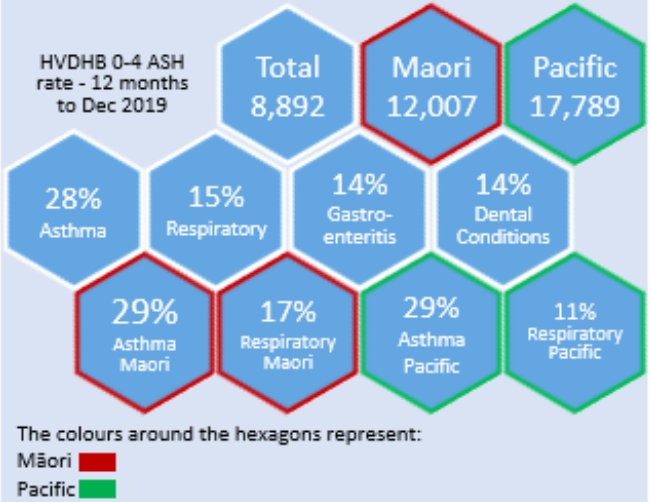
Hutt Valley DHB has prioritised the first 1000 days of life to help ensure children get the best start to life, stay healthy and well, and meet their full potential throughout their lives.



Reducing Ambulatory Sensitive Hospitalisation (ASH) rates and disparities for Māori and Pacific remains our top priority. **Our top 0-4 ASH conditions continue to be asthma, respiratory infections, dental, and gastro/dehydration.**

Our aim is to reduce ASH rates in 0-4 years per 100,000 children to 17,459 for Pacific and 11,676 for Māori by 30 June 2021, reducing the equity gap between Hutt Valley Pacific and Māori ASH rate and the New Zealand Total ASH rate by 5% (against the baseline rate at 12 months to December 2019).

Hutt Valley has high rates of 0-4 ASH admissions compared to the national average for Māori and Pacific populations. Our Pacific 0-4 ASH rate increased from 14,194 in the year to December 2018 to 17,789 in the year to December 2019, which is 169% of the total NZ rate (6,615). Our Māori 0-4 ASH rate increased from 11,187 in the year to December 2018 to 12,007 at December 2019, which is 82% of the total NZ rate (6,615).

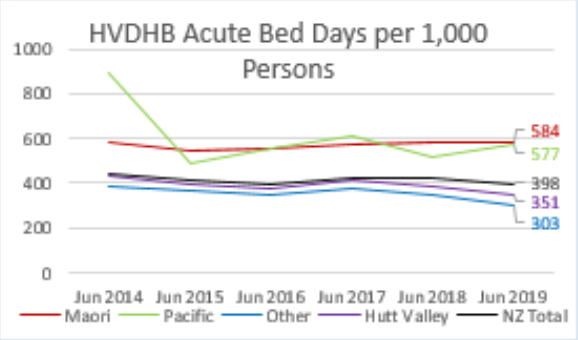


Opportunity	Actions	Contributory Measures
Midwives (including LMCs) and Well Child/Tamariki Ora nurses often visit families in their home. When needed, they can facilitate referrals to Tū Kotahi Māori Asthma and Research Trust (Tū Kotahi) and the Well Homes Service.	▪ Raise the profile and **increase referrals to Tū Kotahi and the Well Homes service** amongst midwives, LMCs, and WCTO nurses. Tū Kotahi offers a range of interventions tailored to high need populations and the Well Homes service assist families to access healthy housing interventions.	▪ Number and ethnicity of referrals to Tū Kotahi. ▪ Number and ethnicity of referrals to Well Homes service.
Children admitted to hospital for asthma and respiratory conditions are at greater risk of repeat admission. However, if we can intervene by offering greater levels of **support and education** to the family (eg on the correct use of asthma medication and inhalers), there is an opportunity to prevent repeat admissions.	▪ PHOs will support general practice teams to strengthen follow-up for children who have had an ASH respiratory admission, with a clear focus on Māori and Pacific children. ▪ Health services (including ED, Kaupapa Māori health providers, After-hours medical centres, general practices, and pharmacies) will support patients and whānau with consistent messages on the correct use of asthma medications.	▪ Rate, number and ethnicity of respiratory related ED attendances and hospital admissions for 0-4 years.
There is an opportunity to access young Māori and Pacific children at Early Childhood Centres and **teach young children about the importance of tooth brushing** and how to do it correctly. Oral health education and information can also be provided to ECC teachers, support staff, students and families to raise awareness of the importance of teeth and key prevention messages. ECCs can also be supported to develop/review nutrition policies to support oral health.	▪ Provide **supervised tooth brushing and education** for up to 300 pre-school aged children at selected Early Childhood Centres with high Māori and Pacific populations. Dental (Regional Child Oral Health Service): ▪ Extend knee-to-knee **oral health examination programmes focusing on pre-school aged children** enrolled in Kohanga and Early Childhood Centres in the Hutt Valley (the knee-to-knee technique does not require a dental chair, as the parent and the health professional sit face to face with their knees touching while the child receives their oral health examination).	▪ Numbers and ethnicity of children provided with supervised tooth brushing and education, and the knee-to-knee programme.

Using health resources effectively

System Level Measure: Acute hospital bed days per capita.

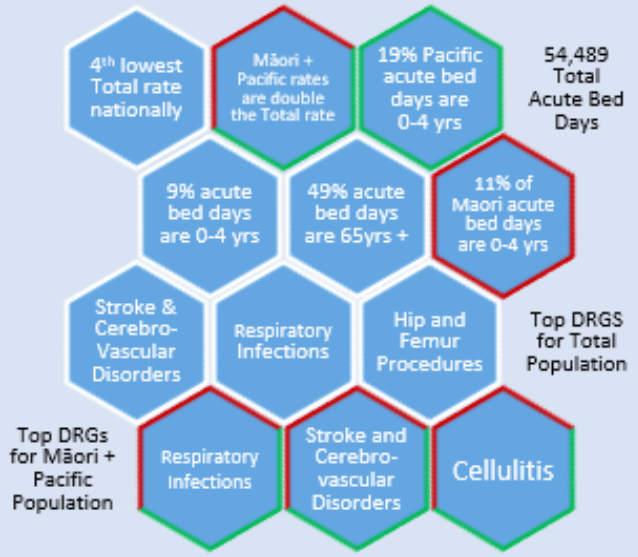
Hutt Valley DHB is focussed on reducing and effectively managing acute demand through improved prevention, early intervention and integration initiatives.



Note the age standardised rate for Māori is higher than Other ethnicities. We use the actual rate per 1,000 to model actual reductions in events and bed days. A reduction in actual acute bed days will also result in a reduction in the standardised rate for Māori.

Our Māori rate is 147% of the New Zealand total rate and our Pacific rate is 145% of the national rate (year-to-June 2019). **We are aiming to reduce this equity gap by 5%**, which means reducing our acute hospital bed days for Māori to 564 bed days per 1,000 people and for Pacific to 538 bed days per 1,000 people by 30 June 2021.

The number of acute bed days is complex and attributable to many factors. Improvements to acute demand and patient flow will enable services to be **smarter about managing/reducing acute demand and improve patient flow** in the hospital. Access to timely diagnostics, comprehensive patient care coordination and logistics, with a well equipped workforce will enable people to receive acute care in primary and community settings. The long-term aim is to ensure that acute bed day rates for Māori and Pacific populations reduce to at least the same rates of the non-Māori and non-Pacific population groups.



Opportunity	Actions	Contributory measure
There is an opportunity to reorient the structure of Community Health Service Group, based at Hutt Hospital, to enable closer working relationships with general practice and **better integrated care** to patients.	We will **implement a 'neighbourhood approach' to integrated care** through the establishment of a community team of nurses and allied health staff working closely with a cluster of general practices wrapped round the Naenae / Taita / Stoke Valley (high deprivation) neighbourhoods. This will enable multidisciplinary working and result in general practice teams and patients benefiting from advice and support from community nurses and allied health staff.	Acute hospital admissions, acute ALOS and acute readmission rate, by ethnicity.
We are focusing on **reducing hospital admissions due to respiratory infections**, because they represent a significant proportion of bed days for the Hutt Valley population. They are the top reason for admission to hospital for Pacific people in the Hutt Valley, and the second-top reason for Māori (19 and 12 bed days per 1000 population in 2018/19, respectively). There is an opportunity to leverage off the COVID-19 messages about physical distancing, coughing into elbows, and hand washing to reduce the spread of colds and flu.	**Implement the next phase of Respiratory Work Programme** throughout 2020/21 to address respiratory related hospital admissions and disparities for Māori and Pacifica. This includes: • implementing the specialist respiratory support model for primary care (targeted to practices with greatest need) • consistent respiratory self-management plans provided to people across community and secondary settings • embed acute care plans and ambulance management for COPD patients (to avoid unplanned care) • proactive planning for Long Term Condition and high-user patients, aligning with Proactive Care activities. • **Media messages and communications** on the need to protect Kaumātua (respected tribal elders), and the importance of physical distancing, coughing into elbows, and hand washing.	COPD and respiratory related ED attendances and hospital admissions, by ethnicity.
There is an opportunity to **apply the learnings from the 2020 flu season** so that we increase the uptake of flu vaccinations in the 2021 season, **reduce the spread of influenza** in the community, and reduce acute hospital admissions.	• General practice teams will pro-actively contact high priority people to offer flu vaccine in clinics • Implement the **Māori Provider Influenza Vaccine Support** Project (eg outreach, marae clinics, and incentives) • Increase the number of services providing influenza vaccine in the 2021 flu season • Facilitate the provision of influenza vaccine to over 65s through **marae and Pacific church settings**	Influenza vaccinations for 65 year olds and over, by ethnicity.

Person centred care

System level measure: Patient experience of care.

It is vital that patients are involved and partnered with in their care, and there is a particular need to improve this for our Māori and Pacific patients.

Patient understanding of their condition(s) and how to manage them (including their medications) is key to good patient care and good health outcomes. With our commitment to reducing inequity, we will focus on Māori and Pacific patients. We aim to reach a target of 65% for Māori and Pasifika patients answering 'yes, always' to "Were you given information you could understand about things you should do to improve your health?"*

To have confidence that the responses to the "understanding" question are based on reasonable numbers of respondents, we also aim to improve the number of Maori and Pacific people responding to the Primary Care Patient Experience Survey (PC PES).

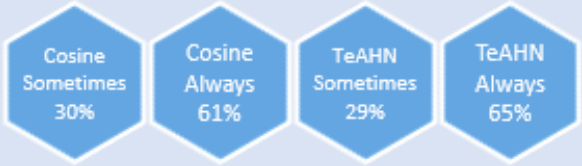
Were you given information you could understand about things you should do to improve your health? 'Yes, always'

Total Te Awakairangi & Cosine PHOs

Feb 2018	May 2018	Aug 2018	Nov 2018	Feb 2019	May 2019	Aug 2019	Nov 2019
65%	66%	65%	66%	62%	64%	62%	69%

Primary Care PES - data from Jan to Dec 2019

Were you given information to improve your Health?



Overall Results for Hutt Valley for Jan to Dec 2019		Communication	Partnership	Physical & Emotional Needs	Coordination
Primary Care	Māori	8.3	7.4	7.4	8.4
	Pacific	8.3	7.0	7.5	8.3
	Other	8.5	7.6	7.8	8.5
	National	8.5	7.8	7.7	8.4
Inpatient	Total	8.7	8.7	8.8	8.9

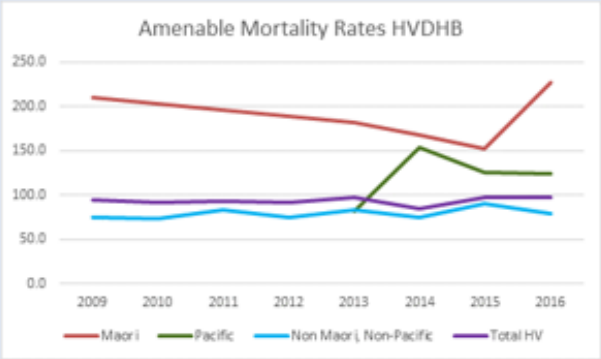
Opportunity	Actions	Contributory measure
There is an opportunity to **improve the uptake of the PC PES for Maori and Pasifika** people by using the survey information to understand how Maori and Pasifika experience local primary care services and thereby enable improved service delivery for Maori and Pasifika people	• PHOs will support general practices to adopt **consistent in-practice and social media messaging** to promote the PES to Māori and Pacific patients around time of the survey • General Practice staff (particularly practice receptionists) will **promote the PES to Māori and Pacific patients,** • **PHOs and general practices will** monitor email collection and opt –out rates by practice and ethnicity and take action to increase uptake.	• Response rate to the Primary Care PES for Māori and Pacific patients.
Improve patients (Maori and Pacific as a priority) experience, understanding, involvement and partnering with their care through the use of **Care Plans** (including Health Care Homes Year of Care Planning) Practices will focus on working in partnership with Pacific and Māori patients **to reduce inequity of outcomes**	• PHOs will identify top three long term conditions, and develop "red flags" for patients who require a care plan (e.g. repeated ED attendance / Hospital admission / other event) • PHOs will create a list for each practice of patients who may benefit from a proactive care plan • Practices will use this list to work with patients to develop care plans, prioritising Māori and Pacific patients with conditions that are not well controlled	• Percentage of patients in the target group with a Care Plan by ethnicity

**ethnicity breakdown for this question is not available for previous surveys, however it is recognised that there is an equity gap between Māori and Pacific answering "yes, always" to this question, and non-Māori non-Pacific answering "yes, always" to this question. We cannot be certain whether 65% is the most appropriate target, however there should be improvement in this measure towards equity*

Prevention and early detection

System level measure: Amenable mortality rates

We are enhancing the management of long term conditions and targeting prevention approaches and support for Māori and Pacific to reduce disparities.

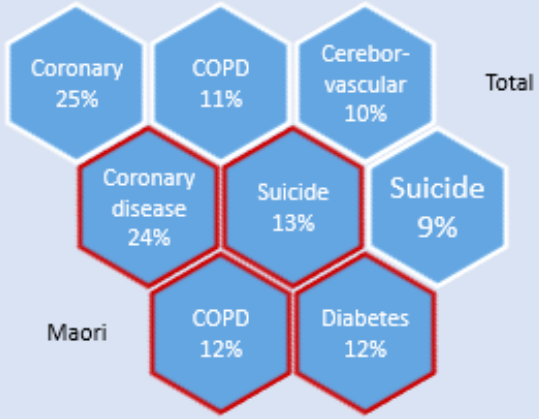


Amenable mortality in the Hutt Valley is reducing over time in line with the national average, but significant disparities exist with higher rates for Māori and Pacific. **The top causes of amenable mortality in the Hutt Valley are: Coronary disease, Chronic Obstructive Pulmonary Disease (COPD), Suicide,** and **Cerebrovascular disease (eg Stroke).**

Based on the most recent data for deaths 2012-2016, we are aiming to reduce the amenable mortality rate by 3% for Māori to 169.6 per 100,000 people aged 0-74 and for Pacific to 142.4 in 2022-26. Our actions now in 2020/21 will have an impact on the number of deaths in the next five 5 years.

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 targeting prevention approaches and support for Māori and Pacific to reduce disparities.

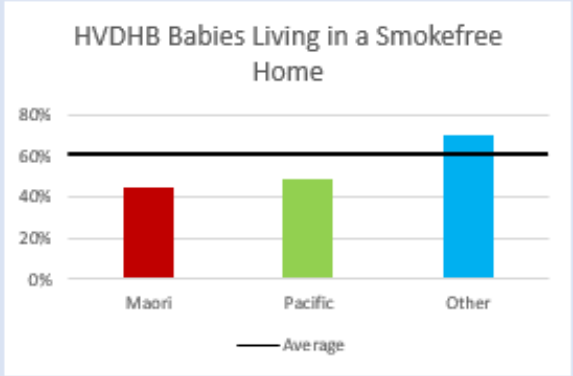
Top causes of amenable deaths in Hutt Valley residents 2012-16



Opportunity	Actions	Contributory measure
We can **improve the management of long term conditions** in primary care.	Implement a proactive approach to managing long term conditions, including: • Te Awakairangi will **review the Long Term Conditions programme** to ensure alignment with HCH 'Year of Care' planning. • Expand the education session pilot delivered by **Clinical Nurse Specialist (Cardiac, Respiratory and Diabetes) in primary care.** • Review the **Diabetes Self-Management education service** to ensure it is useful and achieving outcomes for Māori and Pacific. • **Review the current delivery and performance of our Cardiovascular Disease Risk Assessment programmes**, and explore different models of care and/or alternative programme delivery options, including potential partnerships with Māori/Pacific providers.	• Percentage of the people, by ethnicity, assessed as high CVD risk who have received a review in the last 12 months. • Percentage of people, by ethnicity, with diabetes aged 15-74 years enrolled with a PHO whose latest HbA1c in the last 12 months was <=64 mmol/mol.
We aim to **prevent suicides** in the Hutt Valley. The age-standardised suicide rate 2012-16 in HVDHB is 12.4 per 100,000 (the national rate is 11.3)	• Develop and **establish a Māori mental health and addictions team** within our DHB, and increase our investments in Māori for Māori mental health and addiction services to meet the holistic needs of whānau. • Partner with local communities to support their development of **Māori suicide prevention approaches** that fit their community needs Implement **Te Tumu Waiora** (a model of primary mental health and addictions early intervention and support). • Collaborate with local councils to provide **training sessions to community stakeholders to support first symptoms of mental health.**	• Self-harm presentations to ED, and rates and number of hospitalisations, by age groups and ethnicity.
We can **intervene early in the life course** to support children (and their whanau) to make healthy choices (healthy food, drink and exercise).	• Work in partnership with Sport Wellington and the Ministry of Education to **provide the Healthy Active Learning programme** to schools and early learning services, with a continued emphasis on (a) water-only and (b) low decile schools with Māori and Pacific students.	• Number and ethnicity of children **attending the Healthy Active Learning programme.**

Healthy start

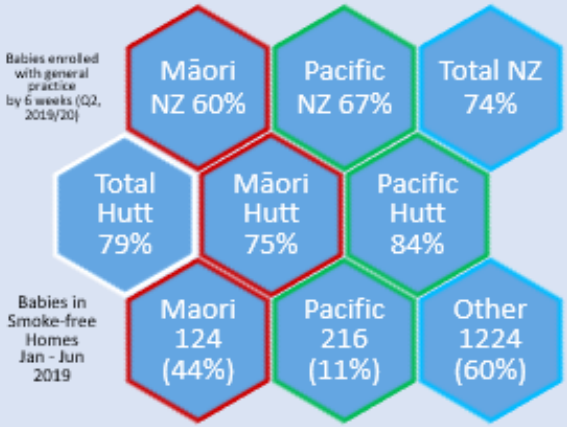
System level measure: proportion of babies who live in a smoke free household at 6 weeks postnatal. We are focussed on ensuring that whanau are supported in their smoking cessation journey as part of their overall health care needs.



We aim to address disparity and **achieve a 5% increase in the rate of Māori and Pacific babies living in a smokefree household** (using the percentages from Jan – Jun 2019 as the baseline). This means our target for 2020/21 is 49% of Māori babies (138 babies) and 54% Pacific babies (59 babies) living in smokefree homes.

Reducing babies' exposure to tobacco smoke through collaboration between the services focussed on child health and smoking cessation is a key aspect of wellness.

We want to ensure that all hāpu wāhine and their whanau are provided with support to quit smoking. We can offer this support through our hospital midwives, community LMCs, Well Child/Tamariki Ora (WCTO) providers, and general practice staff. **We aim to have all babies enrolled with a general practice and WCTO provider by 6 weeks of age.** At Q2, 2019/20, 75% of Māori newborns are enrolled with a general practice by 6 weeks of age.



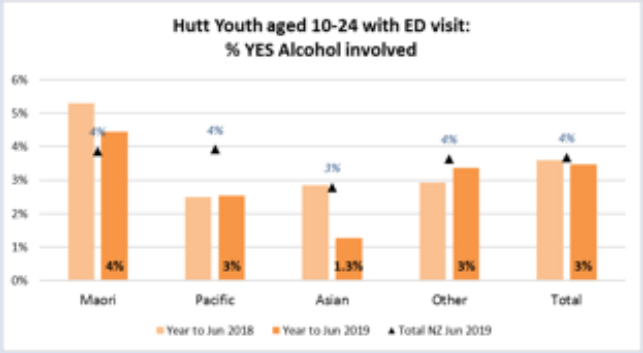
Opportunity	Actions	Contributory measure
Implementation of the **Hutt Valley Smokefree Action Plan** will include targeted actions that support hāpu wāhine and other Māori women and their whānau to quit smoking and adopt smokefree households.	• **Work with and support Takiri Mai Te Ata Regional Stop Smoking Service** (Ministry funded wrap-around stop smoking service) and community providers on strategies to improve smoking cessation, especially for hāpu wāhine, including the possibility of group smoking cessation sessions. • **Promote, and increase access to, the Hapu Mama programme** at Kokiri Marae.	• Referrals to the Hapu Mama programme at Kokiri Marae.
We will **establish Smoking Cessation Champions** in general practice and midwifery, and within the hospital, to help maintain ongoing support for smoking cessation across the DHB.	• Investigate establishing general practice **Smoking Cessation Champions** across general practice in the Hutt Valley (these Champions will be trained in smoking cessation, motivational interviewing, and Nicotine Replacement Therapy). • Investigate establishing a midwifery Smoking Cessation Champion for Hutt Valley DHB.	• Number of GP Smoking Cessation Champions established in 2020/21.
We will provide **resources and training** to health practitioners so that they are well equipped to support pregnant women and their whānau to quit.	• Ensure relevant up-to-date resources are available to general practice teams, WCTO nurses, and midwives. • **Work with Kuia and Kaumatua Groups** to help promote smoking cessation and immunisation amongst hāpu wāhine and their whānau. • Investigate options to **improve access to training for WCTO staff,** to improve brief advice discussions and support of patients who smoke. • **Implement the first stage of Generation 2040 initiative**, which offers pregnant women an Early Pregnancy Assessment including smoking cessation support. This tool will be available for universal use (i.e for every pregnant woman) but the project has a specific focus on equity for Māori babies.	• Update on training delivered to WCTO staff. • Offering advice and support to smokers to quit in primary care and hospital (PH04, SS06, CW09) • Uptake of Generation 2040 initiative

Youth are healthy, safe and supported

System level measure: youth access to and utilisation of youth appropriate health services.

We are implementing the recommendations of a review of youth health needs to ensure our youth are supported to build healthy and safe lives.

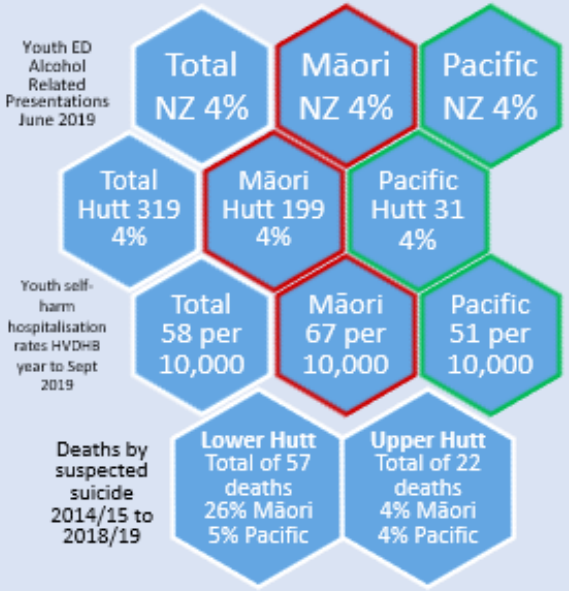
Our rates of youth (age 10-24 years) ED presentations involving alcohol are trending down across all ethnicities, and our total rate is aligned to the national average of 4%. While we have made good progress at reducing the overall rates, we need to eliminate the inequities and reduce the rates for our Māori youth.



We aim to reduce Māori youth (age 10-24 years) ED presentations involving alcohol to 3% for the year June 2021 (the baseline is 4% for the year ending June 2019). A reduction to 3% means we need to achieve about 40 fewer Māori youth ED presentations involving alcohol in 2020/21.

We also need to improve access to mental health services for youth. In 2018 we undertook a **review of the health needs of people 10-15 years** of age at primary, intermediate and secondary schools within Hutt Valley DHB. This identified some gaps and opportunities for improvement, particularly in relation to help with mental health, and social and behavioural issues. We are continuing to implement the recommendations from this review, with a focus on:

- improving wellbeing and achieving equity
- increasing youth access to mental health and addiction services
- reducing youth self-harm and suicide.



Opportunity	Actions	Contributory measures
Improve wellbeing and achieving equity	• Undertake a distinct project looking at how a **model of care** may be developed that **best suits the needs of young people 10-15 years of age**, working with the Naenae Kahui Ako School Cluster and the Taita Stokes Valley Kahui Ako School Cluster.	• Self-harm presentations to ED, and rates and number of hospitalisations, by age groups and ethnicity. • Percentage of patients 0-19 referred to non-urgent child & adolescent services (mental health and addiction) that were seen within eight weeks, specified by ethnicity. • Number of 15-24 year olds accessing AOD and mental health services from primary and community providers (which reduces the risk of suicide).
Increase youth access to mental health and addiction services.	• **Implement the Ministry of Health Piki Pilot** and **Te Tumu Waiora** to enhance and extend primary mental health and addictions services for young people in the Hutt Valley. • Provide **Mental Health and AOD consult liaison and specialist support** to primary and community services.	
Reduce youth self-harm and suicide. Deaths among Māori and Pacific people are more prevalent in the under 20 year, and in the 20 to 30 year age groups, across 3DHB data 2014/15 to 2018/19.	• Explore the potential to roll out **training sessions around** supporting first symptoms of mental health (Mental Health 101) to the Naenae Kahui Ako School Cluster and the Taita Stokes Valley Kahui Ako School Cluster. • **Expand the range of early intervention options for young people with mental distress**, across the range of virtual support, peer support, youth health services (VIBE), general practice and talking therapies, building on existing services, and new models such as Piki and Te Tumu Waiora.	