Hutt Valley District Health Board

Annual Plan:

2021/2022

HUTT VALLEY DHB

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

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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Tēnā koe David

Hutt Valley District Health Board 2021/22 Annual Plan

This letter is to advise you that we have jointly approved and signed Hutt Valley District Health Board's (DHB's) 2021/22 annual plan (Plan) for one year.

When setting expectations for 2021/22 it was acknowledged that your Plan would be developed in a period where our COVID-19 response, recovery and immunisation programmes remained a key focus and therefore planning requirements were streamlined towards your DHB's work to improve equity and to embed lessons and innovations from COVID-19. Thank you for providing a strong plan for these areas.

Your Plan for 2021/22 will be delivered in an environment where this work continues to be of critical importance and where our system transition process is underway. We acknowledge that providing clarity on the critical areas for improvement through transition is helpful and, on that basis, we are confirming the top challenges that will be of focus for us through 2021/22:

- Supporting readiness and management of COVID-19.
- Supporting the mental wellbeing of people, particularly of youth and young people.
- Ensuring child wellbeing, particularly through increased immunisation.
- Managing acute demand.
- Managing planned care.

More broadly, we also confirm the importance of your Board delivering on the Plan in a fiscally prudent way and acknowledge that an intensive support programme will be established for Hutt Valley Bay DHB.

It is noted that Capital & Coast DHB now provides all but NGO specialist mental health services to Hutt Valley DHB. Hutt Valley DHB is $0.56 million below the ring fence expectation set by the Ministry of Health (the Ministry), and Capital & Coast DHB is $10.74 million above the ring fence expectation. As this is a combined service provision the Ministry accepts Hutt Valley DHB's proposed ring fence amount.

We invite you to work closely with your regional Chair colleagues to share your skills, expertise, and problem-solving efforts to ensure progress is achieved in these top challenges. As performance progress is discussed through the year, we will look forward to hearing about your joint efforts and progress.

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, including changes in FTE. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

Your 2021/22 Plan provides an important foundation to ensure our health system delivers for New Zealanders during the period of system transition and we expect all DHBs will be disciplined in delivery of their plans.

Please ensure that a copy of this letter is attached to any copies of your signed plan made available to the public.

Nāku noa, nā

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Fionnagh Dougan
Chief Executive of Capital & Coast and Hutt Valley DHBs

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SECTION ONE: Overview of Strategic Priorities

1.1. 2DHB Partnership

We are working in close partnership with Capital & Coast District Health Board (DHB) to align the strategic direction of both DHBs and better organise the delivery of our services across the Wellington region. We already have a joint Board chair and a 2DHB Executive Leadership Team.

Across the two DHBs, we operate three hospitals (Wellington Regional Hospital, Kenepuru Hospital, and Hutt Hospital) and deliver integrated health services in five key localities (Wellington City, Porirua, Kapital Coast, Lower Hutt and Upper Hutt). By working together and combining our resources, we are improving the way we coordinate the specialist services provided by our three hospitals and the specialist, primary, and community services delivered in our five localities. We are using our combined resources to better coordinate our care, achieve more equitable outcomes, and make our communities stronger.

1.2. 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 our commitment to delivering HVDHB's vision of:

"Healthy People, Healthy Families, Healthy Communities"

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 Iwi and 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 for achieving our vision, we are guided by core legislative and governmental strategic directions including:

- Te Tiriti o Waitangi (the Treaty of Waitangi)
- New Zealand Public Health & Disability Act 2000
- the New Zealand Health Strategy
- He Korowai Oranga and Whakamaua 2020-25
- Ola Manuia 2020-2025: Pasifika Health and Wellbeing Action Plan
- the New Zealand Disability Strategy
- the national Healthy Ageing Strategy.

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

1.3. Te Tiriti o Waitangi

Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities to Māori through Te Tiriti o Waitangi, the founding document of Aotearoa. The principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal,[1] underpin the DHB's commitment to Te Tiriti, and guide the actions outlined in this annual plan. The 2019 Hauora report[2] recommends a series of principles be applied to the primary health care system. These principles are applicable to the wider health and disability system as a whole. HVDHB values Te Tiriti and applies these the principles to our work across the health and disability system:

[1] *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641; *New Zealand Maori Council v Attorney-General* [1989] 2 NZLR 142; *New Zealand Maori Council v Attorney-General* [1991] WL 12012744; *New Zealand Maori Council v Attorney-General* [1992] 2 NZLR 576; *New Zealand Maori Council v Attorney-General* [2013] NZSC 6; *The Ngai Tahu report 1991* (Waitangi Tribunal 1991); *Report of the Waitangi Tribunal on the Orakei claim* (Waitangi Tribunal 1987); *Report of the Waitangi Tribunal on the Muriwhenua fishing claim* (Waitangi Tribunal 1988).

[2] *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (Waitangi Tribunal* 2019).

- **Tino rangatiratanga**: Providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services.
- **Equity**: Being committed to achieving equitable health outcomes for Māori.
- **Active protection**: Acting to the fullest extent practicable to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its Treaty partner under Te Tiriti are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options**: Providing for and properly resourcing kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership**: Working in partnership with Māori in the governance, design, delivery and monitoring of health and disability services – Māori must be co-designers, with the Crown, of the primary health system for Māori.

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. We aim to address this through targeting and driving our health services to create equity of health care for Māori, 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. We also have a 2DHB (HVDHB and CCDHB) Māori Council to formalise the relationship between local Iwi and the DHB, build on relationships, and share aspirations and strategic directions.

1.4. Planning

Out-year planning to support system sustainability

HVDHB and CCDHB work together on out-year plans to make our health system sustainable. Both DHBs are committed to a sustainability pathway that emphasises cross-organisation and system governance of financial and service delivery performance. Our investment approach 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.

We are prioritising investment in the use of contemporary Information Communication Technology (ICT) solutions that reduce the need for manual input and improve efficiency. There are multiple opportunities to invest in smart systems that will reduce manual work and duplicated effort in a number of areas, including better use of data to inform service planning and decision making, financial management, workforce planning, production planning, operating room utilisation, and telehealth services. We can also support access to digital solutions that will help people manage their own health, such as patient portals.

Clinical leadership

Clinical leadership supports us meet the health needs of our population. Our Clinical Council comprises hospital and primary care clinicians from different disciplines. It facilitates clinical engagement in organisational decisions and informs effective planning and commissioning based on clinical evidence and expertise. The Council's principal focus is on quality and safety, but it also provides advice on key proposed organisational service changes and measures to use organisational resources effectively and equitably.

We have also established clinical networks (or steering groups) to guide planning and provide oversight to our integration work programme. This work is focussed on improving how primary and secondary health services work together so patients experience well-coordinated and seamless healthcare. The clinical networks report to our Alliance Leadership Team, which is made up of senior DHB managers, clinical leaders and other experts, including representation from Māori, Pasifika and Disability teams and a mix of both hospital and community practitioners. The clinical networks make recommendations on the best use of resources to achieve the optimal outcomes.

1.5. 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.

Our Vision for Change includes a focus on the following key strategic goals:

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

Achieving equity and providing an integrated seamless service is embedded throughout these strategic goals. *Our Vision for Change* is designed to support people and whānau-led wellbeing with the system organised around the two elements: 'People' and 'Place'.

People

We are committed to developing people-focused service delivery models. There are three broad service delivery models for the main users of our health services:

- Core health care service users – those who require any form of urgent and planned care. The health system will be acting early to prevent illness and save lives.
- Maternity service users and children, young people, and their families and whānau – the health system will be providing support in these key life transitions, with a strong focus on children and young people where early action has benefits across the life course.
- People who require system coordination – including disabled people, those who have long-term conditions, are becoming frail or are at the end of their life. These people have multiple needs from the health system and require the system to be easily and effectively navigated to enable them to lead their own health care.

This means recognising those who may need more help including: Māori, Pasifika people, disabled people, refugees and people who are the socially and economically disadvantaged, and people with enduring mental illness or addiction.

Place

Using 'place' as the basis for health and social supports creates immediate links to a community's strengths. It makes it easier to recognise and value community diversity, while organising a consistent system across many groups. Better information about the characteristics of the people being served, shared among those delivering services, is central to succeeding with this approach. It has the potential to reduce health care costs over time as communities increasingly support their own health and wellbeing.

Health care has always been delivered in a variety of settings. The places where care is organised and delivered, together with increased access to better and cheaper technologies, provide the platform for a comprehensive system of care. The plan centres on the following three core care settings:

- People's homes and residential care facilities
- Community Health Networks, including the Health Care Home and the Kāpiti Health Centre
- Wellington, Hutt, and Kenepuru hospitals providing specialist care for the region.

1.6. Health Equity

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. 'Equity' recognises that 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. We know that we do not do as well for Māori, Pasifika People, disabled people, those who have fewer resources available to them, and those with enduring mental illness. We are committed to improving their health outcomes and achieving equity for them. We will continue to deliver against:

- Te Pae Amorangi, HVDHB's Māori Health Strategy 2018-2027
- the Sub Regional Pacific Health and Wellbeing Strategic Plan 2020-2025
- the Sub-Regional Disability Strategy 2017-2022
- Living Life Well – A Strategy for Mental Health and Addiction 2019-2025.

Our focus is on improving performance, ensuring we make the 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 Māori Council, the Sub-Regional Pasifika Strategic Health Group, and the Sub-Regional Disability Advisory Group who provide advice on how we can achieve equitable health outcomes for the people and communities they represent. We promote the routine use of the Health Equity Assessment Tool (HEAT) in all quality improvement and service development projects to ensure they have a focus on achieving equity.

We will contribute to equity priorities through the specific actions and milestones outlined in Section Two. Equity actions are identified with code 'EOA', which means 'equitable outcome action'. We will measure and report on our progress regularly.

1.7. 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 about five years behind non-Māori, and the evidence shows that Māori continue to be over-represented in a number of health care areas. Disability is a significant issue for Māori. Nationally, approximately 200,000 Māori (26%) report having a disability.[3]

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

Mauri Ora – Whānau Ora – Wai Ora (Healthy People – Healthy Families – Healthy Communities)

Te Pae Amorangi is centred on achieving Māori health equity, and advancing Tiriti 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 2021/22. We will measure and report on our progress regularly to the Māori Council on behalf of all Māori in our district.

[3] Ministry of Health. 2018. Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan. Wellington: Ministry of Health.

1.8. Te Upoko O Te Ika Māori Council

Te Upoko O Te Ika Māori Council (TUI MC) was established in 2021 to represent hauora Māori across by HVDHB and CCDHB. TUI MC replaces the both the Māori Partnership Board (CCDHB) and the Mana Whenua Relationship Board (HVDHB). The purpose of TUI MC is to accelerate hauora Māori gains by ensuring hauora Māori is at the forefront of planning, funding and service delivery activities within HVDHB, CCDHB, and the wider community.

TUI MC has the vital role of holding both DHBs to account for meeting their legislative and ethical obligations to Māori under Te Tiriti o Waitangi. This includes:

- enabling Māori to participate in decision-making processes
- achieving health equity for Māori
- identifying and progressing Māori aspirations and needs for wellbeing
- actively participating in and engaging with the 2DHB Board in the development of strategic priorities, and DHB funding and accountability mechanisms
- monitoring the performance of the 2DHB delivered and funded services, to ensure they are responsive to the aspirations and needs of Māori, and eliminate inequities
- promoting and enhancing whānau models of care that support whānau to determine their journeys toward wellness
- monitoring the experiences of whānau to ensure that Māori receive high-quality equitable health and disability care.

TUI MC comprises up to two representatives each of the following Iwi entities: Te Runanganui o Te Atiawa, Taranaki Whānui ki te Upoko o te Ika (PNBST)/ Wellington Tenths Trust, Ngāti Toa Rangatira, Te Atiawa Ki Whakarongotai, and Taurahere Iwi. The Chair is appointed by TUI MC members.

1.9. Whole of system integration

HVDHB and CCDHB have entered into a joint planning process. This supports a consistent approach across our five communities (Upper Hutt, Lower Hutt, Kāpiti, Porirua and Wellington) and three hospitals (Hutt, Kenepuru and Wellington) to improve system performance and sustainability, and achieve equity of access and outcomes. This approach will focus on regional and sub-regional service integration, leveraging and driving innovations, and improving patient/consumer experience.

Health and social outcomes are inter-related and can be improved by building strong effective partnerships with community groups, local councils, providers and agencies and a strong focus on population health. We support these partnerships through our locality-based approaches with our communities. We will be building on our successes of the last three years, developing our community health networks, and continuing locality service integration.

Regional Public Health (RPH) plays an essential role in this space. RPH is the public health unit for the 3DHB sub-region (HVDHB, CCDHB, and Wairarapa DHB). The three DHBs work in partnership with RPH in their work on health promotion/improvement, enhancing the effectiveness of prevention activities in other parts of the health system, and regulatory services. The integration of RPH's activity into the DHB's commissioning function has been completed and will help to ensure our efforts to improve health outcomes in our communities are aligned.

Our 3DHB Disability Group is also working to integrate a disability perspective into the development and delivery of health services. For example, the Disability Group has been working closely with our COVID vaccination managers to ensure that the voice of the disability community is incorporated into the development of the vaccination programme.

1.10. Managing 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, deep rooted inequities, and the combination of multiple co-morbidities increasing patient complexity and non-communicable diseases. Managing the clinical risk and patient safety created by demand and capacity mismatch is driving cost growth in our hospitals.

We continue to implement initiatives and make performance improvements to alleviate some of the pressure on hospital services. These initiatives/improvements include:

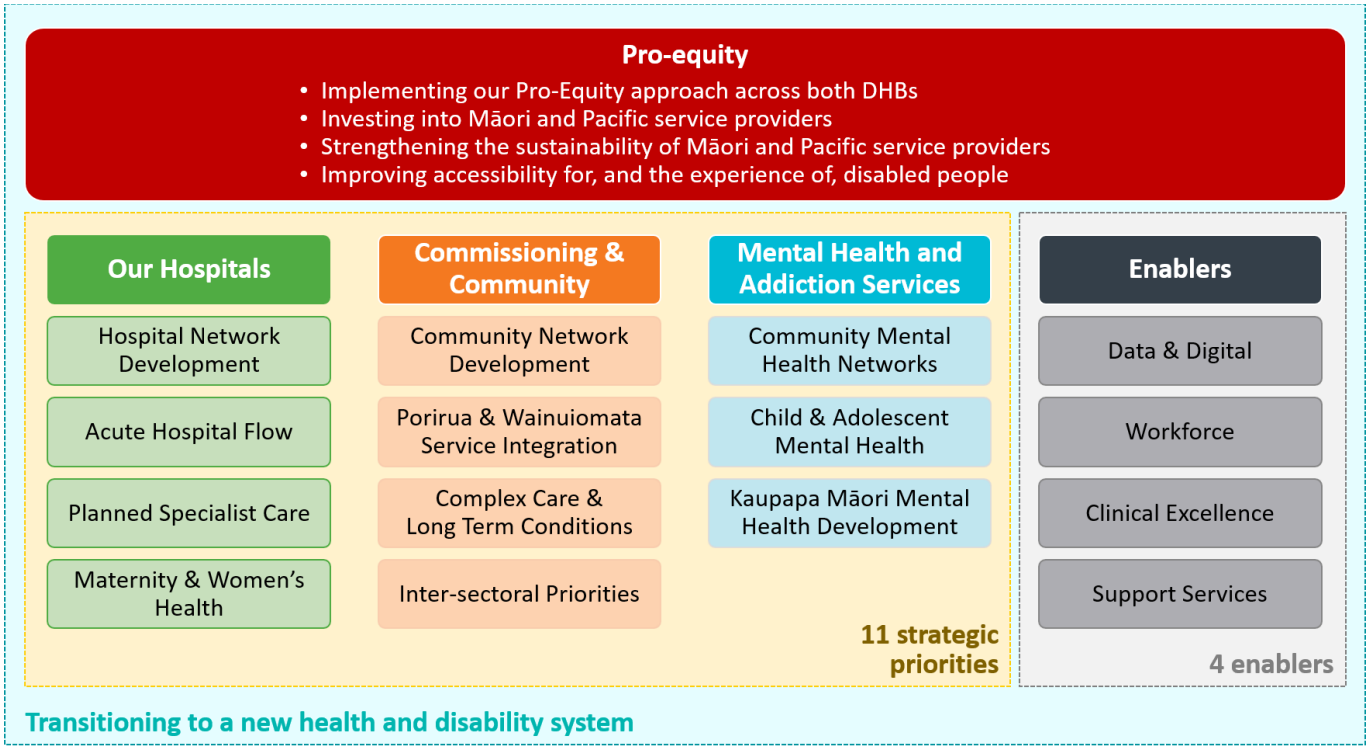
- Building a strong primary and community health care system providing closer-to-home care. We have progressed and embedded the Health Care Home (HCH) patient-centred model of care, which provides a strong basis for the integrated Community Health Networks.
- Increasing specialist support to general practices so they can access this advice for their patients when needed and potentially avoid hospitalisation. This includes the recent addition of a GP Liaison Service to provide specialist mental health and addictions advice to general practices across the Hutt Valley, Wairarapa and Wellington regions. The service strengthens our ability to initiate treatment for people in the community before their condition worsens or becomes acute.
- Inter-agency work to address underlying causes of health and wellbeing. To support implementation of Te Pae Amorangi, we are progressively increasing the resources and capacity of our Māori and Pasifika community health providers to provide holistic health care in partnership with other social services. Regional Public Health is also working with early childhood centres, schools, workplaces, social support agencies, and local councils to encourage and support the development of health-focused policy and healthy environments.
- Working with healthcare providers to rethink what 'access' means for disabled people. Commissioned services are now reporting on their actions to improve access for disabled people in their services. This mechanism has encouraged collaboration with providers to make our services more accessible for disabled people in the community.
- Health promotional activities to raise awareness and promote healthy choices across a range of topics. This includes media campaigns targeted at different ethnic groups that promote flu vaccination, which results in fewer hospitalisations for influenza.
- Contemporary 'closer to home' models of planned care services that improve early access to care and treatment. These include the use of telehealth for specialist appointments, the Mobility Action Programme (an early non-surgical intervention programme targeting musculoskeletal health conditions), skin lesion removals in primary care, and an alternative community-based Ophthalmology service to reduce patient travel and improve access.
- Improved inpatient flow through our hospitals. We have improved the flow of acute (unplanned emergency) patients with 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). Inpatient flow has been improved with the introduction and roll out of the Early Supported Discharge initiative (EDS), where patients are discharged from hospital with multidisciplinary team support and care provided in their own homes. Theatre efficiency and safety has been achieved through the introduction of electronic waitlist management software, which enables us to accurately track patients through their elective surgery journey.

While projects like these have alleviated some of the pressure on our hospitals, we are continually looking for new ways of meeting the current demands. Many of the prevention-focussed initiatives take time before the results materialise into reductions in hospital demand. A programme of transformational change is required so that all parts of the system are working together to create a more sustainable health system focused on prevention, early intervention, and achieving equity.

1.11. Our Priorities for 2021/22

Strategic Priorities

The following strategic and enabling priorities have been agreed to ensure we the needs of our populations are met during a period of change.



The Equity work plan is focused on creating a pro-equity organisation and involves:

- Implementing the Pro-Equity approach across both DHBs.
- Investment into Māori and Pacific providers (additional investment) across the two DHBs
- 2DHB Māori and Pasifika Service Providers Collaborative to strengthen our commitment to the sustainability of the providers.
- Improving accessibility for disabled people to all services and improving the experience of disabled people in accessing and using health services.

There are four focus areas: Our Hospitals, Commissioning & Community, Mental Health & Addiction Services, and Enablers, and within those there are eleven strategic priorities – each of which is focused on providing equitable outcomes for the people of our region:

- Hospital Network Development – ensuring the best use of our hospitals and specialist services to achieve equitable outcomes for the people of our region
- Acute Hospital Flow–- timely and equitable access to acute care, and an integrated system to improve the management and care of older people with frailty
- Planned Specialist Care – timely and accessible planned care services to achieve equitable outcomes for the people of our region
- Maternity and Women's Health – mothers, babies, and families are supported to receive equitable access to services and outcomes, and children get the very best start to life
- Community Network Development – ensuring well-coordinated and integrated services with our primary and community providers for the people in our localities
- Porirua & Wainuiomata Service Integration – partnering with community leaders and providers to deliver locally coordinated services to create a thriving, healthy community that enables equitable outcomes

- Complex Care and Long Term Conditions – an integrated model of care for people with long term conditions, focused achieving equitable outcomes for our priority populations
- Inter-sectoral Priorities – working together to improve housing, prevent suicide and family violence, and reduce child uplifts – ensuring our priority populations have a 'Voice, Choice and Safe Prospects'
- Community Mental Health Networks – establishing Community Mental Health and Wellbeing Hubs within our region
- Child & Adolescent Mental Health –focusing on improving mental health service delivery to children and adolescents
- Kaupapa Māori Mental Health Development –focusing on developing and strengthening kaupapa Māori mental health services.

Four enablers are required to support implementation of the eleven strategic priorities:

- Data & Digital,
- Workforce (including organisational culture), and
- Clinical Excellence (which includes a focus on quality and safety), and
- Support Services (including corporate and financial services).

As represented in the diagram (above), the strategic priorities and enablers are underpinned by our approach to equity.

There are underlying work plans for each strategic priority and enabler, and an executive-level governance structure and performance reporting framework is being established. There are plans for quarterly reporting to the Boards on the performance and progress of work under each focus area.

Health and Disability System Reform

In June 2020 the final report of the Health and Disability System Review (the Review) was released. The Minister of Health commissioned the Review to make key recommendations to the Government on developing a more sustainable health system that improves health outcomes for Māori, shifts the balance from treatment of illness towards health and wellbeing, and responds to the needs of all New Zealanders.

In April 2021, the Minister of Health announced the new structure for the health and disability system in New Zealand:

- All 20 DHBs will be replaced with a new Crown entity, Health New Zealand, which will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.
- A new Māori Health Authority will have the power to commission health services, monitor the state of Māori health and develop policy.
- The Ministry of Health will be strengthened and will continue to monitor performance and advise Government on health and disability policy. Responsibility for public health issues will rest with a new Public Health Authority.

Reform of the health and disability sector will take a number of years to implement. However, changes are likely over 2021/22 and CCDHB and HVDHB expect to be fully engaged in the change process to help ensure the reforms are successfully implemented and achieve benefits for our populations.

Our strategic approach is aligned with the goals of the reform. We are focus on achieving equity for Māori and collaborating across the system to improve health and wellbeing outcomes. Our joint Board chair and 2DHB executive leadership team support Hutt Valley and Capital & Coast DHBs working as one where possible to gain efficiencies across our hospital services, workforce, and safety and quality processes. We work closely with the other DHBs in the Central Region to coordinate how we plan and deliver services across the region.[4]

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

COVID-19 Response and Recovery

COVID-19 is a public health emergency and global pandemic. Aotearoa New Zealand has a strategy for the elimination of COVID-19. The aims are to eliminate transmission chains and to prevent the emergence of new transmission chains originating from cases that arrive from outside the country.
COVID-19 has fundamentally changed the way the New Zealand public health system responds, especially in terms of what and how public health services are delivered. The COVID-19 response and associated activities delivered by the DHB-based public health units (such as Regional Public Health) are now integrated with the Ministry of Health (led by the COVID-19 directorate). For example, New Zealand now has a National Investigation and Tracing Centre and the use of a common IT platform (the National Contact Tracing Solution).
The Ministry has engaged with DHBs to design and implement a national public health response where we more effectively share limited resources, standardise operating procedures, avoid duplication and increase the agility with which we mount a surge response anywhere in the country and address future challenges.
The COVID-19 emergency response, while necessary, also created a backlog of patients waiting to be seen and treated in our system. This will take careful planning and increased effort over a number of years to correct. The demand for mental health services in our district is growing in line with planned development but also affected by the impact of COVID-19.

A safe and effective vaccine for COVID-19 is an essential part of how we protect our communities. Distributing the vaccine and immunising the population will be an important focus for the health sector. HVDHB is committed to supporting the roll out and success of the COVID-19 vaccination programme. Priorities for 2021/22 include working with the Ministry to continually improve the COVID-19 response system, roll out the COVID-19 immunisation programme, and implementing our COVID-19 recovery plans to ensure that our patients receive the care they need.

Joint Message from the Chair and Chief Executive

One of the largest transformations the New Zealand health and disability system has experienced has commenced, with formal transition taking place from July next year. Over the next 12 months it is the responsibility of our DHBs to ensure that we continue to improve health outcomes for the people of our region, and to support the transition to Health New Zealand and the Māori Health Authority so that the new entities have strong foundations for the establishment of a more equitable and sustainable system.

We are excited by the potential of this change, particularly where equity is concerned—for Māori as Treaty partners, and also for Pacific people, the Disability community, and others who experience poor health outcomes.

This has been our direction of travel for some time, and will continue to be our focus for the next 12 months. We have carefully crafted a series of strategic priorities, which identify three inter-linked areas of focus. These are:

- a 2DHB hospital network supporting planned, acute, and specialist services
- commissioning more services in the community
- an enhanced focus on mental health and addictions services in our hospitals and in the community.

We have identified four enablers to help us deliver improvements in these areas: Data & Digital, Workforce, Clinical Excellence, and Support Services.

Our health system vision and focus areas put people, place, and partnership at the heart of what we do. With this in mind it is clear we need new models of service delivery to achieve our goal of eliminating health inequity by 2030. Unpinning this is our commitment to strengthen our financial position through strong fiscal management and optimising the use and distribution of resources.

Together these approaches will see us progress towards a single health system model and support more equitable outcomes.

We are—and will remain—focused on delivering services in the community, working collaboratively across our campuses, and creating a sustainable hospital network across our regions to make the best use of the resources we have.

In reflecting on the shape of the future healthcare system it is appropriate to acknowledge the incredible commitment of our staff, who have iteratively improved the way care is delivered. Our people have worked tirelessly through COVID-19 alert level changes, and are now delivering a vaccination campaign while maintaining business as usual.

Indeed, the rollout of our COVID-19 response and vaccination programme embodies the shape of the future healthcare system, through strong equity foundations, partnership with primary health organisations, continual innovation, and going the extra mile to connect with priority populations.

When we work to improve what we do, we think about people and their needs first. We think about the place that they are in and of the partnerships that we need to be part of to make things happen.

Hutt Valley and Capital & Coast DHBs have already seen the benefits of more unified healthcare delivery, led by a single Executive Leadership Team which now sits across both DHBs, helping share decision-making and knowledge. Over the last 12 months our 2DHBs have strived to work as one to gain efficiencies across our hospital services, workforce, sustainability, safety and quality, and this will continue to be our focus for the year ahead.

It is our privilege to introduce the latest, and final, annual plan as Hutt Valley and Capital & Coast DHBs.

Fionnagh Dougan
Chief Executive
Capital & Coast and Hutt Valley DHBs

David Smol
Chair
Capital & Coast and Hutt Valley DHB

Message from the Chair, Te Upoko o te Ika Māori Council

Kei aku iti, kei aku rahi.

Tēnei te tuku mihi ki ngā mahi kua mahia hei whakakotahi i a tātou katoa i raro i te whakaruruhau o te hauora me te oranga tonutanga o ngā iwi me ngā uri whakatipu e hāere tonu mai ana.

The next year holds great potential locally at our DHBs and across Aotearoa to bring about much-needed change to the way we support healthy whānau. This has come thanks to all those who have had the courage to challenge themselves and others to improve our health system for Māori.

In April 2021, the Minister of Health announced a new structure for the national health and disability system. This included the establishment of a new Māori Health Authority that will have the power to commission health services, monitor the state of Māori health and develop policy. The health system must work smarter to develop the strengths inherent in our communities. It is thanks to the flexibility of many Māori health providers, and their ability to connect with whānau, that our communities were largely protected from COVID-19 and will continue to be with the Pfizer vaccination rollout.

Our council, Te Upoko o te Ika Māori Council (TUI MC), was established in 2021 to represent hauora Māori across by CCDHB and HVDHB. TUI MC replaces the both the Māori Partnership Board (CCDHB) and the Mana Whenua Relationship Board (HVDHB). TUI MC comprises up to two representatives each of the following Iwi entities: Te Runanganui o Te Atiawa, Taranaki Whānui ki te Upoko o te Ika (PNBST)/ Wellington Tenths Trust, Ngāti Toa Rangatira, Te Atiawa Ki Whakarongotai, and Taurahere Iwi.

Our council is looking forward to working with the Māori Health Authority to drive rangatiratanga for Māori in our health system and ensuring Māori are deeply involved in its design.

Locally, Māori health development is undergoing bold change within our DHBs.

The appointment last year of Arawhetu Gray as 2DHB Director Māori Health was the first step to aligning the efforts of the Hutt Valley and Capital & Coast Māori Health teams. Her combined team will work to achieve accountability for delivering the DHBs' strategies to improve equity for Māori health: Te Pae Amorangi and Taurite Ora, including developing the Māori workforce.

Annual plans, such as this one, are important to TUI MC as a means of holding the DHBs to account for their planned actions and commitment to the Te Tiriti and achieving Māori health equity. I look forward to supporting their progress for all whānau in our region.

Ka pū te ruha, ka hao te rangatahi.

Jack Rikihana

Chairman

Te Upoko o te Ika Māori Council

1.12. Signature Page

Agreement for the Capital and Coast DHB 2021/22 Annual Plan between

Hon Andrew Little
Minister of Health
Date:

Hon Grant Robertson
Minister of Finance
Date:

David Smol
Chair
HVDHB
Date: 6/10/2021

Wayne Guppy
Deputy Chair
HVDHB
Date: 6/10/2021

Fionnagh Dougan
Chief Executive
Date: 6/10/2021

SECTION TWO: Delivering on Minister Priorities

This section outlines HVDHB's commitment to deliver on the Minister's Letter of Expectations, and the 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. The focus for 2021/22 is on COVID-19 recovery / learnings and equity, and a shift away from business as usual.

2.1 Government Planning Priorities

Give practical effect to Whakamaua: Māori Health Action Plan 2020-2025

Engagement and obligations as a Treaty partner (A1-HV)		
Actions		**Milestones**
Whakamaua Action 1.1 – develop iwi partnerships that support local-level Māori development and kaupapa Māori service solutions.	The DHB will continue to work in partnership with Te Ātiawa ki Whakarongotai/Kāpiti on the development of Kapiti Community Health Network. Building on the success of the Kapiti Community Health Network, we will partner with mana whenua, community leaders and other agencies to transform the way we commission services in Wainuiomata, our locality that experiences the greatest inequitable outcomes, particularly for Māori, Pasifika, and disabled people. We will commission integrated services that meet people's needs at the earliest and lowest cost opportunity. (EOA) **(HVDHB)**	Q1: Execute a single outcomes based contract, underpinned by an Annual Investment Plan and Outcomes Framework. Q4: Prepare a revised Annual Investment Plan for 2022/23, including increased investment in community based delivery.
Whakamaua Action 2.3 – Design and deliver professional development and training opportunities for Māori DHB board members and members of DHB/iwi/Māori Councils	Extend Te Kawa Whakaruruhau (our Māori cultural safety training programme) to include a short training programme for the Board focussed on Māori health equity, the Treaty of Waitangi, and Tikanga. **(2DHB)**	Q4: Narrative report on progress

Whakamaua: Māori Health Action Plan 2020-2021 (A2-HV)		
Actions		**Milestones**
Whakamaua Action 3.1 – Expand existing Māori health workforce initiatives aimed at encouraging Māori to enter health careers	Work with Kia Ora Hauora to provide work experience and exposure to health careers within the DHB. **(2DHB)**	Q2 and Q4: Status update
Whakamaua Action 4.4 – Increase access to and choice of kaupapa Māori primary mental health and addiction services.	Develop a '2DHB Māori and Pasifika Service Providers Collaborative' and engage in strategic planning with the collaborative to meet the needs of Māori populations and Pasifika populations. We will partner with the collaborative on the development of common goals to achieve equity, service development targeting high needs populations, and the development of common goals agreed with intersectoral partners.	Q2 and Q4: Status update

	The collaborative will be developed in partnership with local Iwi: Te Runanganui o Te Atiawa, Taranaki Whānui ki te Upoko o te Ika (PNBST)/ Wellington Tenths Trust, Ngāti Toa Rangatira, Te Atiawa Ki Whakarongotai, and Taurahere Iwi. **(2DHB)**	
Whakamaua Action 6.1 – Adopt innovative technologies and increase access to telehealth services	Implement ePrescriptions solution to allow outpatient prescriptions to be sent to the pharmacy of choice directly without need for paper forms or face to face contact when telehealth consults were used. **(2DHB)**	Implementation with integration with MoH ePrescription service for all outpatient clinics by Q1.
Whakamaua Action 3.3 – Support DHBs and the Māori health sector to attract, retain, develop and utilise their Māori health workforce effectively	Develop a 2DHB pro-equity approach to recruitment and onboarding, designed to attract and increase our Māori workforce and ensure a positive candidate experience for all. (EOA) **(2DHB)**	Q1. Identify working group, scope and Terms of Reference for development of the approach. Q2. Exploration and design process. Q3. Develop framework and approach. Q4. Launch.
Whakamaua Action 4.7 – Invest in innovative tobacco control, immunisation and screening programmes to increase equitable access and outcomes for Māori.	Complete an audit of referrals to smoking cessation services, including analysis of referral sources, volumes and a view by ethnicity and locality. This is intended to address the gap in smoking rates for Māori populations and Pasifika populations by ensuring appropriate referral processes and behaviours are in place. (EOA) **(2DHB)**	Q1
Whakamaua Action 8.2 – Publish plans and progress in achieving equitable health outcomes for Māori.	Report against five key measures of equity (avoidable hospital admissions, amenable mortality, accessible appointments, primary care utilisation, and community-based services) and make these reports available to the public on the DHB's website. **(2DHB)**	Q2 and Q4: Status update
Whakamaua Action 1.4 – Engage with local Iwi, using the engagement framework and guidelines, when developing major capital business cases. (for DHBs with a major capital project underway)	Finalise the Te Whare Ahuru rebuild to replace the existing building, which is not fit-for-purpose, and incorporate a new model and design that will enhance the service user, whānau, and staff experience.[5] This will also provide more suitable options for acute care while promoting less restrictive practices and provide equitable services. Further engagement with local iwi will occur in the design and implementation phase of this project. **(HVDHB)**	Q2 and Q4: Status update

[5] Te Whare Ahuru is the adult mental health acute inpatient service based on the Hutt Hospital campus. It is the primary provider of inpatient mental health care to residents of Hutt Valley and Wairarapa DHBs. Te Whare Ahuru operates in partnership with Te Whare O Matairangi, the CCDHB inpatient unit based in Wellington on the regional hospital site.

Whakamaua Action 4.9 – Invest in growing the capacity of iwi and the Māori health sector as a connected network of providers to deliver whānau-centred and kaupapa Māori services to provide holistic, locally-led, integrated care and disability support	Identify and facilitate funding / training opportunities for Māori health providers and DHB Māori staff seeking to expand capacity and strengthen capability by: (a) Supporting Māori Provider Development Scheme (MPDS) applications (b) Supporting Health Workforce New Zealand Hauora Māori applications (c) Connecting to Hauora Māori scholarships (d) Promoting other development opportunities. **(2DHB)**	Q2 and Q4: Status update (including module completion)
Whakamaua Action 5.6 – Support the delivery of Whāia te Ao Mārama 2018-2022: The Māori Disability Action Plan	Implement the Disability Equity E-learning module to strengthen cultural competency within the 3DHBs. (EOA) **(3DHB)**	Q2 and Q4: Status update (including module completion)
Whakamaua Action 8.5 – Ensure that major system funding frameworks consider and adjust for unmet need and the equitable distribution of resources to Māori.	The DHB will continue to work in partnership with Te Ātiawa ki Whakarongotai/Kāpiti on the development of Kapiti Community Health Network. Building on the success of the Kapiti Community Health Network, we will partner with mana whenua, community leaders and other agencies to transform the way we commission services in Wainuiomata, our locality that experiences the greatest inequitable outcomes particularly for Māori, Pasifika, and disabled people. We will commission integrated services that meet people's needs at the earliest and lowest cost opportunity. (EOA) **(HVDHB)**	Q1: Execute a single outcomes-based contract, underpinned by an Annual Investment Plan and Outcomes Framework. Q4: Prepare a revised Annual Investment Plan for 2022/23, including increased investment in community-based delivery.

Improving sustainability (confirming the path to breakeven)

Short term focus 2021/22 (B1) and Medium term focus (three years) (B2) – 2DHB

HVDHB and CCDHB are committed to making sure we are in a sustainable financial position. Work is progressing across a number of areas to improve clinical and financial sustainability and meet our obligations to continue to deliver good quality care. Expected savings over 2021/22 and 2022/23 are shown below.

Actions (all 2DHB) - all these actions are included in CCDHB's and HVDHB's path to breakeven over the next three years.		**Expected Savings 2021/22**	**Expected Savings 2022/23**	**Milestones**
Action supported by sustainability funding initiatives (Corporate Sustainability Fund)	Benefits of 2DHB management structure & back office efficiencies (eg ELT and RMO office, cleaning, security, fleet management)	1,255,000	$2,725,000	Q2 and Q4 reports
Action supported by production planning	Benefits of 2DHB clinical networks		$230,000	Q2 and Q4 reports
Action from the set of actions that the DHB is embedding as a result of COVID-19 learning/innovation that is expected to have the most	Property, Procurement, Logistics & Supply Chain efficiencies	$573,000	$1,395,600	Q2 and Q4 reports

significant impact on medium term sustainability	One of the biggest successes of COVID-19 was the ability to flexibly and responsively mobilise investment in Maori, Pasifika and disability providers. We will apply these learnings to develop more streamlined community commissioning processes across the 2DHBs. We will also apply these learnings to our rollout of the COVID-19 immunisation campaign for Māori, Pasifika and disability communities.			
Action supported by national analytics (Workforce Planning and Forecasting) that will contribute the most to a reduction in cost growth over the next three years.	Operating efficiencies (eg ICT licences, rostering, leave, vacancies)	30,798,809	$32,993,252	Q2 and Q4 reports
	Environmental sustainability		$473,600	Q2 and Q4 reports
	Revenue enhancement (eg clinical coding)		$570,000	Q2 and Q4 reports
	Total	$32,626,809	$38,387,452	

Improving maternal, child and youth wellbeing

Maternity care (C1-HV)		
Actions		**Milestones**
Ambulatory sensitive hospitalisations for children age 0-4 years	PHOs to support general practice teams to strengthen follow-up for children who have had an ASH respiratory admission, with a particular focus on Māori and Pacific children. **(HVDHB)**	Q2 and Q4 status updates
	Review the relevant respiratory Health Pathways to reflect best practice and ensure effective and efficient prompts and links to the Porirua Asthma Service or Asthma NZ, Well Homes – Healthy Homes Initiative, and other community health and social services. **(2DHB)**	Q3
Supporting home and primary birthing	1. CCDHB and HVDHB will work together to develop a 2DHB maternal 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 include: a) A focus on midwifery models of care that support home birthing, primary birthing and traditional birthing practices. (EOA) b) A review of access to services including ultrasounds and screening programmes (in both primary and secondary care) to ensure equitable access. Incorporating learnings from COVID-19 to ensure our maternity system is able to respond appropriately. **(2DHB)**	Q1: Establishment of steering group Q3: Status update
Integrated service models	CCDHB and HVDHB will deliver an integrated maternal and child health system. This will include:	Q1:

	a) Ensuring women and whānau have access to a targeted, pro-equity approaches to antenatal parenting education. (EOA) b) Redesign our WCTO collaboration forums with WCTO, Pasifika providers, primary care and child health leaders. Meetings are focused on quality and service integration. Invest in proactively co-ordinated maternal health services including strengthening referral pathways to social services within maternity systems. **(2DHB)**	• Launch online platform to support integrated maternity services • Review membership of WCTO collaboration forums • Execute contracts for parenting education Q3: Status reporting on access to antenatal parenting education, uptake of online platform, attendance at WCTO collaboration forums.
Sustainable workforce	Develop initiatives to support a sustainable workforce through a positive culture. This will include: a) Midwifery workforce strategies will continue to be progressed b) Engagement with MERAS and NZNO will be in place as per the Midwifery Accord c) Embed Te Ao Marama midwifery group to provide pastoral and clinical support to Māori student/graduate midwives and Pasifika student/graduate midwives. (EoA) Maternity Quality Safety programme (MQSP) will develop a comprehensive cultural competency programme that will support mana enhancing and mana protecting midwifery practice. (EOA) **(2DHB)**	Q1: Status update Q3: Report on progress against Midwifery Workforce Strategy
Perinatal and Maternity Mortality Review Committee	Our Maternity Quality Safety Programme (MQSP) has developed an action to embed two recommendations from the PMMRC 14th Annual Report. 1. PMMRC recommends that regulatory bodies require cultural competency training of all individuals working across all areas of the maternity and neonatal workforce. Training should address awareness of, and strategies to reduce and minimise the impact of, implicit bias and racism. • Working with our Maori Health Unit, we will facilitate educational opportunities for DHB staff to improve our workforce's cultural competency appropriateness and awareness. **(2DHB)** 2. PMMRC recommends that DHB maternity services audit the rates of antenatal corticosteroid administration, including repeat doses when indicated, to mothers of neonates live born at less than 34 weeks' gestation, including auditing whether administration is equitable by ethnicity, DHB of residence, and maternal age. • Hutt Valley DHB will plan to audit in the 2021 calendar year (by the end of Q2). **(HVDHB)**	Q1: Status update Q3: Status update

Immunisation (C2-HV)		
Actions		**Milestones**
Improving Immunisation Coverage (0-5 years)	The following actions will be implemented to improve childhood immunisation coverage from infancy to age 5: a) More frequent (monthly) PHO performance monitoring and management to assess MMR 'catch-up' progress and to ensure primary care is prioritising childhood immunisations for all milestone ages; b) Improving Newborn Enrolment processes and performance to increase the number of children enrolled with general practice; c) Strengthening the linkages and referral processes between our B4 School Check provider and primary care/general practices to ensure children are followed-up with by their GP; d) PHOs proactively working with Māori and Pacific providers to promote childhood immunisations at upcoming community events. **(2DHB)** Contributory measures to indicate improvements in 2 year old immunisations include enrolment in Well Child/Tamariki Ora services and enrolment with general practice.	Q2 and Q4: Status update
Promoting Immunisation	CCDHB and HVDHB to work together to implement an communication plan that delivers culturally appropriate and consistent messaging that promotes immunisations and increase education around the importance of immunisation. **(2DHB)**	Q2 and Q4: Status update
Māori Influenza Immunisation Programme	CCDHB and HVDHB to work together to develop a Māori Influenza Immunisation Programme that is that Māori-led, Māori-focused and contributes to improving equitable immunisation coverage for Māori. This work will include: a) Undertake a geo-mapping process to identify target areas of Māori 65+, Māori living in areas of high deprivation and Māori 50+ with high health need b) Implement a co-designed, co-led Māori Influenza Immunisation Programme that contributes to improving equitable immunisation coverage for Māori (MOH Funding dependant). Activities listed here also align with Whakamaua: Māori Health Action Plan 2020-2021 - A2. (EOA) **(2DHB)**	Q2 and Q4: Status update
Maintaining immunisation coverage during the COVID-19 immunisation programme	CCDHB and HVDHB will design and manage separate but connected immunisation campaigns across Covid-19, influenza and MMR. Each project has separate budgets, contracts, and governance mechanisms to track the vaccinator capacity available and performance of each campaign, to ensure capacity in 'BAU' childhood immunisation teams is not disrupted. Individual campaigns will be supported by robust analytics and communications expertise, to ensure the campaigns are working in a complementary way to achieve immunisation coverage targets. Our 2DHB (childhood) Immunisation Network remains in place as the mechanism to monitor immunisation coverage and system performance for childhood immunisation. **(2DHB)**	Q2
Outreach Immunisation	The Outreach Immunisation Service (OIS) is fundamental service to ensure we achieve our childhood immunisation targets across the population. a) Exploration of the current OIS service delivery model that considers its effectiveness, service gaps, opportunity for change, growth and innovation that best suit the community. b) Develop collective strategies with child immunisation providers to work with people who have not been immunised through general practice, and people who may find accessing childhood immunisations harder as a result of COVID-19. (EOA) c) Undertake activities to strengthen relationships between OIS partners, to ensure effective collaboration and support for delivery of the service.	Q2 and Q4: Status update

	Contributory measures include newborn enrolment and referral to Well Child Tamariki Ora provider by 28 days of age. **(2DHB)**	

Youth health and wellbeing (C3-HV)		
Actions		**Milestones**
Priority youth populations	Provide narrative reports on the actions of the 2DHB Youth Integrated Care Collaborative (ICC) to improve the health of the DHB's priority youth populations with a focus on Māori populations and Pasifika populations as well as disabled youth, LGBTQI+, refugee/migrant families and those living in higher levels of deprivation. The ICC focuses on projects and initiatives that will drive equity improvements including updates on the System Level Measures (SLM); improving access to sex and gender diverse healthcare, the integration of youth services in Porirua, activity and initiatives through the existing Youth One Stop Shops, and any other pieces of work discussed at the Youth ICC. (EOA) **(2DHB)**	Status update: Q1, Q2, Q3, Q4
Quality improvement	Implement the Youth Health Care in Secondary Schools framework by creating a formal youth engagement process in co-design with young people to support future DHB work. Once complete the process will be applied across the youth work programme. **(2DHB)**	Q1: Co-design Q2: Process agreed Q4: Implementation
Access to telehealth	HVDHB will meet with Vibe, the provider of school-based health services (SBHS) to confirm that students will continue to have access to telehealth and other forms of virtual consultations/appointments in decile 1-5 secondary schools, teen parent units and alternative education facilities. The narrative report in Q2 and Q4 will include confirmation of the availability and type of telehealth/other virtual options for students. **(HVDHB)**	Q2 and Q4: Status update

Family Violence and Sexual Violence (C4-HV)	
Actions	**Milestones**
Develop a joint 2DHB Family Violence Strategic Work Programme to re-design the way the 2DHBs respond to people experiencing family violence so we can reduce its impact, improve outcomes, and support safer communities. This work will focus on DHB responses for Māori whānau and Pasifika families. (EOA) **(2DHB)**	Q2 and 4 Progress reporting.
Increase Violence Intervention Programme (VIP) training rates by adopting 2DHB approaches to refine and deliver the training to DHB clinicians (medical, nursing and allied health) in designated services (Emergency Department, Women's Health, Children's Health, Community Mental Health Teams and Addictions Services). Target: 60% of clinicians completed VIP training. **(2DHB)**	Q2 and 4 Progress reporting.
Maintain (and where required increase) Routine Enquiry relating to Intimate Partner Violence (IPV) for eligible patients. Targets are: (a) 35% Emergency Department (b) 50% Children's Health (inpatient) (c) 80% Women's Health, Community Mental Health Teams and Addictions Service. **(HVDHB)**	Q1-4: As outlined in activity statement
Maintain (and where necessary increase) disclosure rates (associated with Routine Enquiry) in line with the VIP clinical audit benchmarks in designated services; target: increase Routine Enquiry Disclosure Rates to >5%. **(HVDHB)**	Q1-4 >5% disclosure rate

Improving mental wellbeing

Improving Mental Health (D1-CC and HV)		
Actions		**Milestones**
COVID-19 response **(3DHB)**	1. All MHAIDS COVID resurgence plans will be updated by end of Q1 and will be updated as 'living documents' in cases of re-emergence or alert level response changes. 2. Review the protocols and agreements with all providers involved in the collective provider and stakeholder forum that was implemented to respond to the COVID 19 and lockdown early in 2020. 3. MHAIDS leadership team will continue to be engaged with the wider 3DHB data and digital, including telehealth, development of updated applications and technologies from the learnings of the DHBs COVID response in 2020. 4. Surveys were conducted post lockdown with service users and staff. The findings of these surveys will be reviewed in Q1 to determine the next steps. 5. Marama Real Time Feedback has been rolled out across MHAIDS and is now our BAU service user family/whanau feedback tool. Due to COVID lockdown, as well as wanting to ensure we have appropriate methods of collection for our different consumer demographics we will now implement a number of different collection methods in Q1 e.g. paper surveys, QR codes, posters and automated text/emails following attended appointments.	1. Q1 2. Q1 3. Q1-4 4. Q1 5. Q1
Integration of primary and specialist services	1. Implement an integrated community mental health and wellbeing hub model that will provide a timely response at a local community level to those who present in distress. In 2021/22 we will to use a co-design approach to design a service model and the completion of an investment business case to implement the model. The proposal is to target a collaborative approach with a strong kaupapa Māori focus and high needs areas. The current priority localities are Porirua and Naenae. **(2DHB)** 2. The MHAIDS GP Liaison Service's dedicated Senior Medical Officer, who can be contacted directly by GPs for advice, will provide 1:1 advice and education on Special Mental Health via Video Conference sessions to GPs across the 3DHBs. **(3DHB)**	1. Q1-4 2. Q1-4
Improve our cultural response, focussing on Māori and Pasifika	1. Develop a '2DHB Māori and Pasifika Service Providers Collaborative' and engage in strategic planning with the collaborative to meet the needs of Māori and Pacifica populations. We will partner with the collaborative on the development of common goals to achieve equity, service development targeting high needs populations, and the development of common goals agreed with inter-sectoral partners. (EOA) **(2DHB)** 2. MHAIDS will continue to participate in the national project "Toward Zero Seclusion'. Maori are over represented in seclusion figures and this project aims to reduce and stop the incidence of seclusion. (EOA) **(3DHB)**	1. Q2 & Q4 status updates 2. Q2 & Q4 status updates
Follow-up within seven days post-discharge **(3DHB)**	1. Adult Community Mental Health and Addiction Services will monitor all inpatient discharges to ensure a community service contact is made and recorded in the seven days immediately following that discharge. 2. Implement a policy and pathway that embeds practices to monitor and respond to any variation/issues in post-discharge. 3. Focus on data quality and completeness aiming for 100% PRIMHD data quality compliance by Q4. **Two locally selected contributory measures:**	1. Q1-Q4 2. Q1-Q4 3. Q4

	• DNA rates – focus and target to reduce DNA rates as a measure of improving service user engagement. Approximately 9 percent of all scheduled MHAIDS community appointments result in a 'Did Not Attend' (DNA). MHAIDS has set a focus on reducing its DNA rate to a target of 5 percent. DNA rate is one way of measuring service user engagement with MHAIDS. By focusing on DNAs we can identify barriers for our service users and make improvements for accessibility. Fewer DNAs will have a positive impact on wait times and less clinical time will be lost. Hutt Valley based services send automated appointment reminders to service users. • Pre-admission care - Adult Community Mental Health and Addiction Services monitor this measure along with the seven day follow up measure. Additional MoH advised measure: • MH03: Transition/discharge planning. Compliance and quality audits will be completed quarterly.	

Improving wellbeing through prevention

Communicable Diseases (E1-HV)	
Actions	**Milestones**
The RPH Māori and Pasifika COVID-19 Response leads will support Māori communities and Pasifika communities to identify and lead COVID-19 recovery projects/plans, including those to improve access to infectious disease related services for Māori and Pasifika people (RPH -core function: health promotion) (EOA). This is a cross service opportunity. **(3DHB)**	Q2 & Q4
Provide a notifiable communicable disease programme to reduce the impact of illness and reduce avoidable hospital admissions of our priority populations for Māori and Pasifika people. Prevent, identify and respond to existing/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 function – Health Promotion, Health Protection, Health Assessment & Surveillance, Public Health Capacity Development and Preventive Interventions) **(3DHB)**	Q2 & Q4

Environmental Sustainability (E2-HV)	
Actions	**Milestones**
The COVID-19 pandemic resulted in supply shortages and minimal availability of disposable PPE gowns. A rapid increase in usage in all red zone areas of the hospital meant an alternative solution for all non-red zone areas had to be found. A local firm was engaged to urgently make reusable PPE gowns for non-red zone areas, significantly reducing the demand on disposable stock. Since COVID-19 the DHB has continued a staged roll out of reusable gowns to ensure all non-red zone areas have PPE gowns available at all times. This change has also resulted in a positive impact on the environment with the continued reduction of waste. **(HVDHB)**	Q1: 30% of services using reusable gowns
Develop a 2DHB Sustainability Strategy and implementation plan. We will engage with our Māori Council during the development of this plan to ensure that it is culturally appropriate and meets the needs of mana whenua. (EOA) **(2DHB)**	Q1 - Engage with Māori and Pasifika partners, including the Māori Council Q2: Sustainability strategy approved Q4: Sustainability implementation plan completed
Implement 2DHB emissions reporting and verification by December 2021, including forecasting of potential offsetting liabilities to decision makers. We will target monthly emission data for at least 80% of gross emissions. We will also develop a 2DHB emissions reduction strategy that includes a pipeline of work and indicative costs for budgeting purposes to be completed by June 2022. **(2DHB)**	Q2: Implement 2DHB emissions reporting a verification Q4: Confirm 2DHB emission reduction strategy

Antimicrobial Resistance (E3-HV)		
Actions		**Milestones**
COVID-19 recovery and learnings	Update of Empiric Antibiotic Guidelines with revision of Community Acquired Pneumonia guideline. **(2DHB)**	Q3 – availability online and on mobile app
	Hand hygiene audit programme implemented and reported in Emergency department & EDOU and in non-ED adult admitting units: MAPU, SAPU. **(2DHB)**	Q1-Q4 – reporting as per HQSC cycles
National AMR action plan	Antimicrobial stewardship – AMS rounds three times week. **(2DHB)**	Q1-Q4 – reporting to AMS committee
Community and primary care	Increase awareness and understanding – facilitate at least two educational activities in ARC facilities specifically targeting AMR and AMS via IPC team **(2DHB)**	At least two targeted education/awareness activities undertaken by end Q4

Drinking Water (E4-HV)	
Actions	**Milestones**
Facilitate the transfer of drinking water regulatory work to the new drinking water regulator Taumata Arowai. **(3DHB)**	Transfer all water supplier records to Taumata Arowai within agreed timeframes
The RPH Māori and Pasifika COVID-19 Response leads will support Marae, schools and high need communities (including communities with high Māori and Pasifika Peoples populations) with their own water supplies to identify and lead COVID-19 recovery projects/plans around drinking water (EOA) (RPH) (Core function-health protection) or any other post COVID-19 public health issue. This is a cross service opportunity. **(3DHB)**	Q2 & Q4
Annual review compliance reporting for 2020/21 is completed.	Q1

Environmental and Border Health (E5-HV)	
Actions	**Milestones**
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. (RPH) (Core function - health protection) **(3DHB)**	Q2 & Q4
Assess the DHB/RPH's ability and processes in relation to encouraging Territorial Authorities (TAs) to always consider improvement of Māori and Pacific health and achievement of equity when the TAs are developing their district and long-term plans so that the DHB/RPH can optimise its input into the TA planning processes in relation to improving Māori and Pacific health and achieving equity. **(EOA) (3DHB)**	Q2 & Q4
Primary health care is the cornerstone to our delivery approach across the Capital and Coast and Hutt Valley districts to support the COVID-19 vaccination programme. Our three Primary Health Organisations (PHOs), Ora Toa PHO, Tu Ora Compass and Te Awakairangi, will scale up and down as required to provide a range of community vaccination centres across the region to meet the demand for all priority groups. Our other PHO (COSINE) will provide supplementary capacity to the delivery of our vaccination programme. **(2DHB)** The CCDHB and HVDHB sequencing is as follows: Phase One – Initial Supply (Nov 20 – May 21): • Completion of Group One (people who work at the border or at one of the Managed Isolated and Quarantine facilities in Wellington), and	Q2 & Q4

• Roll out for Group Two (people working in the health system, frontline emergency service workers, everyone living in long-term residential care, and older Māori and Pasifika people living in the community and the people who live with them). Phase Two – Ramp up (May – August 21): • Completion of Group Two, and • Roll out for Group Three (people aged over 65, anyone who is disabled, people with particular health conditions that put them at higher risk if they were to catch COVID-19, and pregnant women) Phase Three – Open Access (August – December 21): • Completion of Group Three, and • Roll out for Group Four (everybody else who is at least 16 years old). Phase Four – Wash Up (December 21 – February 22). • Completion of Group Four, • Competition of any follow up vaccinations as required, and • Preparation of next vaccination roll out, if required.	

Healthy Food and Drink Environments (E6-HV)	
Actions	**Milestones**
Support the appointment of a new Chair of the 3DHB Healthy Foods and Drink Environments Implementation Group. **(3DHB)**	Q2
Implement a DHB staff consultation to align the National Healthy Food and Drink Policy with policy requirements for fundraising and gifts within the DHB. **(HVDHB and WrDHB)**	Q2 & Q4
The RPH Māori and Pasifika COVID-19 Response leads will support Māori communities and Pasifika communities to identify and lead COVID-19 recovery projects/plans, including those to improve access to reliable healthy food options (RPH -core function: health promotion) (EOA) This is a cross service opportunity. **(3DHB)**	Q2 & Q4
In partnership with Sport Wellington and the Ministry of Education 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 Pasifika 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. (Core function - health promotion). (EOA) **(3DHB)**	Q4

Smokefree 2025 (E7-CC and HV)	
Actions	**Milestones**
CCDHB and HVDHB will develop responses that support smokers with mild to moderate mental health issues who have been impacted by Covid-19. This may include providing easy access to NRT from home. **(2DHB)**	Q1 & Q4: Status update
Through partnering with PHOs, DHB services, Māori, Pasifika and NGO providers, prioritise a focus on lifting the referrals rates to smoking cessation services to pre-Covid-19 levels. (EOA) **(2DHB)**	Q1 & Q4: Status update
Complete an audit of referrals to smoking cessation services, including analysis of referral sources, volumes and a view by ethnicity and locality. This is intended to address the gap in smoking rates for Māori and Pasifika by ensuring appropriate referral processes and behaviours are in place. (EOA) **(2DHB)**	Q1

Develop a 2DHB tobacco control and smoking cessation investment plan, that matches agreed government, DHB and community priorities and commitments for smoking cessation to funding commitments. **(2DHB)**	Q2
Takiri Mai Te Ata (Regional Stop Smoking Service) will work in partnership with 2DHB Pacific Director to develop a Regional Stop Smoking Pacific Plan. **(2DHB)**	Q1 & Q4: Status update

Breast Screening (E8-HV)		
Actions		**Milestone**
HVDHB continues to work with the Regional Screening Services to achieve the 70% screening target for Māori and Pasifika women.		
Māori and Pasifika wāhine prioritised through COVID-19 recovery	Regional Screening Services will progress the work of the 2020 BreastScreen Central Mammography Project for the most effective and efficient way of increasing access to breast screening services with a particular focus on improving access for Māori and Pasifika women. The project will look at additional fixed sites and/or a replacement mobile unit. **Progress will be measured using data from the ethnicity coverage report to measure target success** (EOA) **(2DHB)**	Q2 and Q4: Status update
Eliminate equity gaps	Regional Screening Services will work in partnership with local Māori health providers, Pasifika health providers, PHOs, and primary care and community health services, identifying priority women with PHO data matching activity, use of local clinics, and organising education and health promotional events. We will also engage with our Māori Council to discuss how we can better reach our priority populations. **Progress will be measured using data from the PHO data report against the new enrolment data of Maori & Pacifica**. (EOA) **(2DHB)**	Q2 and Q4: Status update
Improve participation for Māori and Pasifika women	To support the national (BreastScreen Aotearoa) two-year pathway to achieve the 70% screening target for Māori and Pasifika women, Regional Screening Services' recruitment and retention team will aim to support as many additional Māori and Pasifika women as possible who are overdue or unscreened to attend a breast screening clinic. Māori and Pasifika women are given first priority when BreastScreen appointments are scheduled. **Progress will be measured using data from the coverage report by ethnicity and success will be measured from the priority day clinics.** (EOA) **(2DHB)**	Q2 and Q4: Status update
Note: all data used for monitoring and reporting is provided by the BreastScreen Aotearoa (BSA) data reporting services. Our BreastScreen Central data is collected from the BSA information systems and fed into the national database. All monitoring reports are generated from this national database. The Q2 and Q4 reporting is based on the DHB national coverage report produced by the National Screening Unit. Six monthly reporting is also a requirement for BSA. Data from the Ministry (BSA) is supplied for BreastScreening Central using population estimates from the 2013 consensus for regional coverage. Further data for coverage by ethnicity and the target of 70% is used to measure indicator targets and measure performance and progress of the service. Indicator targets are reported in the 6 month Narrative report framework supplied by BSA. Development of a production plan for the Regional Screening services is in development to forecast service demands, meeting targets against resources.		

Cervical Screening (E9-HV)

Actions		Milestones
HVDHB 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 Māori, Pasifika, and Asian women		
Improve Māori coverage and Pasifika coverage	Regional Screening Services will work in partnership with local Māori health providers and Pasifika health providers to attend events where priority populations gather and promote key messages around the importance and benefits of cervical screening. We will provide education and support for women into the screening pathway. We will also engage with our Māori Council to discuss how we can better reach our priority populations. (EOA) **(2DHB)**	Q4
Actions to reduce the equity gap	Regional Screening Services will partner with Te Awakairangi Health Network and Cosine PHO to identity general practices with high volumes of Māori, Pasifika and Asian women overdue or under-screened. We will partner with these practices to support these women into a 'Free Cervical Screening Clinic'. (EOA) **(HVDHB)**	Q2 & Q4: Status update
	Regional Screening Services will provide four weekend free cervical screening clinics at Hutt Hospital per annum to improve Māori and Pasifika screening coverage. These clinics will be combined with breast screening where possible. (EOA) **(HVDHB)**	Q2 & Q4: Status update
	Regional Screening Services will provide support to cervical screening clinics run in in high-needs communities across the CCDHB and HVDHB region targeting Māori, Pasifika, and Asian women. (EOA) **(2DHB)**	Q2 & Q4: Status update
Equitable access to diagnostic and treatment colposcopies	Regional Screening Services will work with the colposcopy unit to ensure women who did not attend diagnostic and treatment colposcopy services are actively followed up and referred to service providers. Regional Screening Services will also facilitate two 3DHB Colposcopy meetings per annum to enhance collaboration and share ideas. **(2DHB)**	Q2 & Q4: Status update

Reducing Alcohol Related Harm (E10-HV)

Actions	Milestones
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)**	Q2 & Q4: Status update
Provide health protection activities relating to the Sale and Supply of Alcohol Act 2012. (RPH: core function – health protection) **(3DHB)**	Q2 & Q4: Status update
Influence policies related to reducing alcohol related harm, e.g. Councils' local alcohol policies. (RPH: core function – health promotion) **(3DHB)**	Q2 & Q4: Status update
The RPH Māori and Pasifika COVID-19 Response leads will support Māori and Pasifika communities to identify and lead COVID-19 recovery projects/plans, including those to reduce alcohol related harm. We will also support communities to have a voice in local alcohol licensing decisions, alcohol and drug policy and legislation development. We engage with Māori and local community leaders to support them to advocate with their communities from their own lived experiences. (EOA) (RPH: core function – health promotion) **(3DHB)**	Q2 & Q4: Status update

Sexual and Reproductive Health (E11-HV)

Actions	Milestones
STI rates increased during the time of the COVID-19 lockdown. RPH will assess the ongoing impact of COVID-19 on STI incidence as part of providing information and advice to communities and health providers for sexually transmitted infections (STIs) outbreaks. (RPH: core function – health promotion) **(3DHB)**	Q2 & Q4: Status update
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, Pasifika, and disabled people. (EOA) (RPH: core function – health promotion) **(3DHB)**	Q2 & Q4: Status update

[Māori Council: The above suggests that work has already been done to identify the sexual health issues identified by Māori, Pasifika, and disabled people. There is a greater need for transparency here. If work has been done, please name and reference this. If work has not been done, please be clear about this.]	
The inability to access sanitary items to manage menstruation impacts people across Aotearoa, widening social and economic inequalities. RPH will work with marae and community-based organisations to ameliorate period poverty across the Hutt Valley. **(HVDHB)**	Q2 & Q4: Status update

Cross-Sectoral Collaboration, including Health-in-all-Policies (E12-HV)	
Actions	**Milestones**
Provide pro-equity focused (Māori, Pasifika, disabled people) and COVID-19 recovery informed public health input as a member of the Wellington Regional Healthy Housing Group (WRHHG) steering group and working group(s) to implement the 2021 and 2022 WRHHG strategy and action plan. (RPH: core function – Health Promotion). **(3DHB)**	Q1-4
Deliver the Health in All Policies programme (HiAP) providing public health input to local, regional and central government policy processes with significant potential for equity focused health impact. This is a cross service opportunity that links to other actions to enhance tino rangatiratanga and achieve equity including for Pasifika populations (RPH: core function – Health Promotion). **(3DHB)**	Q1-4

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

Delivery of Whānau Ora (F1-HV)		
Actions		**Milestones**
COVID-19 Recovery	One of the biggest successes of COVID-19 was the ability to flexibly and responsively mobilise investment in Maori, Pasifika and disability providers. We will apply these learnings to develop more streamlined community commissioning processes across the 2DHBs. We will also apply these learnings to our rollout of the COVID-19 immunisation campaign for Maori, Pasifika and disability communities. **(2DHB)**	Q1: Confirmed delivery model for reach to Maori, Pasifika and disability community Q3: Status update
Equity focussed actions	The DHB will continue to work in partnership with Te Ātiawa ki Whakarongotai/Kāpiti on the development of Kapiti Community Health Network. Building on the success of the Kapiti Community Health Network, we will partner with mana whenua, community leaders and other agencies to transform the way we commission services in Wainuiomata, our locality that experiences the greatest inequitable outcomes particularly for Māori, Pasifika, and disabled people. We will commission integrated services that meet people's needs at the earliest and lowest cost opportunity. (EOA) **(HVDHB)**	Q1: Execute a single outcomes based contract, underpinned by an Annual Investment Plan and Outcomes Framework. Q4: Prepare a revised Annual Investment Plan for 2022/23, including increased investment in community based delivery.
	CCDHB and HVDHB will work together to develop and implement a cultural competency framework to improve cultural responsiveness and increase the capability of the non-Pasifika health workforce to respond appropriately to the needs of Pasifika people. **(2DHB)**	Q3 Develop a cultural competency framework Q4 Implement cultural competency training with the Capability and Development Unit

Ola Manuia: Pasifika Health and Wellbeing Action Plan 2020-2025 (F2-CC and HV)		
Actions		**Milestones**
Supporting contact tracing	Appoint and retain a Pasifika COVID-19 Response Lead within RPH to oversee case investigation and contract tracing from a Pasifika perspective**. (2DHB)**	Q2 and Q4
Improve communications	RPH in collaboration with our Pasifika Health Unit will co-create COVID-19 public health communications to ensure that these communications are effective and targeted to our Pasifika communities. **(2DHB)**	Q2 and Q4
Access to wrap around services	CCDHB and HVDHB will work together with primary care and key stakeholders to develop an implementation plan focused on ensuring access to wrap around health and social services for Pasifika families, especially those with complex needs. **(2DHB)**	Q3 Develop the 2DHB Pasifika Health and Wellbeing Strategic implementation plan Q4 Status report on progress
Maintain good relationships	CCDHB and HVDHB will work together to develop and implement a cultural competency framework to improve cultural responsiveness and increase the capability of the non-Pasifika health workforce to maintain good relationships and respond appropriately to the needs of Pasifika people. **(2DHB)**	Q3 Develop a cultural competency framework Q4 Implement cultural competency training with the Capability and Development Unit
Pasifika health workforce	CCDHB and HVDHB will work together to develop and implement a 2DHB Pasifika Health Workforce Strategy. **(2DHB)**	Q3 Develop a 2DHB Pasifika Workforce Strategy. Q4 Implement a 2DHB career pathway for Pasifika graduates with HR and Recruitment, linked to career opportunities for secondary and tertiary education providers.

Health Outcomes for Disabled People (F3-CC and HV)	
Actions	**Milestones**
Collaborate with the Ministry, DHB staff, community stakeholders and disabled people in each region to develop new Sub Regional Disability Strategy for 2023 – 2028, which will include a specific focus on embedding the learnings from COVID-19. Development of the revised strategy will include targeted engagement with Māori disabled people and Pasifika disabled people to advise and help develop tailored actions to achieve equable outcomes. (EOA). **(3DHB)**	Q4
Work with the Disability Support Advisory Committee to implement a process to collect information (eg standardised disability question) from people with disabilities that enables health services to respond to people with disabilities and be culturally responsive to Māori people and Pasifika people. **(3DHB)**	Q2 & Q4 Narrative report
Deliver core disability responsive education with the newly completed 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 building on the gap identified during the COVID-19 response. **(3DHB)**	Q2 & Q4 Narrative report

Planned Care (F4-HV)		
Strategic Priority	**Actions**	**Milestones**

1: Improve understanding of local health needs	Develop a framework to assist services to change service delivery model and move settings of care from Hospital to community. **(2DHB)**	Q1 Frame work for redesigning models/settings of care is developed Q1-Q4 Models of care/settings of care for prioritised services are redesigned using the framework developed in Q1
2: Balance national consistency and the local context	Implement a sub-regional ENT service that aligns access criteria across the 2DHBs. **(2DHB)**	Q1-2: standardisation of referral prioritisation is achieved and management of FSAs across both DHBs commences. Q3: Align employment model with service provision across the DHBs. Q4: Both CCDHB and Hutt DHB are ESPI 2 and 5 compliant.
3: Support consumers to navigate their health journeys	The DHB will work in partnership with Iwi on the development of a new Community Health Network. Building on the success of the Kapiti Community Health Network, we will establish a Community Health Network in an area with high Māori/Pasifika populations. **(HVDHB)**	Q2 Framework for implementation signed off by Board Q4 At least one new Network established.
4: Optimise sector capacity and capability	A 2DHB elective outsourcing contract is established and increases patient access to elective service provision. **(2DHB)**	Q1 Negotiate contract Q2 Contract implemented
5: Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future.	Construct a five room procedure suite at Hutt Hospital to create a sustainable pathway for day surgery reducing the burden of local anaesthetic surgery in the main operating theatre. The approach will reduce the planned care waiting list and enable greater utilisation of main theatre. **(HVDHB)**	Q1: Tender completed Q2-Q3: Build underway Q3-Q4: Procedure Suite in place
Supporting COVID-19 recovery	Establish increased operating theatre capacity through the use of second acute theatre and development of the procedure suite at Hutt Hospital. In addition, evaluate weekend service provision on Saturdays to reduce the general surgery waiting list. **(HVDHB)**	Q1: Evaluate trial of weekend service provision. Q2: Evaluate the implementation of the second acute theatre introduced in November 2020.
	Implement and evaluate Orthopaedic First Specialist Appointment Planned Care Initiative with an Advanced Physiotherapist role and a multidisciplinary team focus. Explore on-going funding options from February 2022 regarding this initiative. **(HVDHB)**	Q1: Professional feedback for Advanced Physiotherapist role Q2: Evaluate initiative.
Acute Readmissions and Diagnostics waiting times. Two locally selected contributory measures: Acute Readmissions (as agreed with MoH through PCI) and Diagnostics waiting times (as per Planned Care definitions).		

Acute Demand (F5-HV)	
Actions	**Milestones**

Using ED data to improve service design and planning	SNOMED codes enable the DHB's raw patient and service data to be coded consistently with a national standard thereby allowing DHB service managers and the Ministry of Health to better understand patient population trends, service pathways and identify patient needs. Collated data will be used to develop performance dashboards to inform how our services can be streamlined to better meet patient and community needs and demand. This level of business intelligence supports service design and planning, particularly within primary and community care, to reduce demand on hospital services. **(2DHB)**	Q1, Q3 (aligned with integration milestones)
COVID-19 recovery / learning	Use COVID-19 Resurgence Plans for areas such as ED, MAPU, ICU and Medical Ward to formalise the recommendations from the lessons learned previously and decide which recommendations to complete and order of priority. This will be done in conjunction with CCDHB as many themes will be the same. (HVDHB)	Q1: Releasing time to care - nursing staff leading and supporting timely patient assessment. Q4: Understand specialty assessment delays (including MHAIDS) in the ED and agree on timely escalation to improve patient experience and Pae Ora - healthy futures.
Acute care equity action	Work with the ED Māori Advisory Group to develop a flip chart to guide staff on Tikanga Māori approaches to care to help ensure we provide culturally appropriate care to Māori and their whanau who attend ED. (**2DHB)** (EOA)	Q2 – Flip chart developed and provided to ED staff.
Improving wait times for patients	Improving wait times for patients requiring mental health and addiction services who present to ED. Actions to achieve this include working with MHAIDS to deliver efficient care for these patients in the right location, and ensuring the Te Haika link resource matches demand and presentation trends. **(HVDHB)**	Q2 and Q4 status updates.
Partnering with primary care to achieve equity	Specialist staff will participate in the development of the Community Health Network in an area with high Māori/Pasifika population. Integration with primary care will build relationships and networks between primary and secondary care and result in appropriate development of services and workforce to deliver care closer to home. The Community Health Network is expected to improve care coordination and reduce potentially avoidable hospitalisations. **(2DHB)**	Q2 Framework for implementation signed off by Board Q4 At least one new Network established.
	Investigate options to provide telehealth for Acute Clinic patients and more SMO support for GPs. This will ensure patients are reviewed by secondary services in a timely way and potentially avoid presentation to ED. This will need to be carefully investigated to prevent further inequities in health due to lack of mobile devices for patients to access this service. This may also support the GP during times when access to GPs is reduced. **(HVDHB)**	Q2 and Q4 status updates.
Acute Hospital Bed Days per capita	Please refer to our System Level Measures Plan attached.	

Implementation of the Healthy Ageing Strategy 2016 & Priority Actions 2019-22 (F6-2DHB)		
Actions		**Milestones**
COVID-19 Preparedness / Learnings	1. Work with our aged care provider network to review and consolidate what was learnt during the initial stages of COVID-19 including infection prevention and control measures and refresh systems, processes and workforce capacity in Aged Care Facilities. **(2DHB)**	Q1: Complete review of learnings Q2: Work with sector to refresh systems and processes Q4: Implement identified changes
Age-Related Frailty	2. Establish a sustainable Fracture Liaison Service with a particular focus on earlier and preventative intervention such as decreased polypharmacy, osteoporosis screening, falls prevention, and strength and balance programmes. **(2DHB)** 3. Investigate culturally responsive tools, with a focus on Māori and Pasifika communities, to identify signs of frailty earlier and connect with appropriate community supports in a timely way. **(2DHB)**	Q1-Q2: Implement refreshed Fracture Liaison Service Q4: Culturally responsive tools endorsed
Dementia services	4. Develop approaches to address gaps in service across the dementia journey from early diagnosis to end of life care and support that improves equity, availability and access to dementia services. This will include the development of flexible models for respite care for example increased access to respite care hours by Home and Community Support Services and review of day programmes. **(2DHB)** 5. Review and refresh approaches to increase workforce knowledge and skills specific to dementia to decrease stigma, assist timely diagnosis, support and care planning. **(2DHB)**	Q2: Service gaps identified Q3: Flexible respite models developed Q4: Implementation of models Q4 Workforce capability approaches developed
Community-based support and restorative services	6. Expand on early supported discharge services for older people with further focus on stroke services. (2DHB) 7. Develop pathways that enable access to appropriate and responsive services for Māori, Pasifika and people with disabilities. **(2DHB)**	Q2 – Early supported discharge implemented Q4 Responsive pathways developed and implemented

Health Quality & Safety (F7-HV)		
Actions		**Milestones**
COVID-19 Learnings	Hand hygiene audit programme implemented and reported in Emergency Department. **(2DHB)**	Q1 and Q4 as per HQSC requirements
Improving equity	The DHB will develop integrated approaches working with Māori and Pasifika providers and primary care to prevent and manage long-term conditions with a focus on CVD/Diabetes, Gout and respiratory disease.(EOA) This work will include: • Developing pathways to link with community providers of physical health and wellbeing services, education and health literacy • Developing better links between primary care and smoking cessation services across the region • Further developing opportunistic screening services to complete CardioVascular Disease Risk Assessment (CVDRA) checks in high risk Māori and Pasifika people working with a wider workforce.	Q2, Q4

	• Review clinical pharmacist service to ensure it places emphasis on polypharmacy, reducing the risk and impact of fragility fractures, and addressing poorly managed, equity-focused conditions such as gout and diabetes. **(2DHB)**	
Improving Consumer engagement	Hutt Valley DHB will support our consumer engagement partners to implement the Quality and Safety Marker (QSM). We will work within the SURE Framework, which stands for Supporting, Understanding, Responding, and Evaluating. The aim of this framework is to measure how DHBs are listening, responding to and partnering with consumers, and how they honour Te Tiriti o Waitangi in their consumer engagement planning and activities. For 2021/22, Hutt Valley DHB will support implementation of the QSM and report in quarter 1 and 3 using the SURE framework as a guide, as per Health Quality Safety Commission requirements. Hutt Valley will also raise the profile of our consumer engagement partners with DHB staff and consumers as a valuable resource with co-design expertise and links with a diverse range of Hutt Valley communities, that can assist with consumer input into service improvement and design; collate, monitor, and report on the DHB's consumer engagement activities (under the SURE framework), and represent the community voice and advocate for consumers on a range of health and disability issues. **(HVDHB)**	Q1 and Q4 as per HQSC requirements

Cancer Control Agency (F8 - CCDHB and HVDHB)		
Actions		**Milestones**
Actions to ensure the regional Radiation Oncology Model of Service is fit for purpose to meet the current and future needs	Development of medical physics professional development standards	Q1-4 Medical Physics professional framework implemented
	Implementation of new radiation safety standards.	Q1-4 compliant with recently amended radiation safety standards
Action regarding outreach radiation treatment services Radiation Therapy Linac planning for the region in 2021/22.	Options paper for CCDHB and HVDHB board to be developed in 21/22 financial year to examine options for a 4th LINAC and whether that is delivered via a satellite unit. Project lead to be appointed, 2DHB steering committee and TOR developed to commence work. Analysis of population needs and options for service delivery completed Paper for 2DHB Board delivering options for outreach radiation service provision completed.	Q1- steering committee overseeing the development of an options paper for the outreach radiation services. Q2 analysis of HVDHB and Wairarapa DHB population and radiation therapy needs requirements completed. Q3- 4: In 2022 joint CCDHB & HVDHB boards will approved a timeline of when HVDHB & WaiDHB will have improved access to radiation therapy by the CCDHB radiation therapy service.
Actions to address inequalities and access to diagnosis and care for Māori and Pasifika patients	Improve access to locally provided cancer treatments	Q3-4 Completion of fit for purpose dayward at Kenepuru hospital to facilitate closer to home treatment where clinically suitable

	Review of Maori Cancer Nurse Coordinator position to identify opportunities to improve equity of access including diagnostics	Q1-4 act upon recommendations identified in review of Maori Cancer Nurse Coordinator role to improve access, diagnostics and participation in treatment.
Performance improvement actions	Monitor referrals to Oncology services with advanced disease. **(2DHB)**	Q1-4: By the end of 21/22 there will be a reduction in patient presentations with advanced disease at time of referral
	Monitor referrals by reviewing diagnosis of cancer occurring in ED. **(2DHB)**	Q1-4: By the end of 21/22 there will a reduction in diagnosis of cancer occurring in ED.
Tobacco control	Complete an audit of referrals to smoking cessation services, including analysis of referral sources, volumes and a view by ethnicity and locality. This is intended to address the gap in smoking rates for Māori and Pasifika by ensuring appropriate referral processes and behaviours are in place. (EOA) **(2DHB)**	Q1
Reducing alcohol-related harm	Influence policies related to reducing alcohol related harm, e.g. Councils' local alcohol policies. (RPH: core function – health promotion) **(3DHB)**	Q2 & Q4: Status update
Improving nutrition	In partnership with Sport Wellington and the Ministry of Education 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 Pasifika 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. (Core function - health promotion). (EOA) **(3DHB)**	Q4
DHB Bowel Cancer Service Improvement Plan	Following publication of the second national bowel cancer QPI report, we will engage with the Māori Council, the Sub-Regional Pasifika Health Advisory Group, and the HVDHB Consumer Council to inform revision of our Bowel Cancer Service Improvement Plan. **(2DHB)**	Q4
Action to improve FCT data quality	We are focussed on improving visibility of patients with an inpatient admission (via ED) resulting in cancer diagnostics. This will reduce 31 day FCT breaches (data quality). **(2DHB)**	Status update report in Q2 and Q4.
Lung cancer	Quality improvement project to review process and develop guidelines for Māori patients with a high suspicion on cancer presenting to ED. This will improve diagnostics and reduce FCT breaches (data quality). **(2DHB)**	Status update report in Q2 and Q4.
Prostate cancer	Explore a method to report on patients offered a FSA in radiation oncology by Urology team. **(2DHB)**	Status update report in Q2 and Q4.
Action from the Māori Cancer Community Hui	MDM templates to include ethnicity to improve access and timeliness to our most vulnerable patients. **(2DHB)**	Status update report in Q2 and Q4.
Implementation of the HISO standards (including MDM and ACT-NOW)	Implement cancer specific Health Information Standards Organisation (HISO) standards issued by the Ministry of Health, including the Cancer Multidisciplinary Meeting Data Standard and the ACT-NOW data standards. **(2DHB)**	Status update report in Q2 and Q4.

Support of the national travel and accommodation project	Support and participate, as requested, in Te Aho o Te Kahu travel and accommodation project, which aims to improve cancer patient equity of access and treatment. **(2DHB)**	Status update report in Q2 and Q4.
Effective screening programmes that detect cancers early across all population groups and acheive equitable health outcomes	Refer to other sections of this plan: - Breast Screening (E8) - Cervical Screening (E9), and - Bowel Screening and Colonoscopy Wait Times (F9) Actions include: - Māori and Pasifika women are given first priority when BreastScreen appointments are scheduled - Free cervical screening clinics run in high-need communities. Outreach services to priority populations who do not initially return a bowel screening kit.	NA – please refer to other relevant sections of this plan.

Bowel Screening and Colonoscopy Wait Times (F9-HV)		
	Actions	**Milestones**
Reducing wait times	Ensure colonoscopy wait times are consistently met to achieve Bowel Screening Indicator 306. This will be achieved by optimising our SMO FTE and the utilisation of a recently employed Nurse Endoscopist to provide lists. **(HVDHB)**	Q2-4
Achieving equitable access	We are working with our cervical screening retention and recall equity teams to incorporate bowel screening into their plans for increasing participation rates through their provider networks. (EOA) **(HVDHB)**	Q2
	Equitable access to colonoscopy will occur by prioritising our Māori patients and Pasifika patients. This will be achieved using a new tool on our waiting list, as part of an acuity index, which provides a higher acuity to the ethnicity recorded in our patient management system. This in turn allows us to book these patients first. We will also engage with the Māori Council on ways to improve equity and outcomes for Māori. (EOA) **(HVDHB)**	Q1-4
	The bowel screening outreach programme will achieve the 60% Māori and Pasifika participation rates through strengthening the relationship with our Māori and Pasifika healthcare providers who are contracted to deliver the programme and working alongside them to greater define and focus promotional initiatives. (EOA) **(HVDHB)**	Q4
Meeting maximum wait times	Business analysts have fine-tuned our Production Plan / Recovery Plan, and this modelling is predicting that we will consistently be meeting maximum wait targets by November 2021. **(HVDHB)**	Q2 – update on wait times

Health Workforce (F10 – 2DHB)		
Priority	**Actions**	**Milestones**
Using the workforce differently	We will develop a shared and consistent approach to workforce planning across the health system that is aligned to future service development, using the workforce differently as a result of the learnings from COVID, and health system transformation. **Activities:** • Programme of work in collaboration with unions to identify and develop policies and systems that enable increased flexibility in assigning and redeploying staff to different roles.	Q1&2. Review current people policies and processes for alignment for future service development. Q3. Report findings and agree workforce plan. Q4. Implement plan. Q1. Monitor and evaluate success of the current Nursing and Midwifery Recruitment and Retention Strategy.

	• Implementation of flexible working, activity based space utilisation and digital workplace. • Review occupational health responsiveness to workforce needs for flexible assignment/redeployment due to health needs. **Expected outcomes:** • Staff are prepared and able to meet changing requirements over time. • Staff are enabled to work optimally in any place and at any time to meet the needs of the service and patients. • Staff who are no longer able to continue to work in their substantive role, have options to be redeployed to a different role that aligns with their current needs.	Q2. Apply learnings to other vulnerable workforces Q3. Continue implementation of learnings Q4. Review and make recommendations for improvements
Learning from COVID	Working with our union partners, develop an employment relations strategy to support learnings from COVID, emerging models of care, and innovations in service delivery that use the health workforce differently. **Activities:** • Identify recruitment criteria that can be introduced to enable increased diversity in recruitment to leadership positions. • Further develop and strengthen the Māori and Pasifika nurse and midwifery leadership group. (EOA) • The leadership development framework is developed in partnership with Māori, to ensure it enhances the ability of Māori to see themselves as leaders, access opportunities for development and be successful in leadership roles. (EOA) **Expected outcomes:** • Increased diversity of candidates at interview. • Māori and Pasifika nurse and midwife leaders experience ongoing support to lead. • The number of Māori and Pasifika engaging and developing to take up leadership and decision-making roles is increased.	**Employment Relations Strategy** Q1. Using the existing mechanisms for engagement with our union partners (BAG and JCC) collaboratively focus on analysing the learnings from Covid and apply to the future taking into account the health system transformation. Q2. Develop and agree the resulting employment relations strategy taking into account the recruitment and retention strategy work already underway. Q3 and 4: Implement the strategy. **Recruitment Practices** Q1. As a result of the pilot of new pro equity recruitment practices across Allied Health develop a new model of pro equity recruitment across all workforces that results in increased diversity especially in leadership. Q2. Commence implementation of the new pro equity recruitment practices and set review criteria Q3. Continue implementation and put review mechanisms in place Q4. Review, make recommendations for improvements **Māori and Pasifika nurse and midwifery leadership** Q1 and Q2: Through the networks already in place develop further strategies for supporting the Māori and Pasifika nurse and midwifery leadership 3&4. Implement strategies. **Leadership Development Framework** Q1: Continue design of a leadership development framework in partnership

		with Māori to ensure it allows Māori to see themselves in leadership roles. Q2 and Q3: Implement a suite of development opportunities.
Build the swabbing / vaccinator workforces	We will develop/use the swabbing and vaccinator workforce differently and increase the number of vaccinators. **Activities:** • We have a programme of work planned to increase the number of vaccinators. • Utilisation of technology to support future mobility and flexibility in terms of where the workforce work. • Establish a COVID vaccination workforce office to: - Identify, recruit and upskill clinicians currently not in the vaccination workforce (e.g. recently retired, registered health professionals eligible to extend scope of practice into vaccination) - Set up and maintain an easily identified pool of appropriately skilled staff who can provide surge capacity as and when needed. **Expected outcomes:** • Address concerns about workforce pressures on the swabbing/vaccinator workforces because of the pandemic. • Build a sustainable swabbing/vaccinator workforce.	Q2 and Q4: Update report of progress.
Increased diversity of representation in leadership or decision-making roles	In partnership with the Māori Council, develop and launch equity focussed leadership development and talent pipeline approach which grows Māori, Pasifika and disabled people leadership and increases diversity in leadership and decision-making roles. (EOA)	Q1. Develop capability statements for equity focussed leadership in all leadership roles. Q2. Ensure people processes reflect the achievement of equity focussed leadership. Q3. A talent pipeline is developed that increases diversity in leadership. Q4. Embed the priority capability in people /workforce strategies, learning programmes and leadership programmes.
Cultural competence and safety	In partnership with the Māori Council, develop a comprehensive learning programme that supports cultural safety and competency, and increases workforce capability to enact the enablers to achieving equity or outcomes. (EOA)	Q1. Identify cultural safety and capability expectations for all staff, and complete a gap analysis. Q2. Develop a staged capability building programme including a core learning programme for all new staff. Q3. Launch the programme. Q4. Monitor and review.

Ensuring work health and safety, and increased sustainability, health and wellbeing of workforces.	Implement a wellbeing programme designed to value diversity, reduce stigma around mental distress and build a supportive culture for staff.	Q1&2 Deliver capability development programme to build understanding, reduce stigma around mental distress and to increase people leader confidence and capability regarding mental wellbeing at work. Q3&4. Communications and culture campaign focussed on: Mental health and wellbeing. Diversity and inclusion. Interpersonal behaviour, prevention of bullying.

Data and Digital (F11-2DHB)		
Actions		**Milestones**
COVID-19 Recovery / Learnings[6]	1. Continued support, as required, to enhance our response to COVID-19 – for example enablement of the COVID-19 immunisation register and integration to support national rollout. **(3DHB)**	Alignment with the national rollout programme.
	2. Implement ePrescriptions solution to allow outpatient prescriptions to be sent to the pharmacy of choice directly without need for paper forms or face to face contact when telehealth consults were used. **(2DHB)**	Implementation with integration with MoH ePrescription service for all outpatient clinics by Q1. (The solution for the Addictions Service of MHAIDS is a separate project and completion is expected within 1-2 years.)
Most impact on improved outcomes	3. Implement the 3DHB Clinical Portal – a new clinical portal shared by all three DHB's. Patient safety and care quality improved by: • 3DHB patient data accessible in one location. • 3DHB patient data accessible in Central Region. • Cost reductions for the DHBs due to a shared infrastructure and simplified, supported solutions. • 3DHB improved system resilience, availability and disaster recovery capability. **(3DHB)**	Q3 20/21 - Business case signoff from MoH/DHB Q3 21/22 - Hutt Valley module live Q4 21/22 - CCDHB module live
	4. Implement 3DHB Smart eReferrals, intelligent scheduling and appointments platform. Consolidate to common e-referrals platform between primary, community and ambulatory care services across 3DHB. Deliver smart referrals connected to health pathways and consider acute, equity and disability context of patient journey. **(3DHB)**	Q4 21/22 - Deliver ICT foundation capabilities and master data synchronisation End-to-end service enablement process design Implement primary and community referrals

[6] 3DHB ICT were able to respond to the needs of the DHB with regard to our COVID-19 response without any significant delays to strategic initiatives and other work programmes.

	5. Implement Mobile Electronic Patient Observations. Patient safety and care quality improved by: • Reducing errors by removing paper charts and manual calculations • Immediate escalation of concerns based on observations to relevant clinicians • Reduction in effort required to capture observations. • Improved efficiency, as the mobile platform can be extended to other uses, such as drug charting, ordering, task management, results viewing and signoff.	Q1 21/22 - Business case submitted Q2 21/22 - Rollout to pilot teams Q3 21/22 - Rollout to all services Q3
Most important for improving digital inclusion	6. We will co-design healthcare access points and services with community and advocacy groups so that digital services are more widely accessible to all groups.	Q2 21/22 - Mobilising our community workforce to ensure the right enablers are available
Most important for improving equity	7. ICT solutions will support implementation of the Community Health Networks by: • partnering with community groups and leaders to link into targeted, trusted sources of information so that patients can find content that makes sense to them, and they know what they need to do to stay healthy • providing a more joined up view of patient care records, care plans and care participants • enabling mobile solutions for the health workforce • providing access to referral and clinical systems. The Community Health Networks are focussed on improving equitable access and outcomes. They are designed to deliver coordinated health care closer to the community, address population specific needs, and avoid unnecessary visits to ED or the hospital.	Initiate primary care and 3DHB working group for shared electronic health record vision and plan Frame capability requirements for supporting community networks, neighbourhoods initiatives Community Nursing & Allied Health Mobility in the Community requirements Q2 - Q4: Creation and maturity of locality based hubs and community networks (Kapiti, South Porirua, Wainuiomata &, Hutt Region) Q2 – Q4: Enablement of mobility tools for community care workforce Q4: Shared care planning framework and toolkit, in conjunction with shared care records work Q4: Initiation National child development services operating model. (MoH led)

Implementing the New Zealand Health Research Strategy (F12 – 2DHB)		
Actions		**Milestones**
COVID-19 Recovery / Learnings	Action 1: Time critical COVID-19 research will be given a high priory for institutional review via an expedited process. CCDHB will be well positioned to participate in crucial COVID-19 research and uptake learnings from that work. **(2DHB)**	Q1-Q4
	Action 2: Impacts of COVID-19 on clinical trial activity will continue to be monitored for risk assessment. Innovative strategies introduced as a result of COVID-19 will be assessed and implemented as appropriate. **(2DHB)**	Q4
Working with regional research networks	Action 1: Participate and Support funded by the HRC in 2020 Enhancing New Zealand's Clinical Trials (*Towards a national, equitable and sustainable clinical trial system in Aotearoa New Zealand).* **(2DHB)**	Q2
	Action 2: Establish 2021/2022 work plan for the national DHB research officers' collaboration (ROMA). Discuss and support development of national procedures and policies related to research across all DHBs. **(2DHB)**	Q1-4
Building DHB capacity and capability to enhance research and innovation	Action 1 Coordinate Māori consultation to guide proposal development for funding bids to Health Research Council in 2021 in collaboration with Research Advisory Group - Māori. Involvement of Māori at the earliest stage (and throughout) will enhance potential for the research to achieve Māori health advancement. **(2DHB)**	Q1-4
	Action 2: Establish a priority setting framework for specialties to identify and encourage research that will have maximal impact on CCDHB strategic goals. **(2DHB)**	Q4
Providing staff with professional development opportunities	Action 1: Support CCDHB applications for Health Research Council Career Development Awards. **(2DHB)**	Q2
	Action 2: Regular communication of national and international health research funding and training opportunities. **(2DHB)**	Q1-4

Care Capacity Demand Management (F13 - HV)	
Actions	**Milestone(s)**
General a) Develop Business as Usual work plan to commence once full implementation achieved post 1 July 2021 b) Complete Annual Standards Assessment for national governance group c) Complete Quarterly Milestone Report for national governance group d) Present CCDM at Orientation day for new employees e) Complete CCDM Quarterly progress for HVDHB Annual Plan for the Ministry of Health.	Q1-Q4
Governance a) Monthly CCDM Council meetings with stakeholders working in partnership with Unions to monitor and evaluate the CCDM programme b) Ensure programme work streams continue with monitoring and oversight of the CCDM standards	Q1-Q4

c) Continue communications to all stakeholders regarding the CCDM programme with Health Matters publication and staffing updates on the DHB intranet d) Work with the remaining two areas to commence Local Data Council e) Continue to monitor and evaluate the ward using Core Data Set for continuous ward improvement.	
Validated Patient Acuity a) Implement TrendCare updates within 3 months of release b) Complete annual Inter Rater Reliability (IRR) testing for all staff and within 6 weeks employment for new staff c) Attainment of 100% accuracy with the input of information into TrendCare d) Continue with weekly variance meetings to review TrendCare data and monthly exception reporting.	Q1-Q4
Core Data Set a) Continue to participate in the development of a 3 DHB sustainable IT platform for data collection and visibility of the Core Data Set b) Continue to develop the remaining measures for the Core Data Set (5 out of the 23 measures still to be developed) c) Continue the use of the Core Data Set Dashboards for monitoring and evaluation for improvement at Local Data Council, ward, service directorate and hospital level d) Measure success of CCDM through the Core Data Set.	Q1-Q4
Staffing Methodology a) Continue to monitor and report recruitment to approved ward/unit FTE b) FTE calculations to inform the 2020/2021 budgets (based on 2019/2020 data) have been completed and with the Ministry of Health for sign off c) FTE calculations to inform the 2021/2022 budgets (based on 2020/2021 data) will commence June 2021 d) Work with wards/units to reduce the recruitment timing of clinical staff with specific recruitment preference of Māori and Pasifika health professionals.	Q1-Q4
Variance Response Management a) Continue to monitor and evaluate variance response within the ward/unit of the hospital and implement improvements as necessary b) Continue to work with speciality areas to develop escalation plans in collaboration with 2DHB.	Q1-Q4

Better population health outcomes supported by primary health care

Primary Health Care Integration (G1-HV)	
Actions	**Milestones**
Community Health Networks We are re-organising our health system to place Community Health Networks and Community Mental Health and Wellbeing Hubs at the centre of health care service delivery, alongside increased investment in Māori health providers and Pasifika health providers. The Community Health Networks / Wellbeing Hubs will become the central organising point for delivering effective and efficient health care. They will support people to use home-based health services and technologies that treat and support people in the community, and connect people to specialist services and social support services when required.	
The DHB will continue to work in partnership with Te Ātiawa ki Whakarongotai/Kāpiti on the development of Kapiti Community Health Network. Building on the success of the Kapiti Community Health Network, we will establish a Community Health Network in an area with high Māori/Pasifika populations.(EOA) **(2DHB)**	Q2 Framework for implementation signed off by Board Q4 At least one new Network established.

Support all practices in the Health Care Home (HCH) programme to develop capability to deliver telehealth. **(HVDHB)**	Q2
Increase telehealth service delivery to 20% for the general practices in Year 3 of the HCH programme. **(HVDHB)**	Q4

Pharmacy (G2-HV)	
Actions	**Milestones**
Implement ePrescriptions solution to allow outpatient prescriptions to be sent to the pharmacy of choice directly without need for paper forms or face to face contact when telehealth consults were used. **(2DHB)**	Implementation with integration with MoH ePrescription service for all outpatient clinics by Q1. (The solution for the Addictions Service of MHAIDS is a separate project and completion is expected within 1-2 years.)
Boost immunisation capacity by increasing the number of pharmacies involved in immunisation activity. **(2DHB)**	Increase the number of pharmacies ready to provide immunisation services by 2 by Q3.
Identify opportunities for the pharmacy workforce to contribute to activities to increase influenza vaccine uptake, which could include participation, for example, in local events such as marae or church-based vaccination efforts. (EOA) **(2DHB)**	Engagement with Maori and Pasifika communities and providers completed by Q3. Four community based flu-vax clinics completed by Q4.
Review clinical pharmacist service to ensure it places emphasis on polypharmacy, reducing the risk and impact of fragility fractures, and addressing poorly managed, equity-focused conditions such as gout and diabetes. **(2DHB)**	Engagement with primary care completed by Q1. Revised action plan developed and started by Q3.
Improve medicine information access to improve patient safety and reduce search time. **(2DHB)**	Access to Concerto and Conporto enabled for all pharmacies by Q1. Undertake pharmacist training on Concerto and Conporto by Q2.

Reconfiguration of the National Air Ambulance Service Project – Phase Two (G3-2DHB)	
Actions	**Milestones**
CCDHB/HVDHB supports the aims of a world-class integrated aeromedical transport system that provides timely and excellent care to patients and reduces health inequities. CCDHB/HVDHB supports Phase Two of the process and outcomes with a focus on recognition that inter hospital transport involves DHB patients being moved by and under the supervision of DHB clinicians. Reconfiguration of this system must include; a) The expertise of flight nurses and intensive care doctors who are skilled in assessment, management and co-ordination of the critically ill. b) Continuity of the clinical expertise involved in the process of coordinating inter hospital transport of critically ill patients. c) Interoperability and compatibility of aircraft and stretcher systems used by DHB (ICU, NICU and PICU) teams, which is different to those in use in the prehospital domain. d) Provision of tertiary critical care at the bedside within resource-limited in-patient secondary Hospital facilities.	Q4 Status Update report

Long-Term Conditions (G4-HV)	
Actions	**Milestones**

COVID-19 Recovery / Learning	1. The DHB will work with primary care to implement identified opportunities from COVID-19 to increase the accessibility of primary care services, particularly for our Māori and Pasifika populations. (EOA) **(2DHB)** This work will include: • Working with our PHOs, Māori and Pasifika providers to ensure COVID-19 vaccine uptake is accessible for Māori, Pasifika and disabled people as part of Groups 2 and 3 Review access to after/hours services across the region with a particular focus on access for Māori, Pasifika and disabled people.	Q2, Q4
Nutrition and physical activity	2. The DHB and RPH will work with communities to increase awareness and promote healthy nutrition and physical activity to prevent onset and promote the education and management of long term conditions. (EOA) **(HVDHB)** This work will include: • Completing the review of the Diabetes Self-Management education service provided by Melon Health and consider whether this should be expanded or adapted.	Q2, Q4
Early risk assessment	3. Review and strengthen system pathways that support people living with diabetes, particularly Māori, Pasifika, and South East Asian. **(2DHB)** This work will include: • Identifying and prioritising practices with high rates of diabetes • Identifying and addressing gaps in provider education that will improve patient management • Improving referral pathways for specialist services	Q2 – Q4
Management of Long Term Conditions	4. The DHB will develop integrated approaches working with Māori and Pasifika providers and primary care to prevent and manage long-term conditions with a focus on CVD/Diabetes, Gout and respiratory disease.(EOA) **(2DHB)** This work will include: • Developing pathways to link with community providers of physical health and wellbeing services, education and health literacy • Developing better links between primary care and smoking cessation services across the region • Further developing opportunistic screening services to complete CardioVascular Disease Risk Assessment (CVDRA) checks in high risk Māori and Pasifika people working with a wider workforce.	Q2, Q4
Hepatitis C	5. The DHB will work with primary care and wider community providers to identify opportunities to improve the health of the DHB population through access to hepatitis C treatments. This work will be ongoing and further refined as information is released from the draft National Hepatitis C Action Plan. (TBD on release of National Hepatitis C Action Plan). **(2DHB)**	Q4
Improving ASH rates (SS05)	6. The DHB will identify opportunities to reduce ASH rates in top presenting conditions. This action will have a particular focus on our Māori and Pasifika populations. **(HVDHB)** This work will include: • Working with our Pasifika providers to collaboratively address inequities and high unmet needs in the Pasifika community. • Promotion of Primary Options for Acute Care (POAC) uptake for Māori and Pasifika patients. • Identify and implement approaches to improve access to respiratory services.	Q2, Q4
	7. The DHB will work with Primary Care to develop a new action model to deliver our ABC targets for offering brief advice to quit smoking. This model will support greater	Q2

	interactions in primary care and place greater emphasis on referral to smoking cessation services. **(2DHB)** This work will include: • Strengthening the relationships between primary care services and Takiri Mai Te Ata Regional Stop Smoking Service. • Evaluating the smoking targets and developing a plan to increase referrals to smoking cessation services.	
	8. The DHB will develop and implement initiatives to improve access to podiatry services for people living with diabetes. **(2DHB)** This work will include: • Establishing podiatry pathways • Developing approaches for prioritising high risk patients particularly Māori and Pasifika to ensure timely access to services.	Q2, Q4
	9. Provide pro-equity focused (Māori, Pasifika, disabled people) and COVID-19 recovery informed public health input as a member of the Wellington Regional Healthy Housing Group (WRHHG) steering group and working group(s) to implement the 2021 and 2022 WRHHG strategy and action plan. (RPH: core function – Health Promotion). **(3DHB)**	Q1-4
	In addition to the above actions, please refer to our 2021/22 System Level Measure Plan, which includes actions to reduce ASH rates for 0 to 4 year olds, with a particular focus on Māori children and Pasifika children.	
Contributory Measures:	a) Percentage or number of enrolled people in the PHO within the eligible population with a record of a Diabetes Annual Review during the reporting period whose HbA1c test result is 8% or less or 64mmol/mol or less. b) Primary Health Organisation (PHO) enrolled people within the eligible population who have had a Cardiovascular Disease (CVD) risk recorded within the last five years.	

2.2 Financial Performance Summary

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

$000s	2019/20 Audited	2020/21 Forecast	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
Revenue						
Ministry of Health Revenue	474,094	507,982	527,173	553,531	581,208	610,268
Other Government Revenue (including other DHBs)	114,327	132,990	135,335	141,689	148,348	155,327
Other Revenue	4,998	5,889	4,675	4,774	4,875	4,978
Total Revenue	**593,420**	**646,861**	**667,183**	**699,994**	**734,430**	**770,573**
Expenditure						
Personnel	204,366	200,856	206,370	209,466	211,560	213,676
Outsourced	18,385	36,552	22,772	23,181	23,472	23,771
Clinical Supplies	27,169	31,747	30,698	31,158	31,470	31,785
Infrastructure and Non Clinical	32,711	24,061	19,020	18,806	18,994	19,129
Payments to Other DHBs	101,298	107,521	143,894	151,089	158,644	166,576
Payments to Non-DHB Providers	218,584	227,815	231,201	256,411	269,231	282,693
Depreciation and Amortisation	14,917	21,680	15,996	16,996	16,996	16,996
Interest	12	19	24	24	24	24
Capital Charge	10,257	8,607	8,301	8,301	8,301	8,301
Other Expenses	4,504	4,938	5,745	5,823	5,882	5,938
Total Expenditure	**632,203**	**663,795**	**684,022**	**721,256**	**744,575**	**768,888**
Other Comprehensive Income						
Revaluation of Land and Buildings	19,866	-	-	-	-	(0)
Total Comprehensive Income / (Deficit)	**(18,917)**	**(16,934)**	**(16,839)**	**(21,262)**	**(10,144)**	**1,685**

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

$000s	2021\22 Plan	2022\23 Plan	2023\24 Plan
Intensive Assessment & Treatment			
Total Revenue	274,707	293,688	313,604
Total Expenditure	296,739	316,775	324,373
Net Surplus / (Deficit)	**(22,032)**	**(23,088)**	**(10,769)**
Prevention			
Total Revenue	27,173	28,511	29,916
Total Expenditure	25,501	25,425	25,832
Net Surplus / (Deficit)	**1,672**	**3,086**	**4,084**
Early Detection & Management			
Total Revenue	294,162	302,616	311,493
Total Expenditure	287,906	301,527	312,772
Net Surplus / (Deficit)	**6,256**	**1,090**	**(1,279)**
Rehabilitation & Support			
Total Revenue	71,141	75,182	79,425
Total Expenditure	73,877	77,529	81,597
Net Surplus / (Deficit)	**(2,736)**	**(2,346)**	**(2,172)**
Consolidated Surplus / (Deficit)	**(16,839)**	**(21,258)**	**(10,137)**

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.

HVDHB is not seeking any formal exemptions to the Service Coverage Schedule in 2021/22.

3.2 Service Change

Service Changes 2021/22

For 2021/22 please include a commitment statement confirming the DHB will manage its functions in a way that supports the intended direction and anticipated system change programme.

The table below describes all active service changes that have been approved or proposed for implementation in 2021/22.

Summary of Service Changes for 2021/22

Change	Description of Change/Initiatives	Benefits of Change	Location
National Agreements	Hutt Valley DHB will implement service changes arising out of national agreement processes including: • Integrated Community Pharmacy Services Agreement • PHO Services Agreement • Age Related Residential Care • Combined Dental Agreement.	The agreements are developed using annual processes to identify priorities for service change in with consultation with the respective sector and DHB representatives.	National
FACT accreditation	CCDHB will be a FACT (Foundation for the accreditation of Cellular Therapies) service by the end of 21/22. FACT accreditation is the international certification required for Stem cell transplantations units to confirm they are running a high-quality clinical service.	FACT is important for allogeneic transplant units such as at CCDHB because the international donor registries are imminently moving to only collect stem cells for units that are FACT accredited. Not being FACT accredited is a threat to ongoing viability of the Stem cell transplantation unit.	Regional
Hospital Provider Performance	• Joint 2DHB planning to deliver local volumes and manage through peak occupancies • Increasing specialist support for primary care to lower unnecessary hospitalisation • Establishing robust outsourcing arrangements • Embedding virtual outpatient assessments and virtual advice to GPs	• Improved control of planned care contributing to maximisation of planned care revenue • Optimising use of outsourcing to deliver planned care efficiently.	Sub-regional

Change	Description of Change/Initiatives	Benefits of Change	Location
	Developing procedure rooms at the Hutt campus for those non-theatre procedures currently done in theatre.	• Improved productivity of surgical and procedure delivery optimising cost of service delivery.	
Acute and urgent care management in the community	• Partnering with Mana Whenua and community leaders to commission integrated services in Porirua and Wainuiomata • Working in partnership with other agencies to address the underlying determinants of health, including cross-agency work on improving housing, suicide prevention, and preventing family violence. • Community activities to increase the uptake of flu vaccinations • Working with the Ministry to continually improve the COVID-19 response system, roll out the COVID-19 immunisation programme (once developed), and implement our COVID-19 recovery plans to ensure that our patients receive the care they need. • Improving access to primary care, especially after-hours services, particularly for Māori and Pasifika children and families. Introduction of a permanent second acute OT at HVDHB.	• Improved access to care closer to home • Reduce avoidable admissions to hospital • Reduced operating costs	Sub-regional
Joint 2DHB Clinical Networks	We are establishing 2DHB clinical networks to maximise the effective use of resources and workforces across the two DHBs (HVDHB and CCDHB) and three hospital site (Wellington, Kenepuru and Hutt Valley). This supports clinically sustainable services and improves the financial sustainability of both DHBs, and infrastructure that enables ongoing sustainable care provision.	• Improved local access to services • More equitable health outcomes • Improved clinical pathways and service alignment across the region • Enhanced service sustainability and resource utilisation • Networked services which maximise resource utilisation to make best use of capacity • Enhanced training opportunity	CCDHB and HVDHB
Community Health Networks	Building on the Kāpiti Community Health Network (CHN) prototype established in 2020, Community Health Networks will be rolled out across both districts to improve access, experience of care, and outcomes for people living in defined local areas. The CHNs are community teams of nurses and allied health staff supporting GP practices. The CHNs will become the central organising point for delivering effective and efficient health care. They will support people to use home-based health services and technologies that treat and support people in the community, and connect people to specialist services when required. In 2021/22 we will establish at least one CHN in CCDHB and at least one in HVDHB. Both CHNs will	• Improved equity of access and outcomes for Māori and Pasifika populations. • Improved access to care closer to home. • Improved management of frailty and avoidable hospitalisation. • Improved patient experience and outcomes.	CCDHB and HVDHB

Change	Description of Change/Initiatives	Benefits of Change	Location
	be located in areas with high Māori and Pasifika populations.		
Community mental health and wellbeing hubs	In 2021/22 we will co-design a service model and complete an investment business case to implement an integrated community mental health and wellbeing hub in high deprivation areas. The current priority localities are Porirua and Naenae. The will be a collaborative process with a strong kaupapa Māori focus. **(2DHB)**	• Improved equity of access and outcomes for Māori and Pasifika populations. • Improved access to care closer to home. • Improved management of mental health conditions and avoidable hospitalisation. • Improved patient experience and outcomes.	CCDHB and HVDHB
Maternity Facility Redevelopment **2021-2023**	Improvement to community midwifery assessment space, maternity assessment unit, antenatal / postnatal and birthing / SCBU. Capital investment funding secured. Addresses safety and quality issues for women, babies and staff.	• Improved health and wellbeing outcomes • Improved equity with culturally responsive environment • Greater flexibility and efficiency with redesign of physical environment	HVDHB
Community Radiology	We expect to make eligibility changes to community radiology to put greater emphasis on equity.	• Improve overall access to community radiology • Greater emphasis on equity • More equitable health outcomes	CCDHB and HVDHB

FTE Reconciliation - HVDHB

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.

Full Time Equivalent (FTE)	2020/21 Plan	2021/22 Plan	Change
Medical Personnel	289	289	-
Nursing Personnel	838	788	(50)
Allied Health Personnel	418	365	(53)
Support Personnel	137	147	10
Management/Administration Personnel	388	338	(50)
Total FTE	**2070**	**1928**	**(142)**

Hutt Valley DHB has also been following a pathway to breakeven over three years, dependent on 2DHB Hospital network and back office consolidation. Drivers impacting this are lower revenue increase than expected in 21/22, continuing cost pressure and risks built up over years of successive deficits. FTE numbers have been tightly controlled with minimal growth to the underlying base.

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.

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 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.

The DHB and RPH continue to collaborate with Te Hiringa Hauora (the Health Promotion Agency), 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, Pasifika, and people on low incomes is a key focus of this work.

Work health and safety

Work health and safety is integral to DHB operations. We are committed to improving health and safety across the health workforce as is evidenced with the introduction of a 2DHB Quality and Safety framework. This is an overarching framework that drives our programmes of quality and safety, reduced harm, clinical excellence and reflects the interdependencies between staff and patient safety. The framework supports 2DHB to meet or exceed is legislative obligations under the Health and Safety at Work Act 2015. The framework principles mirror those held within the Quadruple aim and are:

- Commitment to deliver safe, quality care to patients and whanau, and ensuring staff safety.
- Strengthen quality and safety at every level through effective leadership, integrated governance and defined accountabilities across health and disability

- Build staff resilience through leadership, professional development and mentorship for staff.
- Making safety and quality the accountability of each and every employee so as to lead a culture where organisational values drives actions and teams work together to keep patients and staff safe.

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.

4.2 Building Capability

Capital and infrastructure development

In 2020 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 was 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 included $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

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.

Our health and disability system is poised for significant transformation. Our workforce priorities for the coming period focus on sustaining high quality healthcare provision and achieving increased equity outcomes in the context of complex change. Building readiness to realise the improved health outcomes includes; increasing diversity of representation, cultural competence and safety and ensuring that we have a sustainable and robust workforce.

The arrival of COVID-19, means that the context for this change is one of volatility and uncertainty. Key capabilities for our health workforce and systems will include the ability to forecast proactively and respond rapidly and flexibly to future challenges, through development of a technologically capable workforce that is supported to excel.

A collaborative whole of system approach will be essential in navigating these challenges, connecting local activity with regional and national planning priorities, developing cross-functional professional and structural relationships and in partnership with unions to enhance workforce capability and wellbeing.

HVDHB employs over 2600 staff, making us the largest single employer in the Hutt Valley (Te Awakairangi).

Workforce priorities for 2021/22:

- Grow our Māori, Pasifika, and disability workforce, to increase the diversity of representation in leadership and decision making roles, and to reflect the communities we serve
- Increase the capability of our workforces to provide culturally safe care
- Create the conditions for innovative ways of working, to ensure that the expertise and skills of the whole workforce are utilised optimally (right skill, right time, right place)
- Articulate accurate workforce data and analytics, which enable enhanced understanding of workforce dynamics to support pro-equity initiatives
- Develop sustainable workforce plans to address workforce vulnerabilities (that impact access and sustainability of services)
- Training for Postgraduate Year One and Two resident doctors (PGY1s and PGY2s).

Organisational Culture priorities for 2021/22

- Create an organisation culture and systems that are pro-equity
- Enable a technologically capable workforce
- Build a culture of collaborative relationships with and between professional groups to work together to achieve improved patient outcomes
- Enable people to excel and achieve transformation goals
- Learn from COVID-19 experiences to identify opportunities to use workforces differently and to increase workforce flexibility and mobility
- Support and strengthen system resilience and staff health, safety and wellbeing, including mental wellbeing.

Information technology and communications systems

Over the next financial year and beyond, 3DHB Data and Digital will continue to deliver high quality, fit for purpose digital tools to the DHBs and the wider health community. 3DHB Data and Digital supports the DHB to deliver its strategic goals as well as the expectations of the Minister of Health and the Ministry.

3DHB Data and Digital have developed a new digital strategy, consisting of five major themes that inform our operating model for a modern data and digital business unit:

3DHB Data and Digital works at a national level and with regional partners to ensure that we leverage good thinking and existing solutions to reduce the national complexity and variety of Heath ICT solutions. A critical success factor will be the co-development of national health data interoperability standards. These standards will enable sharing of information across all DHBs thus achieving a virtual national health record.

The table below shows how the 3DHB Data and Digital strategic themes are related to meeting the government's planning priorities and the DHB's strategic priorities.

Government Priority	DHB Strategic Priority	Data and Digital Strategic Theme
Giving practical effect to the Maori health action plan	Intensify service delivery for those who have higher needs to reduce inequalities	Theme 4: Equity of access and health outcomes, especially for Maori, Pasifika, and people with disabilities
Improving sustainability	Organise technology and interdisciplinary teams in homes, communities and hospital to ensure efficient use of resources Implement models of care that intervene earlier in lower cost settings	Theme 5: Empowering our workforce to deliver high quality, efficient care
Improving child wellbeing	Work in communities to improve health and wellbeing and prevent or delay the onset of illness	Theme 1: Health Options in our Communities
Improving mental health wellbeing	MHAIDS Service Improvement	Theme 1: Health Options in our Communities Theme 2: Empowering people as partners in their care
Improving wellbeing through prevention	Work in communities to improve health and wellbeing and prevent or delay the onset of illness	Theme 1: Health Options in our Communities Theme 2: Empowering people as partners in their care Theme 3: Seamless collaboration across our greater Wellington sub-region and wider health ecosystem
Better population outcomes supported by a strong and equitable public health and disability system	Intensify service delivery for those who have higher needs to reduce inequalities	Theme 3: Seamless collaboration across our greater Wellington sub-region and wider health ecosystem
Better population health and outcomes supported by primary care	Work in communities to improve health and wellbeing and prevent or delay the onset of illness	Theme 2: Empowering people as partners in their care

3DHB Data and Digital continues to upgrade and update our legacy technology 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.

We continue to progress our programme of consolidation of disparate bespoke solutions across the Wellington regional DHBs. Key initiatives, such as patient administration systems (WebPAS) consolidation, will enable centralised and consistent patient management. We are also consolidating the clinical portals (Concerto) that will enable better patient care and cost efficiencies. There is also an increased focus on the corporate systems and the tools needed to run an effective health service. We are working with the corporate functions across the three DHBs to standardise the tools and systems.

3DHB Data and Digital also actively supports the DHBs with regard to their Covid-19 response and improving systems to support any further community outbreaks and potential lockdowns. The Digital Workplace programme is particularly important in this area as this will further our workforce to work remotely.

There are four key programmes of work aimed at improving the stability and resiliency of our existing clinical and corporate systems, improving operational efficiency, and enhancing patient care. The key programmes of work are described below.

Clinical Workspace Programme

The Clinical Workspace programme includes five primary projects designed to modernise and mobilise systems and processes within the health sector. These projects are:

- **3DHB Clinical Portal** – a new clinical portal shared by all three DHBs. The value to the business and to our communities by ensuring patient data is accessible in one location and able to be accessed through the central region clinical portal, supported by increased resilience, availability and disaster recovery.
- **3DHB Éclair** – consolidating 3DHB laboratory ordering, processing and sign-off, which provides value through laboratory data accessible in one location via the 3DHB Clinical Portal and available to the central region. Reduced costs for the DHB through shared infrastructure and increased resilience.
- **ePrescribing for Outpatients** an electronic prescribing tool whose value includes, patient safety and care quality improvement and more convenience for patients when collecting prescriptions combined. The tool also ensures our compliance with the Medicines Act and is integrated into our 3DHB Clinical Portal.
- **3DHB Regional Radiology Information System** replacing our existing aging and out of support radiology information system which is currently posing significant risk and adds additional value through shared infrastructure and simplified, supported solutions and the ability to outsource clinical investigations and/or reporting between both DHB's and external partners.
- **Mobile Clinical Platform (MEPO)**, a new mobile platform, initially for the purposes of electronic observations, early warning scores, nursing assessments and clinical photography – but with the scope to replace other manual and paper based systems though a mobile phone interface. Expected to deliver new value to the DHB's though clinical efficiencies, reduction in errors seen with manual paper charts and provides extensibility to other functions such as ordering, results viewing and signoff, electronic drug charting and administration.
- **3DHB eReferrals for Primary, Community and Ambulatory Care** provides a smart eReferrals, intelligent scheduling and appointment platform, this provides for patient safety and care quality improvements, shared infrastructure and simplified, supported solutions, integration into the 3DHB Clinical Portal as a single source of digital information.

Digital Workplace Programme

The Digital Workspace Programme aims are to deliver modern digital desktop and devices, with robust information management practices, together with modern collaboration and communication tools. The programme includes four focus areas to transform the digital environment within the organisation:

- **Modern Devices, Desktops and Office**: delivers devices to staff which meet their requirements with regard to form factor and capability. Implements managed, modern Windows 10 environment with O365 including Teams, SharePoint and OneDrive. Allows for access to the same IT resources across multiple device types, enhanced user experiences with information easy to find and provides for flexible working options creating better outcomes for pandemic response, staff mobility, morale and operational efficiency.
- **Digital Foundations**: delivers the foundational infrastructure and improved policy and system configuration to support the rollout of the new modern way of working through new remote access solutions to support seamless end user experience whether working in the office or remotely, improved on campus Wi-Fi to support predominantly mobile workforce with high degree of security and ensuring that the right individuals have the appropriate access to technology resources together with improved protection of our data assets and our Identities from malicious actors.
- **Unified Communications:** replaces legacy PBX systems with cloud based contact centre platform, new IP based telephony end points for critical areas and MS Teams based Telephony (chat, calling, and

conferencing) for individual users by de-risking the DHB's communications systems failure by replacing aged telephony systems (PBXs), improving availability and functionality of critical communication services and enhances organisational resilience and ability to respond to emergency scenarios (e.g. pandemic/earthquake) with capability to support fully mobile workforce.

- **Information Management:** implements good Information Management practice ensuring data is correctly categorised, retained and easily searchable where, staff are able to access and locate the right information they need and when they need it. Makes the data easily searchable and accessible to relevant staff and solution that meets our obligations under the Public Records act. Reduces the number of duplicated tools which will reduce costs to maintain, update and support and increases the ability to utilise cross-functional and cross sector teams to address health system challenges.

Resilient Systems

To ensure that DHB systems continue to function with minimal downtime and that data on these systems is can be restored in the event of data loss 3DHB data and digital have a number of projects currently underway and planned for the next financial year. These projects include:

- Improving resilience of clinical and corporate systems and staff productivity through replacement and increasing the availability of PCs, Tablets, Laptops, Terminals, & Screens.
- Improve information security through implementation of tools such as threat detection and auditing, this includes all security systems with an ICT component, improving resilience and performance of clinical and corporate systems through replacement of aged ICT servers and a planned migration of DHB systems as a service offerings.

Additionally we will maintain stable, secure systems by ensuring our aged network equipment is replaced. We are in the process of updating our backup and recovery system so ensure that our data is safe and can be easily retrieved in a reliable and cost effective manner. We also have a programme for the continuous upgrading of clinical and corporate systems to ensure they are up to date.

Regional/National Systems

3DHB ICT continue to contribute to regional and national systems and, in particular, the regional clinical portal via data sharing, regional WebPAS and Regional Radiology Information System (RRIS) work. The DHB will be supporting and aligning our technology decisions to support national programmes, including the National Health Informatics Platform (NHIP HIRA) as well as the NHI and HCP systems through the adoption of Application Programming Interface (API's) and the use of interoperability standards such as FHIR (Fast Healthcare Interoperability Resources).

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 2021/22 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 2021/22 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 Pasifika 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 Pasifika 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	Focus area 1 (Youth SLAT): Provide reports as required	
		Focus area 2 (School Based Health Services): Provide reports as required	
		Focus area 3: (Youth Primary Mental Health services) refer MH04	
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 (0-24 year olds)	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	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	Provide rates and narrative around what the data is telling us	
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.	
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)	≤4340	
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*	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*	11.8%.	
		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 2021/22 year.	

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 85% and less than 95%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		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 4: Improving the quality of ethnicity data.		
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified		
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions to: Support people with LTC to self-manage and build health literacy.	
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*	
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity	
		Focus Area 3: Cardiovascular health	Provide reports as specified	

		Focus Area 4: Acute heart service	**Indicator 1: Door to cath** - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram**.**
			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and **Indicator 2b:** ≥ 99% within 3 months.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - 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 2021/22

System Level Measures Improvement Plan 2021/22

22 February 2021

Signatories for the 2021/22 HVDHB SLM Plan

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HVDHB and CCDHB

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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. In 2020 COVID-19 both progressed model of care transformation and delayed some parts of our 20/21 SLM delivery. We have reviewed and updated the plan, introducing new actions to reflect current priorities where appropriate.

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. All measures, including contributory measures, will be broken down by ethnicity so that we can monitor equity on a population basis.

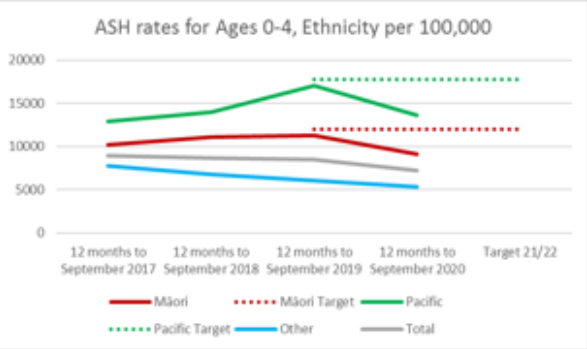
This integration work programme is driven by the networks and sub-groups of the Alliance Leadership Team. Child Health, Mental Health, Acute Demand, Health of Older People and Youth Health are the five key areas of focus for the Alliance. The membership of Hutt Inc includes representation from across 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.

Hutt Valley and Capital and Coast DHBs are increasingly taking a 2DHB approach to addressing health need, creating improvements and delivering health care. This year our Alliances will work together to share and develop initiatives in order to drive improvements across both DHBs.

Keeping children out of hospital

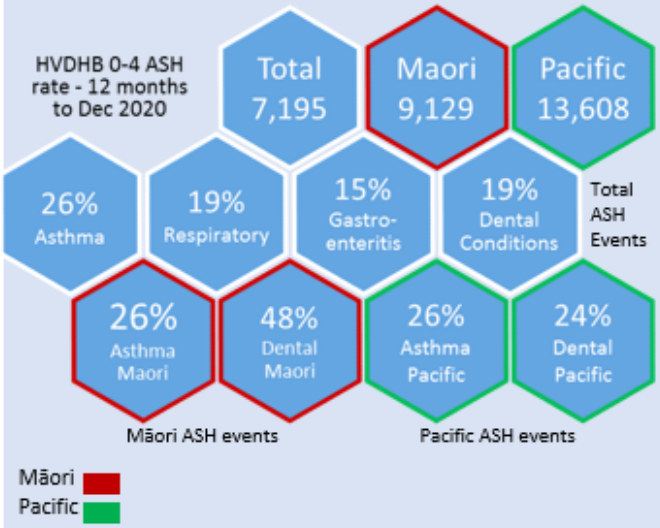
System Level Measure: ASH rates per 100,000 for 0-4 years.

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.** Hutt Valley has high rates of 0-4 ASH admissions compared to the national average for Māori and Pacific populations

There was a reduction in ASH rates 0-4 years during 2020 which is likely due to Covid-19 response, with early signs that this trend is reversing. Our aim is to maintain ASH rates in 0-4 years per 100,000 children at or below December 2020 rates, (12,007 for Māori, 17,789 for Pacific) and also to reduce the equity gap between Hutt Valley Pacific and Māori ASH rate and the Hutt Valley Other ASH rate by 5% (As of Sept-20, Māori/Other gap: 3,797 and Pacific/Other gap: 8,275. By Jun-22 we wish to reduce this gap to Māori/Other gap: 3607 and Pacific/Other gap: 7,861).

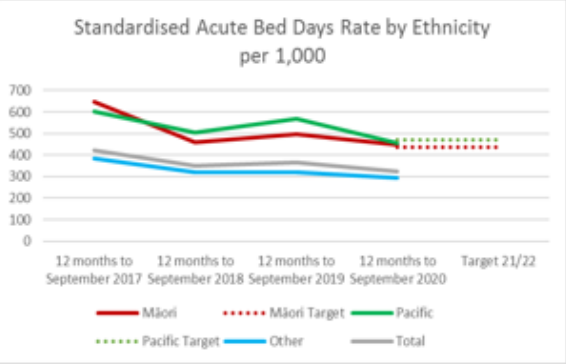


Opportunity	Actions	Contributory Measures
Midwives (including LMCs) and Well Child/Tamariki Ora nurses often visit families in their home. When needed, they can facilitate referrals to Tū Kotahi Māori Asthma and Research Trust (Tū Kotahi) and the Well Homes Service.	• Review the relevant respiratory Health Pathways to reflect best practice and ensure effective and efficient prompts and links for referrals to Tū Kotahi, Well Homes, and other community health and social services	• Number referrals to Tū Kotahi and Well Homes service
Over 20% of children admitted to hospital with asthma/wheeze have 2 or more admissions within the year. 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. • PHO's clinical pharmacists will provide education about the new asthma guidelines, and correct inhaler technique to General Practice clinical teams • Work with the paediatric inpatient unit to enable Tū Kotahi to provide support and education to patients and whānau on the ward	• Number of proactive care plans • Respiratory-related ASH rates for 0-4yrs
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 of children provided with supervised tooth brushing and education, and the knee-to-knee programme. • Dental ASH rates for 0-4yrs

Using health resources effectively

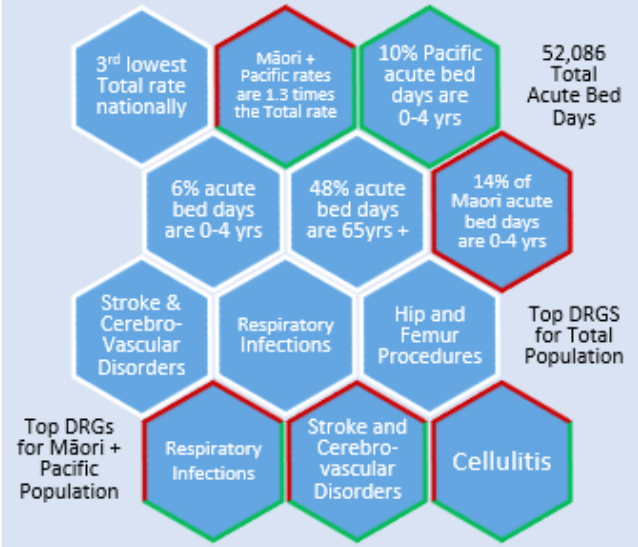
System Level Measure: Acute hospital bed days per capita.

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



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. 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.

There was a reduction in Acute Hospital Bed Days during 2020 which is likely due to Covid-19 response, with early signs that this trend is reversing. Our aim is to maintain acute hospital bed days at or below December 2020 rates (436 for Māori, and 469 for Pacific), and also to reduce the equity gap between acute hospital bed days for Pacific and Māori, and Other by 5% (As of Sept-20, Māori/Other gap: 151 and Pacific/Other gap: 162. By Jun-22 we wish to reduce this gap to Māori/Other gap: 143 and Pacific/Other gap: 154).

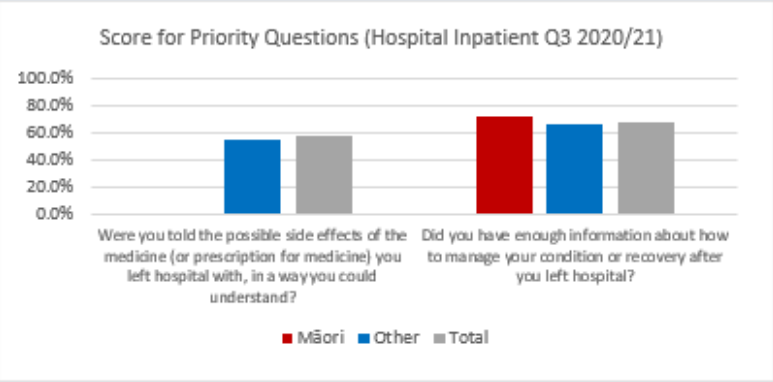


Opportunity	Actions	Contributory measure
Growth in ED presentation numbers continues. Enhancing the management of people in primary care via community based services will support people to receive care in the community, reducing the need for ED presentation. We are focusing on **reducing hospital admissions 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.	• Implement at least one Community Network in the Hutt Valley to enable integrated ways of working across all health services. Community Networks will allow us to identify and focus on priority populations such as those people with Respiratory illness, and improve services to address the local need • Increase the number of care plans, prioritising Māori, Pacific and high-user patients	• Respiratory-related ASH rates for 45-64yrs • Age-standardised ED presentation rate • Number of care plans
There is an opportunity to **apply the learnings from the 2020 flu season** so that we maintain the high 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 • Increase the number of services and sites providing influenza vaccine, including pharmacies, marae, churches and other community settings • PHOs will support General Practice to appropriately prioritise flu vaccine or Covid-19 vaccine, based on most current recommendations, knowing that Covid-19 vaccine cannot be given concomitantly with the flu vaccine this year	• Influenza vaccinations for 65 year olds and over

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.



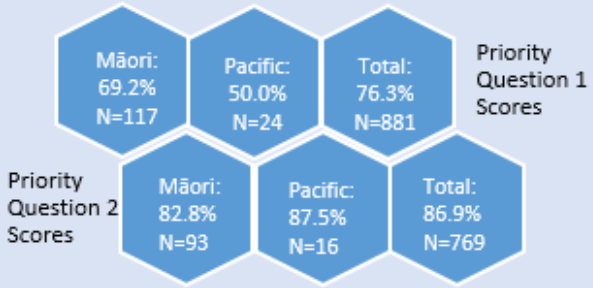
Please Note: Please Note: Pacific Scores and the Māori score for question 1 are not available due to low sample size.

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, however a measure to reduce the equity gap in these questions is not useful, owing to the high variability for Pacific and Māori results due to low sample sizes.

We aim to increase the total score for the priority questions in the Hospital Survey by 5% (to 52% for Question 1 and 55.8% for Question 2).

We aim to increase the total score in the priority questions in the Primary Care survey by 2% (to 78.3% for Question 1 and 88.9% for Question 2).

Primary Care PES - data from Q2 2020/21



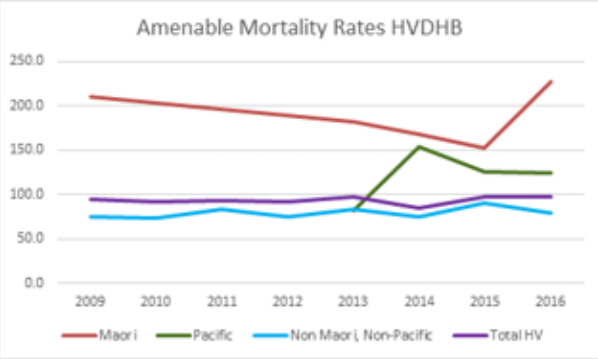
Priority Questions
1. In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you couldn't get it? **Answered No**
2. "Did the [HCP] involve you as much as you wanted to be in making decisions about your treatment and care?" **Answered Yes**

Opportunity	Actions	Contributory measure
Improve staff understanding of Te Ao Māori and Māori patient's cultural needs. This will improve experience of Māori admitted to hospital, and the quality of discharge information they receive.	• Continue to provide Module 1 of Te Kawa Whakaruruhau cultural safety training (Te Tiriti o Waitangi and Māori history) which is available to all clinical (and non-clinical) staff at the DHB and in Primary Care • Start delivery of Module 2 of Te Kawa Whakaruruhau cultural safety training (Te ao Māori) • Māori Health Unit and the Quality Team will work with hospital departments to ensure an equity lens over Quality Improvement Projects, and support and encourage the use of HEAT (Health Equity Assessment Tool). Results of the patient experience survey, including discharge processes, will be one of the drivers of Quality Improvement Projects	• Numbers of staff attending Module 1 and Module 2 of cultural safety training • Results of hospital survey question: "Did you feel your cultural needs were met?"
Improve patients (Maori and Pacific as a priority) experience, understanding, involvement and partnering with their care in Primary Care	• Increase the number of practices that actively seek consumer input into services (for example consumer stakeholder groups) • 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). 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	• Number of practices with a formalised consumer consultation process • Percentage of patients in the target group with a Care Plan

Prevention and early detection

System level measure: Amenable mortality rates

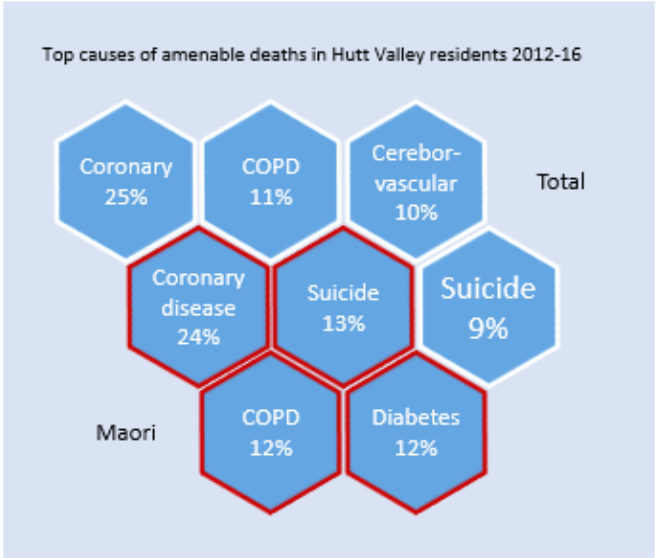
We are enhancing the management of long term conditions and targeting prevention approaches and support for Māori and Pacific to reduce disparities.



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.

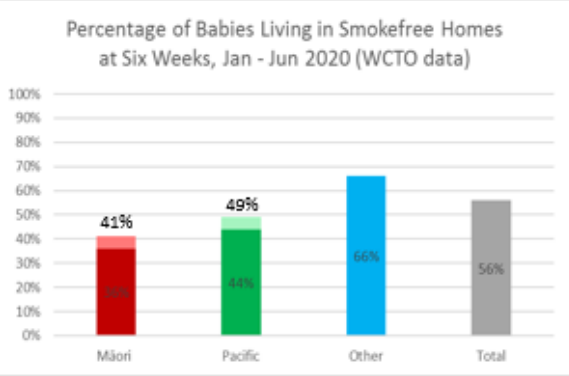
The actions in our improvement plan focus on prevention by strengthening community wellbeing, access to screening and early intervention, enhancing the management of long term conditions, and targeting prevention approaches and support for Māori and Pacific to reduce disparities.



Opportunity	Actions	Contributory measure
We can **improve the management of long term conditions** in primary care.	• PHO clinical pharmacists will develop a programme with practices to identify Māori, Pacific and South Asian people (males >30 years and females >40 years) with no cardiovascular history for proactive screening and assessment, as per CVDRA guidelines • Practices will increase numbers of care plans, prioritising Māori and Pacific patients	• No. of cardiovascular disease risk assessments completed for identified population • No. of people with a CVD event in the previous year, on appropriate treatment (BP check, statin and aspirin prescription) • Percentage of people with diabetes aged 15-74 years 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. • Develop options to improve access to maternal mental health services supporting mild to moderate presentation, particularly for Maori, Pacific and those living in deprivation. • Maintain and expand the connections between the general practice teams, secondary mental health services and NGOs	• Self-harm presentations to ED, and rates and number of hospitalisations, by age groups
We can **intervene early in the life course** to support children (and their whanau) to make healthy choices	• 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

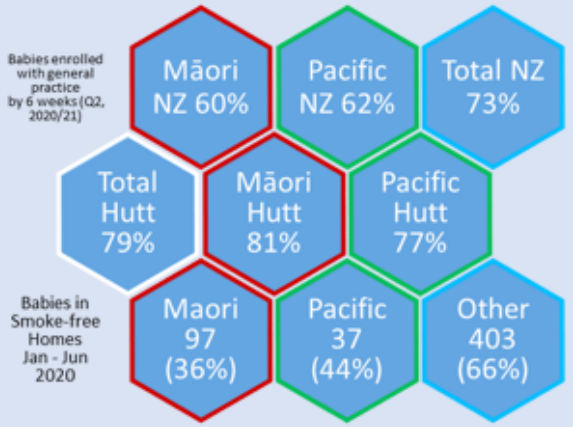
System level measure: proportion of babies who live in a smoke free household at 6 weeks postnatal. We are focussed on ensuring that whanau are supported in their smoking cessation journey as part of their overall health care needs.



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 2020 as the baseline). This means our target for 2021/22 is 41% of Māori babies (111 babies) and 49% Pacific babies (41 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, 2020/21, 81.4% of Māori newborns are enrolled with a general practice by 6 weeks of age.



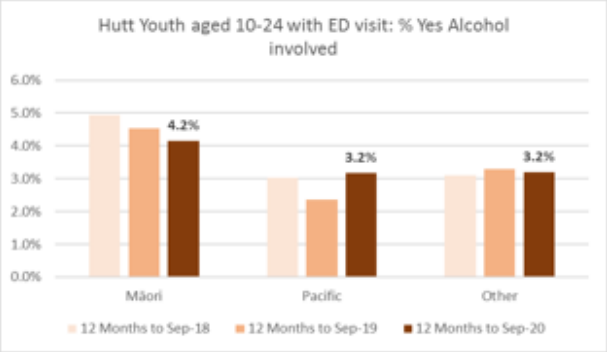
Opportunity	Actions	Contributory measure
Hutt Valley Smokefree Action Plan will include targeted actions that support hāpu wāhine and other Māori women and their whānau to quit smoking and adopt smokefree households.	• PHOs to support education for non-registered health workers in Primary Care (Health Coaches, Kaiawhina and Primary Care Practice Assistants) around smoking cessation brief advice, and smoking cessation services available	• Better Help for Smokers to Quit Primary Care results – brief advice
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.	• Establishment of more 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). • Work with the newly established midwifery Smoking Cessation Champion for Hutt Valley DHB to develop and embed the role	• Number of GP Smoking Cessation Champions established in 2021/22 • Better Help for Smokers to Quit Primary Care results – cessation support
We will provide **resources and training** to health practitioners so that they are well equipped to support pregnant women and their whānau to quit.	• Support the provision of **training for WCTO staff,** to improve brief advice discussions and support of patients who smoke. • **Continue to embed the Generation 2040 initiative**, which offers pregnant women an Early Pregnancy Assessment including smoking cessation support.	• Better Help for Smokers to Quit Maternity results – brief advice and cessation support • Uptake of Generation 2040 initiative

Youth are healthy, safe and supported

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

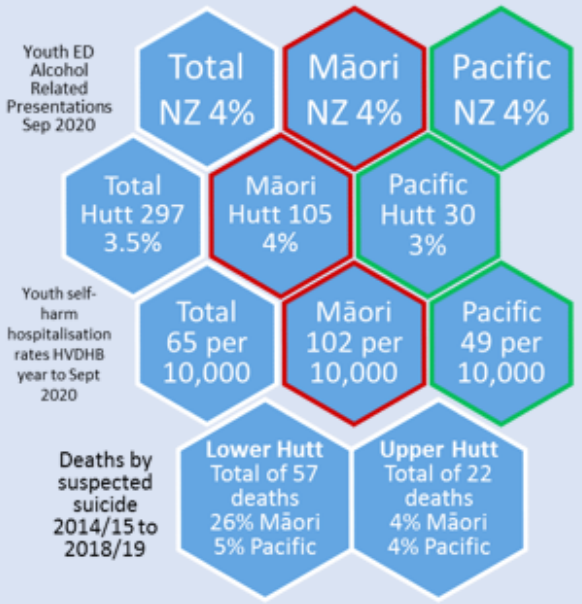
We are implementing the recommendations of a review of youth health needs to ensure our youth are supported to build healthy and safe lives.

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%. Our rates for alcohol involvement 'unknown' are low compared to the national standard, so we have focussed on 'yes' responses. 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 3.2% for the year to June 2022 (the baseline is 4.2% for the year ending September 2020). A reduction to 3.2% means we need to achieve about 25 fewer Māori youth ED presentations involving alcohol in 2021/22.

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.



Opportunity	Actions	Contributory measures
Improve wellbeing and achieving equity	• Design and commission 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. • Referrals to the Mental Health and AOD consult liaison service • Attendance rate at wellbeing education course • Evaluation of wellbeing education course completed
Increase youth access to mental health and addiction services.	• **Embed the Access and Choice model, based on Te Tumu Waiora** to enhance and extend primary mental health and addictions services for young people in the Hutt Valley. • Embed, monitor and expand **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	• Implement the Youth Health Care in Secondary Schools framework by creating a formal youth engagement process in co-design with young people to support future DHB work. • Evaluate the secondary school wellbeing education module (Rangitahi Whakapakiri Tinana) at Naenae High School, and consider the benefits and requirements for wider provision of this course	