HAWKE'S BAY District Health Board Whakawāteatia	**FINAL DRAFT Hawke's Bay District Health Board Annual Plan 2017/18 and Regional Service Plan 2017/18** 66
	For the attention of: **HBDHB Board**
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Reviewed by:	n/a
Month:	June, 2017
Consideration:	For Approval

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RECOMMENDATION

That HBDHB Board

- Approve the Final Draft Regional Services Plan 2017/18 and give permission for Central TAS to use the CEO and Chair's signatures in the Final.
- Approve the Final Draft Annual Plan and delegate two signatories to sign off the Final Plan once the financials are completed and Ministry of Health (MOH) approval has been received.

OVERVIEW

The Draft HBDHB Annual Plan 2017/18 and Central Region Regional Service Plan 2017/18 was submitted to the Ministry of Health (MOH) in March 2017. Since then we have received guidance on additional priorities to include in the plans and feedback on the drafts that were submitted.

A number of delays in information received from the MOH has led to ongoing delays in the planning process. The Regional Service Plan 2017 is attached in its final draft form, however the Annual Plan will be evolving right up until the due date of the 30th June. Due to the late delivery of the funding envelope, the financial section of the Annual Plan has not been included as the budget has not been approved in time to include in the paper. This will be made available to the Board as soon as possible following approval of 2017/18 budget.

Final Draft Regional Services Plan

The Regional Service Plan has been developed through the Regional Networks in each of the priority areas. The priority areas have remained similar to last year with the addition of a new emerging priority added late in May– Sudden Unexpected Death in Infancy National Prevention Programme in response to the Minister's new programme to be implemented from July 2017. The plan also includes refreshed Central Regional vision, values, priorities and governance.

Approval:

It is recommended that the Board approve the Regional Service Plan 2017/18 and give permission for Central TAS to use the CEO and Chair's signatures in the Final Plan.

Final Draft Annual Plan

The Final Draft Annual Plan is being submitted as a late paper and still requires more work prior to submitting to the MOH on 30th June.

The guidance on the two new Better Public Service targets to include in the 2017/18 plan was not received from the MOH until mid-June. These targets are:

- Healthy Mums and Babies: 'By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups'
- Keeping Kids Healthy: 'By 2021, a 25% reduction in the rate of hospitalisations for avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019'

Feedback from the MOH on the draft was centred around being more explicit about equity actions for Elective Health Target, Raising Health Kids Health Target, Mental Health and Primary Care Integration.

Due to the change in timeline this year for the funding envelope, the financials have not been confirmed in time to submit with these papers as they will be presented at the same Board meeting and therefore are not included in the Final Draft presented to you. Once approved, the financials will be slotted into the Annual Plan.

Approval:

It is recommended that the Board approve the Final Draft Annual Plan 2017/18 and delegate two signatories (in addition to the Chair) to sign off the plan once it is complete. It will be shared with the Board in its final state, prior to sign off.

ATTACHMENTS

Central Region Regional Service Plan 2017/18

Late Paper – Hawke's Bay District Health Board Annual Plan 2017/18

E83

Hawke's Bay District Health Board

Annual Plan and Statement of Performance Expectations 2017/18

Final Draft v2.0

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OUR VISION

"HEALTHY HAWKE'S BAY"

"TE HAUORA O TE MATAU-A-MAUI"

Excellent health services working in partnership to improve the health and well-being of our people and to reduce health inequities within our community.

OUR VALUES

TAUWHIRO

Delivering high quality care to patients and consumers

RĀRANGA TE TIRA

Working together in partnership across the community

HE KAUANUANU

Showing respect for each other, our staff, patients and consumers

ĀKINA

Continuously improving everything we do

Hawke's Bay District Health Board Annual Plan 2017/18

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1 OVERVIEW OF STRATEGIC PRIORITIES

1.1 Strategic Intentions

Hawke's Bay District Health Board (HBDHB) is a Crown Entity and is the Government's funder and provider of public health and disability services for the population in our defined district. Our Statement of Intent 2016-19 outlines our strategic intentions for the next four years and shows how local outputs impact on our population and contribute to local, regional and system-level outcomes.

As a sector we have a common vision: "Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community." We face challenges such as the growth in chronic illness, our aging population and vulnerability in a large sector of our community. Our strategy, Transform and Sustain, seeks to overcome these challenges. Our three long term goals are: everyone experiences consistent, high quality care; the health system is efficient and sustainable; and people live longer, healthier lives.

In 2016 Transform and Sustain was refreshed to ensure that we are closely aligned to the New Zealand Health Strategy and it's themes as shown in figure 1 below.

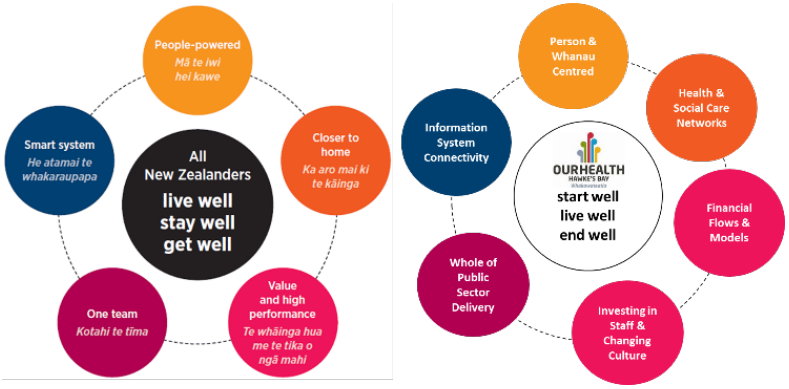

Figure 1: Transform and Sustain linked to the New Zealand Health Strategy themes.

We work collaboratively with our Central Region partners, our local primary health organisation (PHO), Health Hawke's Bay and other sectors for optimal arrangements. Using these relationships we have planned our contribution to the Government's priorities for the health system, which include fiscal discipline, working across government, and achieving the National Health Target.

HBDHB is committed to the UN convention on the Rights of Persons with Disabilities.

1.2 Our Population

The population of Hawke's Bay district has some unique characteristics compared to the rest of New Zealand in terms of health status and socio-demographics, and this provides us with some specific challenges. We have a higher proportion of Māori (26% vs 16%), more people aged over 65 years (19% vs 15%) (Statistics New Zealand, Summary of Resident Total Population Projections, 2018-2043; 2013 base) and more people living in areas with relatively high material deprivation (28% vs 20%)

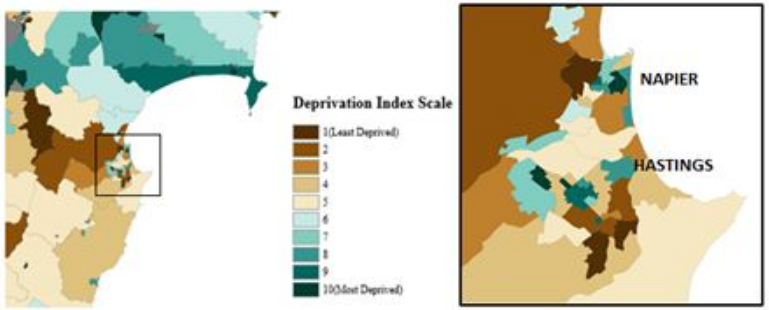

Figure 2: Hawke's Bay District relative deprivation NZDep13

Growth in the population is being driven by a younger age profile in the Māori and Pasifika population, which results in a higher birth rate, plus increased life expectancy across our whole population.

These projected population changes emphasise the need for HBDHB to maintain our focus on improving Māori and Pasifika health and to reorient our services to address and manage age-related health issues as guided by the New Zealand Healthy Ageing Strategy

Te Tiriti o Waitangi guarantees equitable health and social outcomes for everyone, and all Government agencies have a role in making sure that happens. The role and expectations of District Health Boards (DHBs) is emphasised in the New Zealand Public Health and Disability Act, 2000 (NZPHD Act) and our DHB partners with Health Hawke's Bay to co-ordinate the delivery of publicly funded health care and wellness support services. DHB responsibilities are based on:

- **Partnership** – working together with Iwi, hapū, whānau and Māori communities to develop strategies for improving the health status of Māori.
- **Participation** – involving Māori at all levels of the sector in planning, developing and delivering of health and disability services that are put in place to improve the health status of Māori.
- **Protection** – ensuring Māori well-being is protected and improved, and safeguarding Māori cultural concepts, values and practices. This includes the elimination of Māori health disparities by improving access to services and health outcomes for Māori.

Mai, our Māori Health Strategy 2014-19 and our Pacific Health Action Plan 2014-2018 have been developed to align with; the above principles and Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018.

In 2016 we updated the Health Equity in Hawke's Bay report, an analysis and report on health status in Hawke's Bay. The main focus of the report is equity because health inequities are differences in health status that are avoidable or preventable and therefore unfair.

The report finds many inequities in health in Hawke's Bay, particularly for Māori, Pasifika and people living in more-deprived areas. There are also areas where, with determined and focused effort, we have improved outcomes and reduced inequities. This demonstrates that inequities are not inevitable. We can change them if we have the courage and determination to do so.

The Health Equity Report concludes that inequity affects everyone and, for a difference to be made, we must tackle this collectively and take responsibility as a community. Since release, the findings of the report have been widely shared. The level of interest has been very positive and has led to the Hawke's Bay Intersectoral Forum, LIFT Hawke's Bay,[1] taking a role in developing a Social Inclusion Strategy to address priority areas. This multi-agency approach aims to bring a full range of relevant providers together with public, philanthropic and private funders to implement novel opportunities to integrate efforts that will address inequity as a community.

1.3 Long Term Investment

As a District Health Board, we have worked hard to create financial stability and use our internally generated funds to systematically invest in improved health services for our population. Looking forward, we aim to maintain this stability and continue to make smart investment decisions to meet the changing needs of the population.

Our Long Term Investment Plan (LTIP) outlines Hawke's Bay District Health Board's ten year investment plan based on a simplified outlook to the future from a local, regional and National perspective. In 2017/18 a Clinical Services Plan.is being developed to best inform where we will need to prioritise future investment and the LTIP will be updated accordingly.

[1] Includes Mayors, Members of Parliament, Iwi, Local and Regional Councils, Business HB, EIT, Government agencies – Housing NZ; Police, Corrections, Ministry of Social Development, Ministry of Education, Te Puni Kokiri, DHB

Statement from the Chair and Chief Executive

X_____
Dr Kevin Snee, Chief Executive
Hawke's Bay District Health Board

X_____
Kevin Atkinson, Board Chair
Hawke's Bay District Health Board

MINISTER OF HEALTH

X_____
Hon. Dr Jonathan Coleman, Minister of Health

THE PRIMARY HEALTHCARE ORGANISATION

X_____
Wayne Woolrich, General Manager Health Hawke's Bay – Te Oranga Hawke's Bay

MĀORI RELATIONSHIP BOARD

X_____
Ngahiwi Tomoana, Chair - HBDHB Māori Relationship Board

2 DELIVERING ON PRIORITIES

This section outlines activity to improve performance against Government priorities, and our contribution to the Central Region's priorities. It provides a sense of our commitment of resources to implementing those priorities, how we coordinate our efforts, and how we will measure success.

Acknowledgement

The 2017/18 planning process for this Annual Plan included setting up groups of stakeholders around each priority area. Accountability for collating each section was shared between co-leads from Health Hawke's Bay and HBDHB to ensure that there was PHO participation in the preparation of this plan. The public health unit and frontline clinicians played a vital role in developing the sections over the planning period in 2017.

Leaders from Māori and Pacific Health were consulted with at various stages in the planning process. Māori health priorities are indicated throughout the document and where possible, all measures will be reported on by ethnicity.

2.1 Government Planning Priorities

Government Planning Priority	Focus Expected for Hawke's Bay DHB	Link to NZ Health Strategy	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance	1. Complete proposal for group therapies in primary care, led by Child, Adolescent and Family Services (CAFS) clinician, working toward an increase in access to evidence-based intervention	Q1, Q3	PP25: Prime Minister's Youth Mental Health Project
			2. Work collaboratively with NGOs to enhance capability and to reduce demand for secondary services	Q2, Q3	
			3. School Based Health Services (SBHS) in decile 1-3 secondary schools, teen parent units and alternative education centres, participate with mental health services working toward 'Youth One Stop Shop'	Q1-4	
			4. Explore ways to expand Kaupapa Māori services as part of the development of new 'Model of Care' for Primary Mental Health services	Q1	
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered	1. Train all School Based Health Service (SBHS) nurses to use advanced standing orders for contraception.	Q4 100% trained	PP38: Delivery of response actions agreed in annual plan (section 1)
			2. Extend the SBHS to include a kaiāwhina in decile 1-3 schools	Q3	
			3. All nurses, both SBHS and primary and community, working under standing orders, have an annual update and assessment	Q4 100% completion	

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			4. Develop initiatives within the Sexual Health Governance Group action plan to better engage males in their reproductive health 5. Monitor difference in access rates and teenage pregnancy rates by ethnicity following implementation of above initiatives.	Q4 5% increase in males accessing Q1-4	
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	**One team**	1. Violence Intervention Programme (VIP) Improvement Group to; establish aggregated quarterly reporting for all health service units; review quarterly report and provide operational support and leadership to services who wish to improve; establish a VIP improvement plan in each area 2. Develop a family violence screening KPI for Health Services to be implemented in 18/19 3. Extend scope of multi-agency Maternal Wellbeing and Child Protection Group to provide support for pregnant women and children up to 2 years(as opposed to 6 weeks as in the past)	Q1-4 Q4 Q1-4	PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	**One team**	1. Roll out consumer resource and public marketing campaign with 'Top 5 for my Baby to Thrive' and measure effectiveness of this. 2. Continue to build relationships with GP practices to facilitate seamless transition of care from Primary Care to Lead Maternity Carer	Q1 Q3 evaluation Q1-4	PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	**One team**	1. Implement 0-5 Caries free 4 year Project in order to improve rates of Māori children who are caries free under 5 years; This will involve increasing engagement by Māori with community dental health and reduce dental ASH rates for 0-4 year olds 2. Use learnings from the successful adult respiratory programme, designed to reduce adult hospital admissions due to respiratory conditions, to tailor a paediatric programme.	Q1 Review of initial engagement Q2 Review of project progress Q4 Roll out to general practices	PP38: Delivery of response actions agreed in annual plan (section 1)

Increased Immunisation BPS and Health Target	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	Value and high performance	1. Survey all child birth educators on their knowledge, confidence and activity around educating people of all cultures on immunisation 2. Meet all major milestones on the HPV immunisation communication plan to ensure a systematic process and avoid gaps in service delivery 3. Work with Māori providers and other organisations to improve their capability by; providing educations sessions; ensuring there are authorised vaccinators; providing support with the cold chain 4. Develop a 'how to' guide for general practice to enable correct recording of influenza vaccines to ensure these link to the National Immunisation Register (NIR) 5. Work with Kahungunu Executive to explore opportunities to increase capacity and capability for immunisation in Wairoa	Q2 Q1-4 Q3, Q4 Q3 Q4	Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance	1. Develop project to re-set and implement the FLOW programme developed by the Francis Health Group to improve patient journeys using four key focus areas: a. High performing and supported Emergency Department b. Acute Assessment Unit(s) and ambulatory models of care c. improving our discharge systems d. effective processes in managing patients with frailty 2. Implement Internal Professional Standards (Medical Staff) 3. Implement a Nurse Practitioner led model of care 4. Revise general medical model of care 5. Primary Care ED Co-Operative Programme (PCED) to assist key general practices to develop and implement a new multidisciplinary model of care for high users of ED 6. Development of the functions within the Integrated Operations Centre with a focus on Patient Flow including; resource allocation: bed capacity; primary care communication	Q1 ToR Q2 Q2 Q4 Q1 Review of pilot Q3 Further inform evaluation framework to be completed at pilot end Q4 Complete pilot Q4 Hospital at a glance screen developed Q4 Communication strategy and response for primary care in periods of escalation	ED Health Target

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Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance	1. Continue to monitor theatre productivity via Theatre Management committee 2. Go live with the equity focussed Mobility Action Programme and monitor outcomes 3. Scope an end to end surgical pathway data capture project, with a consumer journey focus to monitor flow from referral to discharge. Develop delivery milestones over a five year period in line with IT strategy and the clinical services plan 4. Carry out Service Review for vascular service	Q1-4 Q1 # clients registered Q4 Average change in functional scores Q2 Q4 Q3	Electives Health Target MOH MAP reporting Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team	1. Review the use of electronic referral system, by GPs, for suspicion of cancer 2. Carry out activity post review; a feasibility study to make e-referral for high suspicion mandatory. This may change dependent on review findings. 3. Establish internal standards for: • Time frames from date of referral to multi-disciplinary meeting (MDM) and from MDM to decision to treat • Timeframes from referral to CT and from CT to CT report 4. Develop a protocol for consistent involvement of Clinical Nurse Co-ordinators in referral prioritisation to support identification of high suspicion cancer 5. Develop and implement an alternative pathway for benign breast, in collaboration with primary care 6. Broaden attendance (medical, surgical, radiology) at MDMs 7. Support or comply with Central Cancer Network (CCN) activities 8. Review options to establish an FCT navigator role in primary care to identify the at risk populations and to develop diagnostic pathways which enable equitable access	Qtr3 Review completed Q4 Post review activity Q2 Q1 Q2 Q2 Q1-4 Q3	Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Strengthening the DHB smoking cessation plan with input from primary care and smoking cessation providers.	Value and high performance	1. Implement the co-created Regional Tobacco Strategy 2. Review forms used in primary care patient management system to embed mandatory Smokefree fields 3. Provide benchmarking data and audit support for governance reporting to manage performance of the Health Target	Q1-4 Q2 Progress Report Q1-4	Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals

			4. Support high prevalence populations by providing sufficient training in Wairoa, expanding incentivised programme for young Māori women, monitoring referrals from GPs following the Early Engagement roll out and investigating cessation support tools e.g. 'vaping' 5. Support the establishment of the aligned cessation service, using input from providers and provide project support, development training and communication plans 6. Continue to screen inpatients in maternity services, offering support to quit for mothers and whānau and monitor Smokefree rates at discharge from Maternity Unit	Draft Report Q2 Q1 Q1-4	
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	**Closer to home**	1. Close monitoring of progress against the Health Target 2. Monitor implementation of Healthy Conversation tools 3. Support collective action to reduce childhood obesity by implementing the Best Start: healthy eating and activity plan 4. Monitor family-based nutrition and lifestyle interventions including B4 school check, Be Smarter Goal Planning and Active Families under 5 years. Monitor % interventions, % of programme referrals engaged, % of engaged completing programmes. All by ethnicity. 5. Develop responses to equity issues or gaps identified via monitoring; include programme changes, identification of resources and increasing access	Q1 Meet target Māori and Pacific children equitably represented in referral Q2 Q3 Q2, Q4 Q1 # responses developed	Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	**Value and high performance**	1. Commit to provide IT support of the National Bowel Screening Programme (NBSP) and work with the Ministry on IT integration 2. Engage with Hutt Valley DHB as our regional bowel screening centre 3. Establish local whole of sector project group for bowel screening to prepare for roll out of National Bowel Screening Programme (NBSP) in Hawkes Bay in 2018/2019 4. Develop an implementation plan, with the Health Equity Assessment Tool (HEAT) applied, which describes readiness for bowel screening roll out. This will include actions to sustainably meet colonoscopy wait time indicators.	Q1-4 TBC Q1 Q4	PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators

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Mental Health	Improve the quality of mental health services, including reducing the rate of Māori under community treatment orders.	**One team**	1. Monitor Compulsory Treatment Orders (CTOs) by ethnicity and continue with actions which have contributed to a decrease in CTOs for Māori; partnership with police; education of nurses and key workers to support whanāu to understand legal issues and the process of CTO courts. 2. Explore written material which is used to explain these processes to whanāu in other centres, with a view to using locally, if appropriate.	Ongoing Q2	PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities.
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	**Value and high performance**	3. Establish a Pregnancy and Parenting Service: Assertive Outreach to vulnerable whānau experiencing drug and alcohol issues 4. Use the recommendation from a recent review of primary mental health to formulate a plan to redesign services with a focus on psychological services; group programmes, nurse credentialing, and e-therapies 5. Initiate the Work Ready project: Investigate with key partners across the sector, (schools, tertiary education, social services, police and, Work and Income) opportunities to reduce alcohol and drug harm and addiction 6. Implement, locally, the regional Adult AOD Model of Care pathway	Q2 Q1 Q4 Q1-4	PP38: Delivery of response actions agreed in annual plan (section 2) PP26 PP8
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	**Closer to home**	1. Further integrate the new 'wrap around' model of care, "engAGE", with other service providers, including primary care and St John and use learnings from kaumātua meetings to improve services for older Māori 2. Work with ACC to implement a sector wide co-ordination programme to reduce falls and harm caused by falls, ensuring people receive the right care in the right place as per the associated Outcome Framework and Healthy Ageing Strategy 3. Maintain the hospital Falls Minimisation Committee to co-ordinate HQSC work programmes and monitoring 4. Promote the regional infographic on older people and utilise benchmarking information to inform local service planning 5. Implement relevant actions to deliver the DHB's Regional Service Plan commitments 6. Use Interai data to identify any equity issues 7. Work toward addressing prioritised equity issues	Q3 Q1, Q3 Q1-4 Q1-4 Q1-4 Q1 Q2-4	PP23: Improving Wrap Around Services – Health of Older People

Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards r Diabetes Care.	**Closer to home**	1. The Stanford Programme for self-management of chronic disease will be offered by general practice, to people who are diagnosed with pre-diabetes	Q2 4 sessions	PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
			2. Pre-diabetes patients (meeting inclusion criteria) will be offered participation in the PIPI programme (primary care nurses offering nutrition and lifestyle support)	Q1-4	
			3. Establish audit and reporting processes for both retinal screening and podiatry services for medium to high risk patients	Q2	
			4. All general practices will develop an annual Diabetes Care Improvement Plan (DCIP) with a focus on the delivery of quality care to their respective diabetes population.	Q2 28 practices with plans signed off	
			5. Build capability of our primary care nursing work force by developing outcomes based goals and a role structure for CNS shared care with primary care	Q2	
			6. Analyse diabetes population by monitoring of HbA1c across general practice through provision of trend reports. This will inform the focus to increase services for Māori	Q4	
			7. Review model of care in specialist diabetes services to identify gaps and opportunities specifically relating to sustaining CNS workforce capability and capacity.	Q2 review completion Q3 actions post review	
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these.	**Closer to home**	1. Implement the activities identified for 2017/18 from the Best Start; Healthy Eating and Activity Plan (Childhood Obesity Plan for HBDHB) to deliver a coordinated health sector approach to childhood healthy weight. Integrate activity supporting Raising Healthy Kids target and oral health	Q3 # of planned activities completed	PP38: Delivery of response actions agreed in annual plan (section 2)
			2. Contract local providers to deliver maternal nutrition and activity programme, Active Families and Green Prescription – with an equitable health outcomes focus	Q2 All Contracts include equity targets and monitor behaviour change	
			3. Develop with key community partners, a schools programme (5 to 10 year olds) for schools in high deprivation communities and trial in schools with a clear focus on Māori and Pasifika children and their whānau. Programme will include key messages – water only, 60 minutes a day and healthy eating reflecting national nutrition guidelines	Q1 development Q2 trial	
			4. Coordinate existing programmes and address gaps - to develop/support healthy eating and activity environments in early childhood education settings (ECEs). Include Oral	Q1, Q3	

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			Health, Hauora Services, Ministry of Education and community providers 5. Promote reductions in sugar for children, via key settings (ECEs, schools, family friendly events, sport clubs) and in messaging (national programmes and locally produced resources).Include: water only, not using sugary food/drink as rewards, healthy lunch boxes. Also include Healthy Heart programme.	Q1, Q2	
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**	1. Implement Ngātahi – Vulnerable Children's Workforce Development Project, aligning Education, Health, MSD and other workforces, to identify and address gaps in knowledge and skills of the vulnerable children's workforce in Hawkes Bay in order to work effectively with families and improve outcomes (particularly for tamariki and rangatahi Māori and their whanau) 2. Expand Maternal Wellbeing and Child Protection Multiagency Group to two years postnatal age – see Supporting Vulnerable Children 3. Implement Parenting and Pregnancy (maternal addictions) programme within Mental Health and Addiction Service – see Mental Health	Q2 :Mapping staff skills against core competencies by all agencies working with vulnerable children Q3: Training plan developed post aggregation of data from agencies Q2 Q2	PP38: Delivery of response actions agreed in annual plan (section 2)
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances).	**One team**	1. Representatives for physical and sensory disability and also for intellectual and neurological disability are required on Consumer Council 2. Co-location of Mental Health Emergency services with Emergency Department 3. All new reception builds have a lower section to the counter 4. Allied health departments have tools to support communication, movement, and activities of daily living but use is dependent on request from staff for support tools or assessment	N/A	PP38: Delivery of response actions agreed in annual plan (section 2)
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector	**Closer to home**	1. Develop a guideline for transferal of resource to support capability and capacity in primary care 2. Chief Information Officer(CIO) HBDHB, with input from Health Hawkes Bay, to inform future integration platforms for Information Technology 3. Initiate project to investigate ways of incentivising improved primary care outcomes	Q4 Q1 CIO Project plan reflects primary care input Q4 Options and recommendations tabled	PP22: Delivery of actions to improve system integration including SLMs

			4. Promote joint sector wide clinical leadership and clinically led decision-making through the HB Clinical Council monthly meetings, on behalf of the Alliance Leadership Team	Q1-4 All service level advisory groups are linked to cross-sector clinical leadership and to consumer input	
			5. Under the Transform and Sustain programme; further develop a structure for implementing localised prioritised projects: Health and Social Care Localities. a. Two seed localities established b. Alignment with regional economic development strategy and social inclusion strategies c. Priority areas identified by each seed locality d. HB wide Steering group formed e. Review of current governance /advisory structures	A Q1 b Q2 c Q3 d Q4 e Q4	
			6. Investigate further IT tools which will provide increased compatibility and utility with localisation of collaborative pathways	Q3 Trial and evaluation	
			7. Increase scope of the Oral Health Project to include a specific focus on reducing ASH rates 0-4 for Māori children. The project is will now have a workstream designing a collaborative approach to reducing ASH 0-4 through early primary care intervention and investigating the incidence of children experiencing ASH for more than one condition and how they could be better coordinated for risk factors and advice, especially for Māori, Pacific and low decile populations	Q2 Early intervention developed Q3 Early intervention implemented	
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix	Value and high performance	8. Work with our stakeholders toward our jointly developed and agreed System Level Measure Improvement Plan. See Appendix	Q2	PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team	1. Support local implementation of national pharmacy contract: Integrated Pharmacist Services in the Community	Q1 85% signed up	PP38: Delivery of response actions agreed in annual plan (section 2)
			2. Align Community Based Pharmacy Services in Hawke's Bay Strategic Direction 2016 – 2020 with the Ministry of Health's Pharmacy Action Plan (PAP)	Q2 Q2	

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			3. Work with Health Hawkes Bay to strengthen pharmacy representation at governance and service development level	Q4	
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	**Value and high performance**	1. Maintain front-line ownership of improvement targets by directorate leadership, with oversight provided by Clinical Council representing sector wide clinical leadership 2. Support the ongoing National Patient Experience Survey, supporting the rollout to Primary Care. Focus on "Co-ordination" area relating to discharge planning with the implementation of a number of improvement work streams ensuring patients have sufficient information at discharge. 3. Develop and implement a local patient experience survey, and set of processes to utilise results alongside the National Patient Survey 4. Develop and implement a Consumer Engagement Framework to provide tools to staff and achieve greater consistency across the sector on how and when we engage and partner with consumers 5. Implement and initiate Health Literacy programme of work 6. Maintain and support Consumer Council to advise HBDHB board	Q1-4 Q3 Q3 Q1 Q1 Q1-4	PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	**Value and high performance**	1. HBDHB commits to managing our finances to allow for investment in new and more health initiatives. Our strategic direction, agreed with the MOH, is to provide a $9m surplus over three years ending 30 June 2019. This surplus is required to enable us to continue to invest in various infrastructure initiatives required to meet the needs of our community and progress Transform and Sustain.	Q1-4	Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C.	**NA.**	1. Commence development of a staged business case for percutaneous coronary intervention for HBDHB, in conjunction with the central region 2. Contribute to the review and confirmation of the delivery of after hours on call rosters across the region, Achieve 8% or more of eligible patients are thrombolysed. 3. Continue work on agreed regional clinical guidelines and inter-hospital transfer processes to manage major trauma patients within the region 4. Provide clinical representation on the Central Region Trauma Network to participate in and support the work programme to achieve a contemporary trauma system within the Central Region	Q4 Q1-4 Q2, Q4	NA.

			5. Work with Central Region community Hepatitis C service to ensure all people living with or at risk of Hepatitis C have access to information, testing, assessment and treatment, as appropriate 6. Support the implementation and use of a clinical healthcare pathway, for identification, assessment and treatment of patients with Hepatitis C	Q1-4	

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2.2 Financial Performance Summary

(Refer to Appendix One for further detail)

TBC

2.3 Local and Regional Enablers

Local and Regional Enabler	Focus Expected for Hawke's Bay DHB	Link to NZ Health Strategy	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State when CPOE will be implemented. Complete ePA and nursing documentation implementations.	Smart system	1. Focus on implementation of the Regional Health Informatics Programme (RHIP): Engage with TAS to agree on an implementation plan and timeline for Orion Clinical Portal. Agreed plan and timeline including implementation of clinical forms (including nursing) in first stage	Q2	Quarterly reports from regional leads.
			2. Develop a timeline for commencing implementation of ePA (Medchart)	Q2	
			3. Primary Care Clinical Portal: Roll out implementation of the provider portal for district nurses (providing full access), to additional providers and their services	Q4	
			4. Event Reporting System: Select preferred provider and initiate project	Q2	
			5. Telephone Successor System: Initiate planning work for co-design and contract activities	Q4	
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team	1. Establish a new 'People Strategy' to enable achievement of the overarching Transform & Sustain strategy in driving culture change across the organisation. Develop a reporting framework and key performance indicators	Q1	
			2. Prioritise the development of a local training hub to ensure effective delivery of training across the sector in order to increase capability	Q2	
			3. Initiate a focus on all Māori staff to ensure effective retention strategies are fully in place	Q1	
			4. Reduce inequity for staff paid below living wage through a variety of initiatives including training and health and wellbeing	Q3	
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.		1. Monitor the impact of the settlement agreement including guaranteed hours and workforce training for our kaiāwhina workforce	Q1, Q3	PP23: Improving Wrap Around Services – Health of Older People

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Workforce	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy	**One Team**	2. Monitor the impact of the settlement agreement including guaranteed hours and workforce training for our kaiāwhina workforce	Q1, Q3	PP23: Improving Wrap Around Services – Health of Older People

3 SERVICE CONFIGURATION

3.1 Service Change

The table below is a high-level indication of some potential changes.

Change	Description	Expected Benefits	Local, Regional or National
Urgent Care	In partnership with general practices and emergency department implement Urgent Care Service improvements.	More consistent and effective access to appropriate urgent care across the district. Reduce hospital admissions and improve equity.	Local
Primary Mental Health	A redesign of primary mental health services is underway and this will change current delivery.	Earlier access for mild and moderate mental health concerns targeting under-served populations. Better links between primary, community and secondary mental health services.	Local
Adults Alcohol and Other Drugs (AOD) model of care implementation	Implementation of change management plan for an Adult AOD Model of Care pathway across six Central Region DHB's. As well as residential options, the model includes: Withdrawal management; Respite/stabilisation; Adult AOD peer support; Whānau Ora approaches to care.	Improved care continuity for AOD service consumers Improved access for Māori and Pacific populations Enable provision of services under the proposed Substance Addiction (Compulsory Assessment and Treatment) Bill to be implemented in 2017/18.	Regional
Community Pharmacy and Pharmacist services	Implement the national Community Pharmacy Services Agreement and develop local services.	More integration across the primary care team. Improved access to pharmacist services by consumers. Consumer empowerment. Safe supply of medicines to the consumer. Improved support for vulnerable populations. More use of pharmacists as a first point of contact within primary care.	National
Laboratory Services	Maintaining safe, accessible laboratory services may lead to a change in the range of laboratory services available 24/7 at all current delivery sites.	Service coverage expectations for clinically-appropriate laboratory tests will be emphasised. Better use of health system resources.	Local
Surgical Expansion Project	Project to expand HBDHB surgical in-house capacity to better meet elective health targets and HB population surgical needs.	HBDHB able to better meet elective health targets and population surgical needs in-house and within in budget.	Local
Ophthalmology – Glaucoma	Utilising community optometrists via a shared care model to conduct glaucoma follow ups.	Increased clinic capacity and reduced clinical risk for glaucoma patients	Local
Youth Services	Youth service redesign process continues from 2016 and is a focus for 2017/19. This is based on the HBDHB youth health strategy 2016-19	Better access for youth. Services designed with input from youth and stakeholders.	Local
	U18 free access to General Practice Services for high needs youth population i.e. Maori, Pasifika.	67% of the 13-17 year population will have access to free primary care (in and out of hours).	Local
	Completion by General Practice of Youth Friendly Primary Care assessment tool.	General practice can be more responsive and receptive to the needs of Youth population.	Local
Model of Care (primary)	Funding allocated by PHO/DHB to support the development of models of care that support patient / relationship centred practice.	Patient care models that demonstrate – consumer input into model of care and priority areas that will lead to heightened self-management and improved health outcomes particularly for Long Term Conditions	Local

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		Models will demonstrate utilisation of multidisciplinary and interdisciplinary team approaches and increased utilisation of the nursing workforce as clinical leads in primary care provision	
Long Term Conditions (LTC) Management	LTC Framework developed for implementation to begin May 2017	More consistent and effective approach to manage LTC and support self-management	Regional
Health and Social Care Localities	Providing integrated service models specific to geographical localities based on local identified health needs	Consumers accessing appropriate services closer to their home	Local
Faster Cancer Treatment	From 1/07/2017 HBDHB will be repatriating from MidCentral DHB all Hawke's Bay delivered volumes. This will involve the; Redesigning of our oncology service model and redesign and refurbishing of our buildings.	More streamlined services working toward meeting the FCT target	Regional

Service Integration

In line with Transform and Sustain and the National drive to shift services out of the specialised hospital setting and into the community, HBDHB are continually reviewing services and considering where these could be provided in the community and/or with better integration with primary care.

Procurement of Health & Disability Services

HBDHB periodically undertakes competitive processes (Registration of Interest, Request for Proposals etc.), in accordance with the Ministry of Business Innovation and Employments Government Rules of Sourcing. Competitive processes may be undertaken for several reasons including, the time since the last competitive process and changes in service design. Competitive processes ensure cost effective services, increase innovation and can enhance efficient service provision. Competitive processes may result in a change of provider

Note A: HBDHB is permitted and empowered under Section 25 of the New Zealand Public Health and Disability Act 2000 (the Act) to negotiate and enter into any service agreements (and amendments to service agreements) which it considers necessary in fulfilling its objectives and/or performing its functions pursuant to the Act.

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4 STEWARDSHIP

Our transform and sustain programme is showing good results. We are making significant improvements in delivering services for patients, achieving more equitable health outcomes and improving staff engagement. Initiatives such as Acute Inpatient Management 24/7 (AIM 24/7) and others focusing on our after-hours services, theatre productivity, mental health model of care and health of older persons services, are all delivering significant improvement across the sector. These improvements are being achieved within our current funding. In addition, our engagement with and commitment to the Health Quality and Safety Commission's programmes – specifically, Quality and Safety Markers (QSMs), Quality Accounts, and Patient Experience Indicators – provide the public with evidence and transparent links comparing our performance to national benchmarks and declarations about the quality of the services we fund and provide.

4.1 Managing our Business

Processes for Achieving Regular Financial Surpluses

Closing the gap between planned expenditure and expected income is normal business in the health system. As the world economic environment puts even more pressure on all Government spending, Hawke's Bay DHB, as the lead Government agent for the Hawke's Bay public health budget, must continually look for ways to live within an expectation of lower funding growth.

Hawke's Bay DHB continues with its strategic direction to provide a year-on-year surplus. This surplus is required to enable us to continue to invest in various infrastructure initiatives required to meet the needs of our community.

We continue with our strategy of responsible reduction in our cost base by

- Stopping doing things that are clinically ineffective of for which there is insufficient supporting evidence
- Doing things more efficiently by redesigning processes to drive out waste or errors
- Embracing opportunity to enhance quality by providing better care with the available resources

Our focus on reducing our cost base together with opportunities to increase our revenues will produce additional resources for our transformation program.

Shifting Resources

To ensure that our change in focus is also matched by a shift of resources, we have agreed measures to monitor changes in deploying resources over time from specialised hospital services into primary and community services.

The shape of the curve will change, with the care models fundamentally transformed to enable more effective deployment of resources. This is not about shifting resources from one provider to another, but rather it is about changing the service model.

Investment and Asset Management

Regional capital investment approaches are outlined in RSP and individual sections contain capital investment plans. HBDHB is committed to working with the regional capital planning committee on the development of our local plans and assisting our regional colleagues in development of the regional capital plan and its implementation.

Formal asset management planning is undertaken at HBDHB. We have developed a 10 year long term investment plan which outlines our planed asset expenditure in the absence of a clinical services plan.

Approvals at regional and national level are sought depending on the threshold of any proposed investment to help ensure that there is some national consistency in development of the health assets. We will continue to work nationally with the development of the various national initiatives and regionally on the development of a regional solution for our information technology applications.

Organisational Performance Management

Given the scale and scope of our services, HBDHB has developed and implemented a comprehensive organisational performance management framework. This provides for the provision of relevant reports and performance management decision making at appropriate levels. Reports provided as part of this framework include:

Strategic

- Ministry of Health – DHB Performance Monitoring
- HBDHB Transform and Sustain Strategic Dashboard.

Operational

- Exceptions Report on Annual Plan performance
- Exceptions Report on Annual Māori Health Plan
- Pasifika Health Dashboard

- MoH Quarterly Health Target Report

Risk Management

- Monthly Strategic and High / Emerging Risk Report
- Occupational Health and Safety

General

- Chief Executive Report
- Financial Performance
- Human Resources Key Performance Indicators
- Transform and Sustain Programme Overview
- Transform & Sustain Projects Progress

Shared Services

HBDHB has a shareholding interest in, and receives shared services from:

- NZ Health Partnerships Ltd
- Central Region Technical Advisory Services Ltd
- Allied Laundry Services Ltd

Risk Management

Risk Registers are maintained throughout HBDHB with high and emerging risks and trends regularly reviewed at operational, senior management and governance levels. During 2017/18 HBDHB will be implementing a new integrated risk management system to further enhance and promote the regular identification, monitoring and management of risk.

Quality Assurance and Improvement.

Delivering consistent high quality care continues to be one of the key themes and enablers to achieving our Transform and Sustain strategy. The Working in Partnership for Quality Healthcare in Hawke's Bay framework identified clinical leadership and consumer partnership throughout the health sector as the most important aspect of improving quality health care and patient safety. We use our framework to align our local efforts in support of the national quality improvement work coordinated by the Health Quality and Safety Commission (HQSC). The Quality Improvement and Patient Safety (QIPS) team provide support for integrated quality improvement and performance across the Hawke's Bay health sector and help clinical teams to recognise and define priority areas and to identify actions for implementation. Our focus for the coming year will be on continuing to sustain the improvements made in the past twelve months and implementing our Health Literacy Framework and Consumer Engagement Strategy, enabling a shift in the culture to becoming far more person and whānau centred

4.2 Building Capability

Workforce

The health system needs skilled clinical leaders, team leaders and managers in place to support team performance so that we can achieve transformation. Our teams must continually focus on providing excellent services, improving health and well-being, working in partnership and improving equity, and they must be empowered to try new ways of doing things. This applies to service delivery and support functions. We are working together to support and develop the workforce and the organisations.

Development of a new workforce development framework and strategy focussing on our medical, nursing, allied, support and management and administration workforces.Our Child Protection Policies comply with the requirements of the Vulnerable Children Act, 2014. A copy is available from our website: www.Hawke'sbay.health.nz

Communications

The communications team is committed to looking at new and fresh ways to engage successfully with our community and our staff. We challenge our staff to think about effective strategies and how best to communicate them so people can better manage their way through the complexities of the health system. We are always looking to help staff promote new ideas and new initiatives through more effective and compelling communication.

Health Information

In transforming the health system, one of the biggest challenges we face is developing an information system that matches our ambitions for service integration. We are working with our regional partners to deliver a regional health informatics strategy to support improvements in Information Communication Technology (ICT) over the outlook period. The Central Region ICT vision is about the efficient delivery of the right information to the right people at the right time, on an anywhere, anyhow basis to achieve the desired health outcomes and improved organisational performance

Achieving the region's vision for health informatics will contribute to improved consumer experience, better support for clinicians and other health professionals and more integrated care.

There are many areas that require better ICT support and we recognise the importance of rigorous investment to achieve this. We have developed and information systems strategy and a business intelligence work plan to underpin and complement Transform and Sustain.

Inter-Agency Collaboration

Hawke's Bay District Health Board is working closely with other agencies to improve outcomes for the population through 'LIFT Hawke's Bay – Kia Tapatahi'. The group is working towards a common vision: Hawke's Bay is a vibrant, cohesive and diverse community, where every household and every whānau is actively engaged in, contributing to, and benefiting from, a thriving Hawke's Bay". Two strategies being developed and implemented through this forum are the Regional Economic Development Strategy and a Social Inclusion Strategy.

Note A: Subsidiary Companies and Investments

Currently, there are no subsidiary companies in which HBDHB has a controlling interest[2] and HBDHB has no plans to acquire shares or interests in terms of section 100 of the Crown Entities Act 2004. HBDHB has an interest in one multi-parent subsidiary: Allied Laundry Services Limited. Other shareholders are MidCentral DHB, Taranaki DHB, Whanganui DHB, Capital and Coast DHB and Hutt Valley DHB. Allied Laundry Services Limited has an exemption from producing a Statement of Intent (SOI). MidCentral DHB will report on Allied Laundry Services Limited in its SOI, on behalf of Hawke's Bay, Taranaki and Whanganui DHB

Note B: HBDHB has a Health and Safety Policy detailing our commitment to providing a safe and healthy environment for all persons on our sites and business. The policy incorporates the Board-approved Health and Safety Statement which is reviewed every 2 years. The last review was in April 2014.

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[2] As defined in section 58 of the Companies Act 1993

5 PERFORMANCE MEASURES

5.1 2017/18 Performance Measures

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

- Achieving Government's priority goals/objectives and targets or 'Policy Priorities'
- Meeting service coverage requirements and supporting sector inter-connectedness or 'System Integration'
- Providing quality services efficiently or 'Ownership'
- Purchasing the right mix and level of services within acceptable financial performance or 'Outputs'.

It is intended that the structure of the framework and associated reports assists stakeholders to 'see at a glance' how well DHBs are performing across the breadth of their activity, including in relation to legislative requirements, but with the balance of measures focused on Government priorities. Each performance measure has a nomenclature to assist with classification as follows:

Code	Dimension
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – establishment of baseline (no target/performance expectation is set)
SLM	Inclusion of 'SLM'in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2017/18.

Performance measure	Performance expectation
HS: Supporting delivery of the New Zealand Health Strategy	Quarterly highlight report against the Strategy themes.
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19 Age 20-64 Age 65+
PP7: Improving mental health services using wellness and transition (discharge) planning	95% of clients
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	80% of people seen within 3 weeks. 95% of people seen within 8 weeks.
PP10: Oral Health- Mean DMFT score at Year 8	Year 1: Year 2:
PP11: Children caries-free at five years of age	Year 1: Year 2:
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	Year 1: 85% Year 2: 85%
PP13: Improving the number of children enrolled in DHB funded dental services	Year 1: 95% Year 2: 95%
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	**Focus Area 1: Long term conditions** - Report on activities in the Annual Plan. **Focus Area 2: Diabetes services** - Implement actions from Living Well with Diabetes - Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator). **Focus Area 3: Cardiovascular health**

Performance measure	Performance expectation
	- 90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years. - 90% of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years. **Focus Area 4: Acute heart service** - 70% of high-risk patients receive an angiogram within 3 days of admission. - Over 90% of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days. - Over 95% of patients undergoing cardiac surgery at the regional cardiac centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge. **Focus Area 5: Stroke services** - 8% or more of potentially eligible stroke patients thrombolysed 24/7. - 80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway. - 80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.
PP21: Immunisation coverage	95% of two year olds fully immunised 95% of four year olds fully immunised 75% of girls fully immunised – HPV vaccine 75% of 65+ year olds immunised – flu vaccine
PP22: Delivery of actions to improve system integration including SLMs	Report on activities in the Annual Plan.
PP23: Improving Wrap Around Services for Older People	Report on activities in the Annual Plan.
PP25: Prime Minister's youth mental health initiative	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement Youth Health Care in Secondary Schools: A

Performance measure	Performance expectation
	framework for continuous quality improvement in each school (or group of schools) with SBHS. Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below). Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for the focus areas of Primary Mental Health, District Suicide Prevention and Postvention, Improving Crisis Response services, improving outcomes for children, and improving employment and physical health needs of people with low prevalence conditions.
PP27: Supporting vulnerable children	Report on activities in the Annual Plan.
PP28: Reducing Rheumatic fever	Focus Area 1: Reducing the Incidence of First Episode Rheumatic Fever Report progress against BPS target. Provide progress report against rheumatic fever prevention plan. Provide report on lessons learned and actions taken following reviews. Focus Area 2: report progress in following-up known risk factors and system failure points in cases of first episode and recurrent acute rheumatic fever.
PP29: Improving waiting times for diagnostic services	95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days). 95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).

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Performance measure	Performance expectation
	90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days. 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days. 70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.
PP30: Faster cancer treatment	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.
PP31: Better help for smokers to quit in public hospitals	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.
PP32: Improving the accuracy of ethnicity reporting in PHO registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).
PP33: Improving Māori enrolment in PHOs	Meet and/or maintain the national average enrolment rate of 90%.
PP34: Improving the percentage of women who are smoke free at two weeks postnatal	Developmental
PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities.	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.
PP37: Improving breastfeeding rates	60% of infants are exclusively or fully breastfed at three months.
PP38: Delivery of response actions agreed in annual plan	Report on activities in the Annual Plan.

Performance measure	Performance expectation
SI1: Ambulatory sensitive hospitalisations	TBC
SI2: Delivery of Regional Service Plans	Provision of a progress report on behalf of the region agreed by all DHBs within that region.
SI3: Ensuring delivery of Service Coverage	Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement procedures - a target intervention rate of 21 per 10,000 of population. Cataract procedures - a target intervention rate of 27 per 10,000 of population. Cardiac surgery - a target intervention rate of 6.5 per 10,000 of population. Percutaneous revascularization - a target rate of at least 12.5 per 10,000 of population. Coronary angiography services - a target rate of at least 34.7 per 10,000 of population.
SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco.
SI7: SLM total acute hospital bed days per capita	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI8: SLM patient experience of care	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI9: SLM amenable mortality	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.

Performance measure	Performance expectation
SI10: Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.
SI11: Improving breast screening rates	70% coverage for all ethnic groups and overall.
OS3: Inpatient Length of Stay	Elective LOS suggested target is 1.47 days, which represents the 75th centile of national performance. Acute LOS suggested target is 2.3 days, which represents the 75th centile of national performance.
OS8: Reducing Acute Readmissions to Hospital	TBA – indicator definition currently under review.
OS10: 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) Group A >2% and <= 4%, Group B >1% and <=3%, Group C >1.5% and <= 6% Recording of non-specific ethnicity in new NHI registrations - >0.5% and <= 2% Update of specific ethnicity value in existing NHI record with non-specific value - >0.5% and <= 2% Validated addresses excluding overseas, unknown and dot (.) in line 1 - >76% and <= 85% Invalid NHI data updates – TBA **Focus Area 2: Improving the quality of data submitted to National Collections** NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS) - >= 97% and <99.5% National Collections File load Success - >= 98% and <99.5% Assessment of data reported to NMDS - >= 75% Timeliness of NNPAC data - >= 95% and <98%

Performance measure	Performance expectation
	Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD) Provide reports as specified about data quality audits.
Output 1: Mental health 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.
DV4: Improving patient experience	No performance expectation/target set.
DV6: SLM youth access to and utilisation of youth appropriate health services	No performance expectation/target set.
DV7: SLM number of babies who live in a smoke-free household at six weeks post natal	No performance expectation/target set.

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APPENDIX A: STATEMENT OF PERFORMANCE EXPECTATIONS & FINANCIAL PERFORMANCE

1 Statement of Performance Expectations

This section includes information about the measures and standards against which Hawke's Bay District Health Board's (HBDHB) service performance will be assessed. For the purpose of our Statement Performance Expectations (SPE), our services are grouped into four reportable Output Classes:

- **Prevention Services;**
- **Early Detection and Management Services;**
- **Intensive Assessment and Treatment Services;**
- **Rehabilitation and Support Services.**

The SPE describes information in respect of the first financial year of our Statement of Intent and the performance measures are forecast to provide accountability. The outputs and measures presented are a reasonable representation of the full range of services provided by the organisation. Where possible, we have included past performance (baseline data) and the performance target to give the context of what we are trying to achieve and to enable better evaluation of our performance.

Service Performance

Explaining the contribution that our services make towards achieving the population and system level outcomes and impacts outlined in our Statement of Intent above, requires consideration of service performance. For each output class, we will assess performance in terms of the New Zealand Triple Aim (Figure 2). Maintaining a balance of focus across the Triple Aim is at the core of the Health Quality and Safety Commission's drive for quality improvement across the health sector.

The system dimension: Best value for public health system resources

For each output class we show expected funding and expenditure to demonstrate how output class performance will contribute to the outcome of a financially sustainable system.

The population dimension: Improved health and equity for all populations

Services may target the whole population or specified sub-populations. In either case we select measures that apply to the relevant group. These measures usually refer to rates of coverage or proportions of targeted populations who are served and are indicative or responsiveness to need.

The individual dimension: Improved quality, safety and experience of care

Ensuring quality and safety, within hospitals and wider health services, is a fundamental responsibility of DHBs. Measurements in this dimension indicate how well the system responds to expected standards and contributes to patient and consumer satisfaction.

Note: all targets are an annual target or, where monitored quarterly, show the expected performance by the end of quarter four. Targets are set at the total population level and monitored, where appropriate, across different population groups to gauge the equity of results. A detailed technical description of each indicator is available in a data dictionary maintained by our information services.

The HBDHB Statement of Performance Expectations for the 2016/17 year follows:

X_____ X_____

Board Member Board Member

Code		Description
MH		Māori Health Plan Targets
HT		Health Targets
MoH Performance Measures - see Appendix 4	**PP**	Policy Priorities
	SI	System Integration
	OP	Outputs
	OS	Ownership
	DV	Developmental
N/A		Data not available

OUTPUT CLASS 1: Prevention Services

Prevention Services are publicly funded services that protect and promote good health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population, as distinct from treatment services which repair or support health and disability dysfunction. Prevention Services address individual behaviours by targeting population-wide physical and social environments to influence health and well-being. Prevention Services include: health promotion and education services; statutory and regulatory services; population based screening programmes; immunisation services; and, well child and school services.

On the continuum of care, Prevention Services are population-wide and are designed to focus attention on wellness of the general population and on keeping the "at risk" population healthy. It is important to emphasise that the concept of wellness extends to the entire population, including those who already have a health condition or disability.

Objective: People are better protected from harm and more informed to support healthier lifestyles and maintenance of wellness

Through collective action with communities and other sectors, we aim to protect the general population from harm and keep them informed about good health so that they are supported to be healthy and empowered to take control of their well-being. We aim to reduce inequities in health outcomes as quickly as practicable and we recognise that they often arise out of issues that originate outside the health system. Prevention programmes include the use of legislation, policy, education and community action to increase the adoption of healthy practices amongst the population and to overcome environmental barriers to good health

Funding TBC.

Table 1 - Funding and Expenditure for Output Class 1: Prevention Services

16.1

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
Better help for smokers to quit	% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	PP31	Oct-Dec 2016	99.2%	100%	98.7%	99.0%	≥95%
	% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	HT	Oct-Dec 2016	85.1%	82.2%	89.8%	87.4%	≥90%
	% 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	HT	Oct-Dec 2016	78.8%	N/A	N/A	88.5%	≥90%
	Proportion of babies who live in a smoke-free household at six weeks post natal	SLM						
	% of pregnant Māori women that are smokefree at 2 weeks postnatal	SI5	Jul-Dec 2015	65.6%	93.5%	92.1%	80.0%	≥95%
Increase Immunisation coverage in Children	% of 8 month olds who complete their primary course of Immunisations	HT	Oct-Dec 2016	94.4%	100%	95.9%	95.3%	≥95%
	% of 2 year olds fully immunised	PP21	Oct-Dec 2016	95.4%	100%	93.6%	94.7%	≥95%
	% of 4 year olds fully immunised by age 5	PP21	Oct-Dec 2016	95.8%	91.2%	91.8%	93.5%	≥95%
Increase HPV immunisation rates	% of girls that have received HPV dose three	PP21	Jun 2016	87.8%	73.3%	54.9%	68.4%	≥75%
Increase the rate of seasonal influenza immunisations in over 65 year olds	% of high needs 65 years olds and over influenza immunisation rate	PP21						≥75%
Reduced incidence of first episode Rheumatic Fever	Acute rheumatic fever initial hospitalisation rate per 100,000	PP28H						≤1.5
More women are screened for cancer	% of women aged 50-69 years receiving breast screening in the last 2 years	SI11	2 Years to Sep 2016	64.7%	65.4%	75.0%	73.6%	≥70%

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
	% of women aged 25–69 years who have had a cervical screening event in the past 36 months	SI10	3 Years to Sep 2016	72.8%	74.8%	78.9%	76.7%	≥80%
Better rates of breastfeeding	% of infants that are exclusively or fully breastfed at 6 weeks of age		6 months to Dec 2015	66%	82%	N/A	72%	75%
	% of infants that are exclusively or fully breastfed at 3 months of age	PP37	6 months to Jun 2016	39%	46%	N/A	51%	60%

16.1

OUTPUT CLASS 2: Early Detection and Management Services

Early Detection and Management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings to individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes, child and adolescent oral health and dental services, pharmacist services, and community referred tests and diagnostic services. The services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the district.

On the continuum of care these services are mostly concerned with the "at risk" population and those with health and disability conditions at all stages.

Objective: People's health issues and risks are detected early and treated to maximise well-being

For people who are at risk of illness and or injury, we will undertake activities that raise awareness and recognition of risky behaviours and practices and improve the opportunity of early detection of health conditions. If people are assisted to identify risk early, and those at risk are screened to detect health conditions early, then behavioural changes and treatment interventions are often easier with less complications and greater chances of returning to a state of good health or of slowing the progression of the disease, injury or illness. Targeting environmental barriers to good health and connecting people with health services earlier is the intention because early detection of health issues or risks leads to better opportunities to influence long-term outcomes

Funding TBC.

Table 2 –Funding and Expenditure for Output Class 2: Early Detection and Management Services

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
Improved access primary care	% of the population enrolled in the PHO	PP33	Oct-16	96.8%	89.9%	97.5%	97.1%	90%
Avoidable hospitalisation is reduced	Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	SI1 / SI5 / PP22(SLM)	12m to Sep-16	5,755		4,469	5,272	TBC[3]
	Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	SI1		7,801		3,167	4,063	TBC
More pregnant women under the care of a Lead Maternity Carer (LMC)	% of women booked with an LMC by week 12 of their pregnancy		Jul to Sep 2016	49.2%	54.5%	75.9%	65.7%	≥80%
Better oral health	% of eligible pre-school enrolments in DHB-funded oral health services	PP13	12 m to Dec-16	72.7%	69.1%	107.0%	89.2%	Yr1 ≥95% Yr2 >95%
	% of children who are carries free at 5 years of age	PP11 / SI5		44.0%	31.0%	74.0%	59.0%	TBC
	% of enrolled preschool and primary school children not examined according to planned recall	PP13		2.2%	2.7%	3.2%	2.8%	
	% of adolescents using DHB-funded dental services	PP12	12m to Dec-15				75.9%	Yr1 ≥85% Yr2 ≥85%
	Mean 'decayed, missing or filled teeth (DMFT)' score at Year 8	PP10	12 m to Dec-16	1.1	1.43	0.63	0.81	
Improved management of long-term conditions	Proportion of people with diabetes who have good or acceptable glycaemic control	PP20	12m to Dec-16	46.2%	39.3%	79.2%	65.4%	>65.4%
	% of the eligible population having had a CVD risk assessment in the last 5 years	PP20	5y to Dec-16	84.5%	84.0%	88.9%	87.8%	≥90%
Less waiting for diagnostic services	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days	PP29	Dec-16				95.1%	≥95%
	% of accepted referrals for MRI scans who receive their scans within 6 weeks	PP29	Dec-16				48.0%	≥90%

[3] *This target will be set as part of the System Level Measures process*

16.1

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
Increase referrals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions	% 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.	HT / SI5	6m to Nov-16	44%	43%	31%	40%	≥95%

OUTPUT CLASS 3: Intensive Assessment and Treatment Services

Intensive Assessment and Treatment Services are delivered by a range of secondary, tertiary and quaternary providers to individuals. This Output Class includes: Mental Health services; Elective and Acute services (including outpatients, inpatients, surgical and medical services); Maternity services; and, Assessment, Treatment and Rehabilitation (AT&R) services. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment, such as a 'hospital', and they are generally complex in nature and provided by specialists and other health care professionals who work closely together. There are also important links with community-based services before people come into hospital services and after they are discharged – these links must be well coordinated and work as seamlessly as possible.

HBDHB provides most of this Output Class through the Provider Arm, Health Services. However, some more specialised hospital services are funded by HBDHB to be provided by other DHBs, private hospitals, or other providers. Where this happens, other providers are monitored in terms of the Operational Policy Framework or specific contracts and in accordance with industry standards. On the continuum of care these services are at the complex end of "conditions" and are focussed on individuals with health conditions and prioritised to those identified as most in need.

Objective: Complications of health conditions are minimised and illness progression is slowed down

People who are suffering from injury or illness will be diagnosed accurately and offered the most effective treatment available as early as possible. We will coordinate activities that support people to reduce the complications of disease, injury and illness progression so that they have better health, in terms of survival, and are also able to participate effectively in society and be more independent. It is important that identified disparities are also reduced as quickly as practicable

Funding TBC.

Table 3 –Funding and Expenditure for Output Class 3: Intensive Assessment and Treatment Services

16.1

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
Less waiting for ED treatment	% of patients admitted, discharged or transferred from an ED within 6 hours	HT	Oct-Dec 2016	94.7%	95.7%	96.5%	94.7%	≥95%
Faster cancer treatment	% 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 from Q1 2016/17	HT	6m to Dec-16				65.4%	≥90%
More elective surgery	Number of elective surgery discharges[4]	HT	12m to Jun-16	N/A	N/A	N/A	7,469	TBC
Patients with ACS receive seamless, coordinated care across the clinical pathway	% of high-risk patients will receiving an angiogram within 3 days of admission.	PP20	Oct to Dec-16	61.1%	100%	75.3%	73.1%	≥70%
	% of angiography patients whose data is recorded on national databases	PP20	Oct to Dec-16	95.0%	66.7%	96.8%	95.5%	≥95%
Equitable access to care for stroke patients	% of potentially eligible stroke patients who are thrombolysed	PP20	Oct to Dec 16				10.2%	≥8%
	% of patients admitted to the demonstrated stroke pathway	PP20	Oct to Dec 16				88.1%	≥80%
	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	PP20	Oct to Dec 16					≥80%
Equitable access to surgery - Standardised intervention rates for surgery per 10,000 population for:	Major joint replacement	SI4	12m to Sep-16	N/A	N/A	N/A	21.5	21
	Cataract procedures			N/A	N/A	N/A	58.7	27
	Cardiac surgery			N/A	N/A	N/A	6.6	6.5
	Percutaneous revascularisation			N/A	N/A	N/A	13.1	12.5
	Coronary angiography			N/A	N/A	N/A	39.0	34.7
Shorter stays in hospital	Average length of stay Elective (days)	OS3	12m to Sep-16	N/A	N/A	N/A	1.56	1.47
	Average length of stay Acute (days)	OS3	12m to Sep-16	N/A	N/A	N/A	2.48	2.3

4 Health Target Elective Discharges is a number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB district.

Short Term Outcome	Indicator		MoH Measure	Baseline					2017/18 Target
				Period	Māori	Pacific	Other	Total	
Fewer readmissions	Acute readmissions to hospital		OS8						TBC
Quicker access to diagnostics	% accepted referrals for elective coronary angiography completed within 90 days		PP29						95%
	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks		PP29	Dec-16	100%	N/A	90.9%	91.7%	90%
	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)		PP29	Dec-16	100%	100%	92.7%	93.9%	70%
	% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date		PP29	Dec-16	100%	-	97.6%	98.1%	70%
Fewer missed outpatient appointments	Did not attend (DNA) rate across first specialist assessments			Oct-Dec 2016	14.2%	22.1%	3.8%	6.7%	≤7.5%
Better mental health services Improving access Better access to mental health and addiction services	Proportion of the) population seen by mental health and addiction services	Child & youth (0-19	PP6	Oct 2015 – Sep 2016	4.92%	2.14%	3.79%	4.26%	TBC
		Adult (20-64)	PP6		9.26%	2.14%	3.83%	5.11%	TBC
		Older adult (65+)	PP6		1.19%	1.00%	1.11%	1.12%	TBC
Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	% of 0-19 year olds seen within 3 weeks of referral	Mental Health Provider Arm	PP8	Oct 2015 – Sep 2016	74.1%	68.4%	71.1%	72.3%	≥80%
		Addictions (Provider Arm and NGO)	PP8		80.5%	-	83.9%	81.1%	≥80%
	% of 0-19 year olds seen within 8 weeks of referral	Mental Health Provider Arm	PP8		93.6%	94.7%	90.0%	91.7%	≥95%
		Addictions (Provider Arm and NGO)	PP8		93.6%	-	96.8%	94.6%	≥95%
Improving mental health services using discharge planning	% children and youth with a transition (discharge) or wellness plan		PP7	Jan-Dec 2016				92.5%	≥95%
Increasing consumer focus More equitable use of Mental Health Act: Section 29 community treatment orders	Rate of s29 orders per 100,000 population		PP36 / SI5	Oct-Dec 2016	179.9	-	62.1	90.1	≤81.5

16.1

OUTPUT CLASS 4: Rehabilitation and Support Services

This output class includes: Needs Assessment and Service Coordination (NASC); palliative care; rehabilitation; home-based support; aged residential care; respite care and day care for adults. Many of these services are delivered following a 'needs assessment' process and involve coordination of input from a range of providers. Rehabilitation and Support services assist people with enduring conditions and disabilities to live independently or to receive the support that they need either temporarily or over the rest of their lives. HBDHB provides NASC services through Options Hawke's Bay - a unit that reports to our General Manager, Integrated Care Services. Other services are provided by our Provider Arm, General Practice and a number of community-based NGOs and private organisations. On the continuum of care these services provide support for individuals who have complex, complicated or end-stage conditions.

Objective: People maintain maximum functional independence and have choices throughout life.

Where returning to full health is not possible we will work with our stakeholders to support and care for people so that they are able to maintain maximum function with the least restriction and the most independence. For people in our population who have end-stage conditions, it is important that they and their family or whānau are supported to cope with the situation, so that the person is able to live comfortably and to die without undue pain or suffering.

Funding TBC.

Table 4 –Funding and Expenditure for Output Class 4: Rehabilitation and Support Services

OUTPUT CLASS 4

Short Term Outcome	Indicator		MoH Measure	Baseline					2017/18 Target
				Period	Māori	Pacific	Other	Total	
Better access to acute care for older people	Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)	75-79 years		Jan 2016 – Dec 2016	164.3	175.0	111.2	124.0	≤130
		80-84 years			208.3	300.0	167.0	167.8	≤170
		85+ years			136.4	0	237.7	216.6	≤225
Better community support for older people	Acute readmission rate: 75 years +								<10%
	% of people receiving home support who have a comprehensive clinical assessment and a completed care plan		PP23						≥95%
	Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment.		PP23	Oct-Dec 2016	-	-	-	77%	85%
	The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long term care facility (LTCF) assessment.		PP23	Oct-Dec 2016	-	-	-	85%	95%
Increased capacity and efficiency in needs assessment and service coordination services	Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment								<13.8%
Prompt response to palliative care referrals	Time from referral receipt to initial Cranford Hospice contact within 48 hours			Oct-Dec 2016	N/A	N/A	N/A	100%	>80%
More day services	Number of day services								≥21,791
More older patients receive falls risk assessment and care plan	% of older patients given a falls risk assessment % of older patients assessed as at risk of falling receive an individualised care plan			Oct-Dec 2016	N/A	N/A	N/A	96.7% 98.0%	90% 98%

16.1

Financial Performance

TBC

APPENDIX B: SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

See PDF Version of System Level Measures Improvement Plan Final Draft

16.1

HAWKE'S BAY

2017/18 System Level Measures Improvement Plan DRAFT

June 2017

16.1

Keeping Children out of Hospital

SYSTEM LEVEL MEASURE

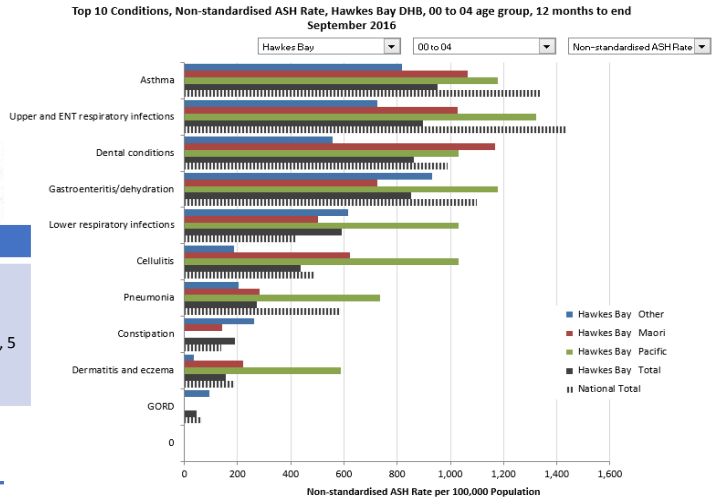
Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds

Ambulatory Sensitive Hospitalisations (ASH) reflect hospital admissions for conditions which could potentially be prevented by early access to treatment in care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access.

However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socioeconomic and ethnic disparities in child health exist, a greater emphasis may need to be placed on addressing those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). This is because, even with optimal access, the ability of a general practitioner to prevent a paediatric pneumonia admission after the first crucial hours may be limited, but the opportunities available for a DHB to prevent paediatric respiratory infections via e.g. healthy housing projects and parental smoking cessation programmes may be considerable.

There is an inequity in the ASH rates 0-4 for Māori, Pacific and other. The largest inequity is observed in dental and we are worse than the National rate in Lower Respiratory Conditions.

The top ASH conditions for Māori are Asthma, Dental conditions, Respiratory Infections- Upper and ENT, Respiratory Infections – Lower, Gastroenteritis/ Dehydration and Cellulitis.



	Baseline*	2017/18 Milestone
Total	5,272	Reduce the difference between Māori and other rate to ≤1,028 (20% reduction in gap, 5 year elimination)
Māori	5,755	
Pacific	8,088	
Other	4,469	

*12 months to September 2016

CONTRIBUTORY MEASURES

Measure	Baseline	Goal
Decreased hospitalisations due to dental conditions for Māori & Pacific 0-4	1,167	≤934 (20% reduction)
Decreased hospitalisations due to respiratory for total population 0-4	2,713	≤2,170 (20% reduction)
% of 8 month olds who complete their primary course of Immunisations (HT)	95.3%	≥95%

HOW WILL WE ACHIEVE IT?

- Use learnings from the successful adult respiratory programme, designed to reduce adult hospital admissions due to respiratory conditions, to tailor a paediatric programme and roll out to general practices by Q4.
- Increase scope of the Oral Health Project to include a specific focus on reducing ASH rates. The project is generally focused on increasing carried free at 5 years but will now have a workstream designing a collaborative approach to reducing ASH 0-4 through early primary care intervention and investigating the incidence of children experiencing ASH for more than one condition and how they could be better coordinated for risk factors and advice, especially for Māori, Pacific and low decile populations
- Form one whole sector governance group for under 5s for better coordination of initiatives for this age group.
- Design and implement a quality improvement initiative in primary care based on rapid oral rehydration to reduce the number of kids requiring admission for dehydration.

Using Health Resources Effectively

SYSTEM LEVEL MEASURE: Acute hospital bed days per capita

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers. This includes access to diagnostics services.

Reducing acute hospital bed days aligns with our challenge in Transform and Sustain of being more efficient at what we do.

At the end of 2016, Hawke's Bay's standardised acute hospital bed day rate was the second lowest in the country. Despite this, we continue to focus our efforts on reducing avoidable admissions through more effective care in the community; and reducing length of stay and readmission rates through better hospital processes and collaboration across the sector.

Ambulatory Sensitive hospitalisation (ASH) rates for 45-64 years are a contributing factor to acute hospital bed days and in their own right are a measure of the whole system working effectively. Our top five ASH 45-64 conditions are Angina and chest pain, Myocardial infarction, cellulitis, gastroenteritis/dehydration and COPD. The largest inequity gap between Māori and other is in COPD and Congestive Heart Failure (CHF).

Baseline:

	Estimated Popn	Acute Stays	Acute Bed Days	Standardised Acute Bed Days per 1,000 Popn		
Year	Year to Sep 2016	Year to Sep 2016	Year to Sep 2016	Year to Sep 2014	Year to Sep 2015	Year to Sep 2016
Māori	41,355	5,848	16,427	649	554	545
Pacific	6,040	891	2,146	755	543	525
Other	113,595	15,002	51,206	373	342	345
Total	160,990	21,741	69,780	420	381	384

hospital bed days per 1,000 popn between Māori and other.

CONTRIBUTORY MEASURES

Measure	Baseline	Goal
Decreased Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 45 – 64 year olds Māori	Total: 4,129 Other: 3,262 Māori: 7,636	Māori: 6,761 (20% reduction in gap Māori and other
TBC primary care enrollment or utilization measure		
Uptake of hospital discharge CPO initiative	TBC	TBC

HOW WILL WE ACHIEVE IT?

- Recruit to a new position of intern Nurse Practitioner for Heart Failure working between primary and secondary care to facilitate cardiac management and reduce CHF admissions. Focus on developing the role to transition skills into the community, learning from the success of the adult respiratory programme which was centered around improving capacity and capability in primary care.
- Continue with successful Respiratory programme but focus on equity, moving to a whānau based model with more focus on management rather than screening and diagnosis.
- Develop a programme to implement tracer auditing in long term conditions areas of focus e.g Renal and diabetes, respiratory and cardiology.
- TBC activity to increase enrollment through SIA funding
- TBC activity on increasing uptake of hospital discharge CPO initiative with a focus on inequity

16.1

Prevention and Early Detection

SYSTEM LEVEL MEASURE: Amenable mortality rates

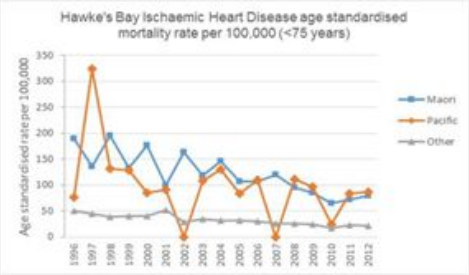
We have seen significant and continued reduction in deaths, which could have been prevented by either prevention or early treatment programmes or better access to medical care. Nearly three-quarters of all deaths before the age of 75 years are avoidable either because of disease prevention or because of effective treatment and health care. Deaths due to these diseases or conditions can be counted and expressed as a rate. Any difference in these rates by ethnicity or by area of residence can therefore be considered to be a health inequity.

The top five causes of amenable mortality for all populations, in order, is Cardiovascular Disease, Suicide, Cerebrovascular disease, COPD and Female breast cancer. For Māori, it is coronary disease, diabetes, suicide, land transport accidents (excluding trains), cerebrovascular diseases and COPD.

Amenable mortality rates are 2.6 and 3 times higher for Māori and Pacific respectively than non-Māori, non-pacific. This highlights a large inequity in prevention and early detection for Māori and Pacific. Given what we know about our top causes, the system will focus on cardiovascular disease and diabetes, particularly for Māori, and cancer. Youth suicide will be a focus of the 'Youth are Healthy, Safe and Supported' SLM and respiratory will be a focus in Using health resources effectively. All of these will contribute to reducing amenable mortality.

Baseline	2017/18 Milestone
Total = 113.1 Māori = 224.9, Pacific = 260.4, NMNP = 87.6 (Amenable mortality, ages 0-74, 2009-2013) Relative Rate between Māori and NMNP = 2.56	Relative Rate between Māori and NMNP ≤1.8 by 2023, ≤1 by 2028

NB: Given the small number in the pacific population, it is difficult to put a target on reducing the standardised rate however, we will be focussing on services to improve equity for Pasifika as well as Māori.



CONTRIBUTORY MEASURES

Measure	Baseline	Goal
Increased number of Māori males 35-44 yrs have had a CVD risk assessment in the past 5 years	Total = 87.8%, Māori & Pacific males 35-44yrs = 67.2% (5yr to Mar 2017)	≥90%
Better help for smokers to quit (PHO HT)	Total = 87.4%, Māori = 85.1% (Oct-Dec16)	≥90%
Faster Cancer Treatment (HT)	Total = 65.4%, (6m to Dec 16)	≥90%

HOW WILL WE ACHIEVE IT?

- Develop a geographical map of diabetes prevalence and screening and management service provision across Hawke's Bay to better understand gaps in service coverage. Use this to inform improvements to service coverage for diabetes.
- Faster Cancer Treatment Group, which includes representation from primary, secondary services and cancer society, to oversee development and implementation of FCT action Plan to improve timeliness of cancer treatment.
- Work with other sectors in Hawke's Bay to develop a Social inclusion action plan and identify the health secor's contribution to delivery of that plan
- TBC actions on CVDRA Māori & Pacific Males
- TBC action on extending the PIP pilot on pre-diabetes and dietary advice

Person and Whānau-centred Care

SYSTEM LEVEL MEASURE: Patient experience of care

How people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Improved patient experience of care will reflect better integration of heath care at the service level, better access to information and more timely access to care.

Patient experience surveys provide scores for four domains which cover key aspects of a patient's experience when interacting with health care services: Communication, partnership, coordination, and physical and emotional needs.

The purpose of these measures is to ensure patients in New Zealand are receiving quality, effective and integrated health services. Evidence suggests that if patients experience good care, they are more engaged with the health system and therefore likely to have better health outcomes

This measure captures patient experience in two settings:

- Hospital inpatient surveys (currently undertaken quarterly since 2014)
- Primary care survey (introduced in a phased approach quarterly from Feb 2016)

Our Hospital Inpatient baseline results are as follows:

Domains	Inpatient Results (Oct-Dec 16)
Communication	8.3
Partnership	8.4
Coordination	8.3
Physical and Emotional needs	8.8

SLM 2017/18 Milestone: 100% of General Practices undertaking the primary care survey by March 2017
Baseline: 0%

Although our Milestone is based on rolling out the survey in general practice, our plan is focused on improving uptake and experience across both settings.

CONTRIBUTORY MEASURES

Measure	Baseline	Goal
Patients completing the primary care patient experience survey	0%	>0%
HQSC Inpatient survey response rate	21% (Nov 2016)	>27% (current national baseline)
Decreased did not attend (DNA) rate for first specialist appointment (FSA)	Total = 6.7% Māori = 14.2%	≤7.5%
Proportion of staff carrying out relationship centred practice training	DHB: TBC General Practice: 0%	DHB: ≥50% General Practice: ≥10%

HOW WILL WE ACHIEVE IT?

- Roll out the HQSC Patient Experience Survey in primary care
- Carry out analysis across both surveys to look at who is and is not being represented in the responses to the patient experience survey and work together as a whole system to develop a plan to address these gaps.
- Form a group across both surveys to develop a process where responses are analysed and feedback to services to drive service improvement.
- Facilitate access to health literacy e learning training programme and HB relationship centred practice training, socialising the benefits of completion to General practice and enrolled patients.
- Carry out audits for youth friendly services in general practices involved in free under 18 visits and form a cluster plan based on the audit and youth consumer feedback.
- Deliver monthly seminars on customer service to administration staff for on going development e.g. organisation values and dealing with challenging behaviour

16.1

Youth are Healthy, Safe and Supported

SYSTEM LEVEL MEASURE: Youth access to and utilisation of youth appropriate health services - Developmental

Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or 'risk factors'. Evidence shows that youth are not in the habit of seeking the services or advice of a registered health practitioner when unwell. Generally they cope with illness with advice from friends and whānau as they see fit. Attending a health clinic is often viewed as a last resort instead of a reasonable first choice.

This measure focuses on youth accessing primary and preventive health care services. Research shows that youth whose healthcare needs are unmet can lead to increased risk for poor health as adults and overall poor life outcomes through disengagement and isolation from society and riskier behaviours in terms of drug and alcohol abuse and criminal activities.

Hawke's Bay has a Youth Strategy which conveys a shared vision for young people by identifying a common set of youth outcomes and indicators that cuts across the work of many organisations/services working with youth. The strategy aligns with the youth development approach, focusing on a balance between services designed to prevent, intervene or treat health problems as well as promoting development through preparation, participation and leadership experiences with youth.

The Hawke's Bay Youth Consumer Council has identified Alcohol and Other Drugs and Mental Health and Wellbeing as their two top priorities for the System Level Measure. These areas will be developed with a strong focus on youth experience of the health sector.

SLM Milestone TBC – waiting on data. Options: Alcohol-related Emergency Department (ED) Presentations for 10 – 24 year olds and Self-Harm Hospitalisations and short stay ED presentations for under 24 year olds

CONTRIBUTORY MEASURES

Measure	Baseline	Goal
Reduce the % of 'unkown '		
TBC data quality		

HOW WILL WE ACHIEVE IT?

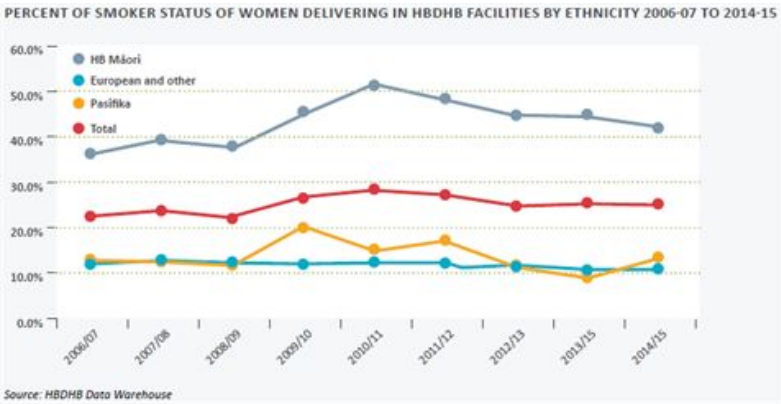
- Hold workshops with youth service providers to map out patient pathways for the two priority areas. Use the maps to identify gaps in service provision for youth and use this to inform decisions for youth services.
- Complete a tender process to procure strengthened youth services in line with the Youth Health Strategy Outcomes
- Implement free GP visits for U18 year olds in Hake's Bay
- Continue to support and utilise the Youth Consumer Council for decisions relating to Youth Health in Hawke's Bay.

Healthy Start

SYSTEM LEVEL MEASURE: Proportion of babies who live in a smoke-free household at six weeks postnatal - Developmental

This measure aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment and will encourage an integrated approach between maternity, community and primary care.

SLM Milestone TBC – waiting on data. Number of new babies with No recorded for household smoker at a WCTO Core Contact before 50 days of age (source: WCTO NHI data set).



CONTRIBUTORY MEASURES

Measure	Baseline	Goal
Pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer who are offered brief advice and support to stop smoking (HT)	Māori: 78.8% Total: 88.5%	≥90%
Proportion of babies who live in a smoke-free household at LMC registration		
Proportion of babies who live in a smoke-free household at discharge from maternity unit		
% of women, by ethnicity, booked with an LMC by week 12 of their pregnancy	Māori: 49.2% Pacific: 54.5% Other: 75.9% Total: 65.7%	≥80%

HOW WILL WE ACHIEVE IT?

- Hold workshops with service providers and population health to map out specific population pathways for smokefree interventions across their lifetime. Use the map to identify areas for improvement. Speak to Maori women who are not smokefree about how their pathway could be improved and why they are not smokefree.
- Carry out a project to gain understanding of why people do not engage with Te Haa Matea following referral and implement changes as a result of that feedback
- Work with WCTO providers to ensure good data quality.
- Form a group with representatives from key providers to progress work in this area.

16.1

tas
KAHUI TUITUI TANGATA

REGIONAL
SERVICES PROGRAMME

16.2

Central Region
Regional Service Plan 2017/18

Version: Final Draft

Capital & Coast District Health Board
WHANGANUI DISTRICT HEALTH BOARD
HUTT VALLEY DHB
MidCentral District Health Board
HAWKE'S BAY District Health Board
Wairarapa DHB

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Letter from Minister

16.2

Table of Contents

Executive summary

This document outlines the Central Region's Regional Service Plan (RSP) 2017/18. The RSP has been developed collaboratively by the six District Health Boards (DHBs) in the Central Region and reflects a strong focus on active partnership, collaboration and co-design principles across the regional work programme.

In developing the RSP the six DHBs recognise and acknowledge the guiding principles of the New Zealand Health Strategy (2016), the Ministry's system outcomes and government commitments, and the evolving nature of the health sector and the challenges we face in improving outcomes for our population.

The RSP describes the Central Region's efforts to improve quality, safety and experiences of care across the region, with the ultimate objective of improving health outcomes and equity. Underpinning this is a strong focus on delivering the greatest value possible within the strict resourcing and financial constraints of the DHBs.

An emphasis has been placed on embedding the five themes of the New Zealand Health Strategy across the various regional work programmes and there is a strong focus on integration and reducing siloes, thinking holistically and looking at a whole of system approach, building the necessary relationships and platforms for sharing knowledge, and establishing a stronger foundation for working better together. The Central Region has also revisited its vision and regional outcomes and now has a unified line of sight that supports an aligned approach to prioritisation, planning and implementation. This reflects a strategic focus and commitment to thinking and planning beyond the narrow definitions of health and collaborating with others to achieve well-being. Achieving this requires local, sub-regional and regional responses, alignment to national effort and proactively looking for partnerships and collaboration outside of traditional boundaries.

While each of the six Central Region DHBs is individually responsible for the provision of services to its own population, we recognise that working regionally enables us to better address our shared challenges. Together we are committed to a sustainable health system focused on keeping people well and providing equitable and timely access to safe, effective, high-quality services as close to people's homes as possible.

In the upcoming financial year of 2017/18 established programmes of work and commitment to delivering on the Ministry priorities will continue. The Sudden Unexpected Death in Infancy Prevention Programme has also been added to the priorities. These priorities are supported and enabled by Information Communication Technology, Workforce and Quality and Safety.

The priorities include:

1. Cancer Services
2. Cardiac Services
3. Diagnostic Services
4. Elective Services
5. Healthy Ageing
6. Hepatitis C
7. Major Trauma
8. Mental Health and Addiction
9. Stroke Services
10. Palliative Care / End of Life Care
11. Sudden Unexpected Death in Infancy Prevention Programme (new)

Enablers

1. Information Communication Technology
2. Workforce
3. Quality and Safety

The Central Region DHBs will prioritise their combined effort on programmes where regional work adds the greatest benefit to the health of the population and the combined resources of the DHBs.

Introduction

This document outlines the Central Region's Regional Service Plan (RSP) 2017/18. The RSP has been developed collaboratively by the six District Health Boards (DHBs) in the Central Region and reflects a strong focus on active partnership, collaboration and co-design principles across the regional work programme. In developing the RSP the six DHBs recognise and acknowledge the guiding principles of the New Zealand Health Strategy (2016), the evolving nature of the health sector and the challenges we face in improving outcomes for our population.

The RSP describes the Central Region's efforts to improve quality, safety and experiences of care across the region, with the ultimate objective of improving health outcomes and equity. Underpinning this is a strong focus on delivering the greatest value possible within the strict resourcing and financial constraints of the DHBs.

In 2017/18 the Central Region will continue to focus on improving health outcomes and health equity for all. The RSP initiatives are intended to strengthen services and contribute to improved outcomes for patients and their whānau, enhance service sustainability, cross-sector integration and financial viability. An emphasis has been placed on embedding the five themes of the New Zealand Health Strategy across the various regional work programmes and there is a strong focus on integration and reducing siloes, thinking holistically and looking at a whole of system approach, building the necessary relationships and platforms for sharing knowledge and establishing a stronger foundation for working better together. The Central Region has also revisited its vision and now has a unified line of sight that supports an aligned approach to prioritisation, planning and implementation. The regional plans have been moderated by individual DHBs to ensure there is alignment to their Annual Plans and strategic intent. The RSP has also been moderated by Chief Operating Officers and Planning and Funding Managers to provide assurance that, across the region, time and effort is being used in the most effective way to address priority areas.

In developing a regional approach it is important to be mindful of and understand the diverse nature of the Central Region's population in terms of deprivation, ethnicity and urban and rural geographic drivers. This often requires a regional approach that has the flexibility of local implementation to meet the particular needs of that population. This often requires sub-regional initiatives and agility in service provision to ensure that health outcomes are improved and that there is equity in the access of services. To achieve this the partnership across the region is committed to being flexible, proactive and inclusive by involving people and service users through co-designs of new and improved solutions to the various problems and opportunities that we are faced with as a region.

Government Expectations

DHBs are guided by the New Zealand Public Health and Disability Act 2000, with the New Zealand Health Strategy (2016) providing an overarching direction supported by a range of population health strategies.

These strategies include among other: the New Zealand Disability Strategy; He Korowai Oranga – Māori Health Strategy, 'Ala Mo'ui – Pathways to Pacific Health and Wellbeing; Healthy Aging Strategy; Primary Care Strategy and Rising to the Challenge: Mental Health; and the Addiction Service Development Plan. He Korowai Oranga, the Māori Health Strategy, is a key priority nationally and regionally. To improve equity, Māori health outcomes need to improve to reflect more closely to those of non-Māori populations and is of key importance in achieving the goals of the New Zealand Health Strategy.

Combined these strategies contribute to achieving the overall goal of the New Zealand Health Strategy that:

ALL NEW ZEALANDERS LIVE WELL, STAY WELL AND GET WELL

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

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

DHBs are expected to contribute to meeting these system outcomes and government commitments to provide 'better public services' by: increasing access to services; improving quality and patient safety; supporting the health of children, older people and those with mental illness; making the best use of IT; and strengthening our health workforce.

Working regionally is a key expectation of both the Ministry and the Minister of Health to ensure that DHBs maximise the effectiveness of their long term strategic planning activities and collaborate across the region to deliver improved health outcomes

In delivering its commitment to better public services and better, sooner, more convenient health services, the government also has clear expectations of increased regional collaboration and alignment between DHBs.

Global Challenges

- Health and social services must be provided to increasing numbers of older people who are living longer.
- The health burden of long-term conditions, such as heart disease, diabetes, depression, dementia, and musculo-skeletal conditions, is growing.
- Benefits need to be assessed in light of affordability as new technologies and drugs emerge and expectations about health services rise.
- The global workforce is highly mobile.
- New infections and antibiotic resistance are emerging.
- Climate change has health and social consequences.

New Zealand Health Strategy 2016

16.2

Implementation of the New Zealand Health Strategy

The New Zealand Health Strategy (2016) is a refresh of the original New Zealand Health Strategy (2000) and has five interlinked themes built around a revised suite of eight population and person-centred principles for the sector.

FIGURE 1: FIVE STRATEGIC THEMES OF THE HEALTH STRATEGY

The five themes and associated action areas contribute to a five-year plan to deliver an improved New Zealand health system and improved health outcomes for New Zealanders.

The direction of the Health Strategy is an empowering one that enables the system to more easily facilitate behaviour shifts at a system level:

- from treatment to prevention and support for independence
- from service-centred delivery to people-centred services
- from competition to trust, cohesion and collaboration
- from fragmented health sector silos to integrated social responses.

This shift in focus presents a change to the way the Central Region collaborates and plans, reflecting a strategic move away from traditional and established ways of working in health and care. The Central Region is committed to thinking and planning beyond the narrow definitions of health and collaborating with others to achieve wellbeing.

Implementing the five themes of the refreshed New Zealand Health Strategy and delivering on the Government's commitment to cross agency collaboration requires both local, sub-regional and regional level planning responses as well as proactively looking for partnerships and collaboration outside of traditional boundaries. Please refer to Appendix 1 for further information on regional alignment to the Health Strategy.

Regional Context

While each of the six Central Region DHBs is individually responsible for the provision of services to its own population, we recognise that working regionally enables us to better address our shared challenges. Together we are committed to a sustainable health system focused on keeping people well and providing equitable and timely access to safe, effective, high-quality services as close to people's homes as possible.

The interconnected and 'whole-of-system' approach to service planning required to deliver on the suite of national and regional priorities is complex and reflects the nature of a socially integrated model of health and care. The traditional life course continuum of care approach to models of care is reflective of a single sector approach to planning. The New Zealand Health Strategy asks that the wider environmental and community determinants of health and care become a feature of our planning and approach. This requires a focus on improving equity of outcomes and access to services through the adoption of models that address the social determinants of health and wellbeing.

This system-wide coordinated view of health and social service planning and delivery is representative of the collective approaches required to ensure that the various activities and initiatives at the national, regional and DHB (local) levels are aligned.

The RSP also supports the integration of initiatives to improve equity and improve Māori health outcomes into all health services and provides transparent linkages between local initiatives (including iwi and hapū initiatives) and national priorities.

RSP development

In developing the RSP, the direction and focus of regional planning initiatives have been developed and refined in an ongoing collaboration with DHB planners, regional governing groups and other key stakeholders. The RSP goes through several moderations to ensure and agree on:

- direction and content
- alignment to the Central Region strategic direction
- resources, time, effort and prioritisation across the region
- and that work is carried out in the most effective way to deliver on improved outcomes for our population.

Improving Health Outcomes for Our Population

In 2017/18 and beyond, DHBs are required to deliver outcomes against the five key themes of the New Zealand Health Strategy and the national health sector outcomes. The Triple Aim principles also give the Central Region a mechanism to provide service outcomes that are sustainable, meet quality and safety expectations, and are delivered within available resources.

As part of this accountability, DHBs need to demonstrate they are succeeding in meeting these commitments and improving the health and wellbeing of their populations. There is no single simple measure that can demonstrate the impact of the work DHBs do, so a combination of indicators at a population and health service level are used to demonstrate the impact and effectiveness of improvement activities on the health status of the population and the effectiveness of the health system.

The Central Region has taken an approach to consolidate the work in the identified priority areas. An 'Outcomes Framework' (See Appendix 2) provides a framework for achieving our priorities against the Ministry's health system outcomes.

Alongside the Outcomes Framework, the Central Region looks to the Māori Health Strategy He Korowai Oranga as a fundamental component of all planning activities.

The achievement of these high-level outcomes, along with the operationally-focused, clinically-led outcomes across the networks, will have real impacts on the lives of the Central Region's population. Deliverables that enable the region to achieve these outcomes are the outlined in the Central Region's work programmes.

The Central Region

Profile

The region's population will grow by 6% over the next 20 years and there will be an 89% increase in people aged over 70 years. Our health workforce is aging too with a forecasted decrease in people aged 50-59 years.

Communities will become more diverse with more Māori, Asian and Pacific people. The number of people who identify as Māori will increase by 37%. The Asian population will increase by 60%.

The region has pockets of people who demonstrate risky health behaviours, live in highly deprived areas and have limited access to transport and employment. Approximately 89,500 people live in the most deprived areas of the region.

Population distribution

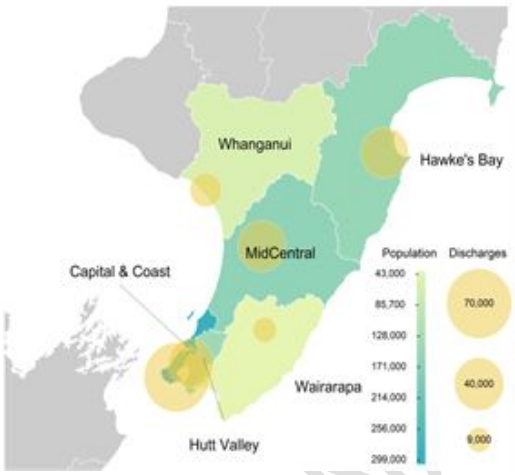

FIGURE 2 THE CENTRAL REGION DHBS

12%	Of our population live across our two smallest DHB regions: Whanganui and Wairarapa.
53%	Of our population live across our two largest DHB regions: MidCentral and Capital & Coast.

The Central Region population is
895,000 (19% of NZ total)

The region's population in 20 years
950,500 (6% increase)
86,000 more people aged 70+ (89% increase)

Population growth

Estimated population growth will not be evenly distributed across the Central Region DHBs, with CCDHB experiencing the greatest increase and WhaDHB's population expected to decrease. Please refer to Appendix 3 for detailed demographics of the Central Region.

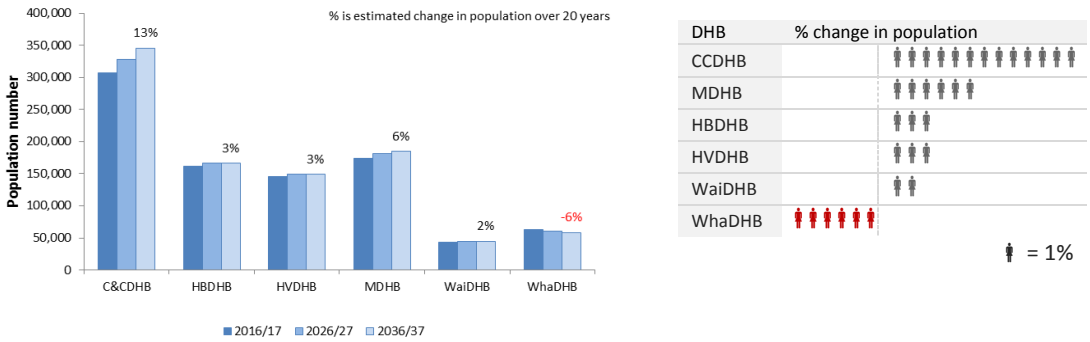

FIGURE 3 POPULATION ESTIMATES AND CHANGE BY DHBS

Regional Governance and Leadership

In November 2016 the Central Region Chief Executives and members of their leadership teams came together to discuss a refresh in the Central Region Vision and Strategy. There was general consensus that this was a timely discussion and there was willingness and engagement across the DHBs to come together and clearly articulate a future direction for the Central Region.

The result of this initial discussion was a number of strategic workshops, wider consultation and engagement across the region to ensure that the Central Region Vision and Strategy was developed from a combined top-down, bottom-up approach, with relevant input and feedback across all levels of the DHBs. The end result was a clearly defined vision for the Central Region, a strategy for achieving that vision over the course of the next 3-5 years, as well as agreed regional values, behavioural statements, roles and responsibilities and a decision making framework. Throughout this work the refreshed New Zealand Health Strategy and the Triple Aim underpinned the discussion and outcome.

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This refreshed vision and emergent strategy will set the foundation for the region moving forward and will be further evolved and elaborated on in the coming year. The key priorities that have been identified for the Central Region, in addition to the revised values, roles and responsibilities, will feed into the 2018/19 Regional Services Plan.

Vision and values

Central Region Vision

CENTRAL REGION DHBS LEADING TOGETHER TO ACHIEVE

NEW ZEALAND'S HEALTHIEST COMMUNITIES

What does the future look like?

- No matter who you are and where you live you can expect the same result/quality of outcome
- Our communities are resilient and connected
- People are owners of their health and wellbeing
- All clinical services are delivered as locally as possible, as specialised as necessary

How do we get there?

- Highly capable and compassionate workforce
- Partnerships address social determinants
- A digitally enabled health system
- Fully connected information to support decision-making
- Effective decision making and prioritisation (and investment choices)
- Transformed care at a system level
- Networked specialist services across the region
- Highly skilled and courageous leadership
- Consumers as owners design services supported by specialist knowledge
- Commitment to continually improve quality and safety

Central Region Values

*To realise our vision, as **partners** we will…*

*Strive for **excellence***

*act with **integrity***

*be **courageous***

***inspire** each other*

Mahi ngātahi - Partnership

We all share responsibility for this kaupapa

We actively support our partners and colleagues

We understand and take ownership for our role in

Kounga - Excellence

We strive for best practice in everything we do

We are patient and whanau centered

We constantly drive improvements

Whai Mana - Integrity

We demonstrate understanding, honesty and openness

We build trust by turning our words into actions

We embody respect with the way we treat others

Māia - Courage

We don't shy away from hard decisions or difficult conversations

We're not afraid to take calculated risks when the benefits warrant it

We are prepared to challenge accepted wisdom

Whakaohooho - Inspire

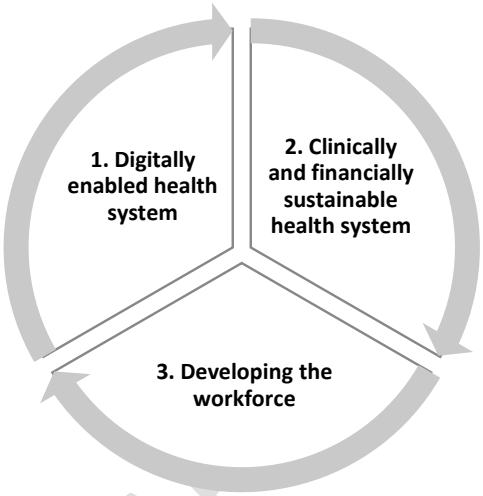
We celebrate and share success

We are role models by living our values

We proactively develop our teams and our successors

Priorities

To guide the region on this journey three key priorities have been identified that will be the core focus for the next three years.



These three priorities will inform a regional work programme where outcomes will be clearly defined, alliances made with known trade-offs and benefits, requirements clearly scoped and detailed planning for resourcing, scheduling and relevant funding will be worked through. Once this is approved the work programme will feed into the regional networks and provide regional direction to inform regional efforts.

Promoting strong clinical governance

It is a principle of the Central Region that the regional work is led by clinicians. This work is overseen by a governance structure for the networks that supports them through detailed planning, scoping of requirements, estimating the funding required and the value proposition of new initiatives. The DHB Boards then meet biannually to provide oversight and review the regional priorities against performance and to determine new priorities that may emerge with a changing landscape.

The opportunity exists to create regional agreements on service care arrangements. The region's governing groups and clinical networks will be working together in 2017/18 to assess opportunities of improved care arrangements which will then be driven through the networks with clinical leads involved throughout the entire process from design to implementation.

Governance

There is a commitment in the Central Region to ensure that each DHB benefits from the investment in collaborative work. To support this the Central Region governance is structured as demonstrated in Figure 4.

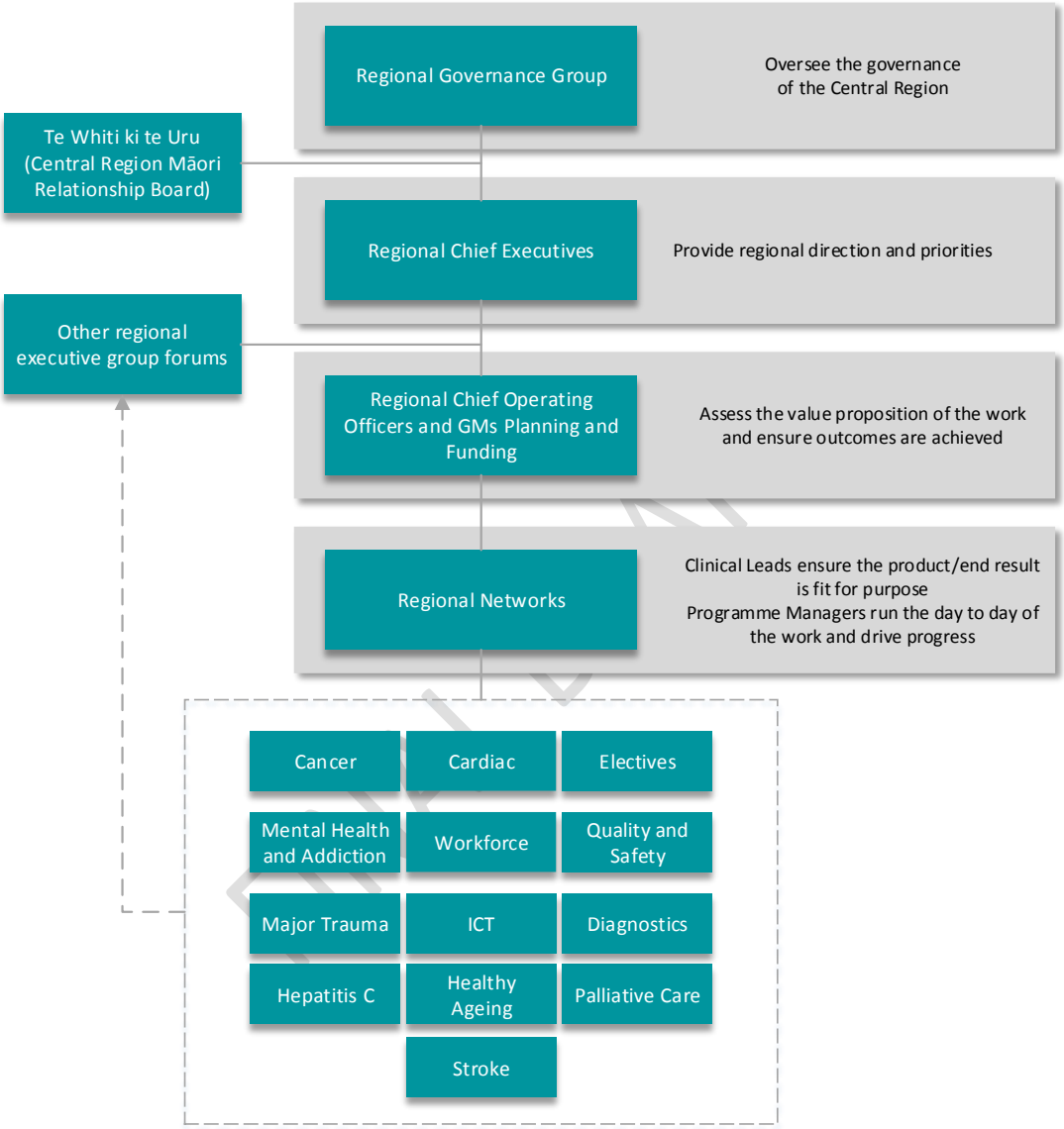


FIGURE 4 CENTRAL REGION GOVERNANCE

16.2

Improving Quality and Safety

The Health Quality and Safety Commission leads and co-ordinates quality improvement in New Zealand to improve the quality and safety of health care. The Commission works with DHBs and other health care providers across a number of established national programmes including Falls prevention, medication management and pressure injury prevention as well as building improvement capability and capacity and setting national expectations for quality improvement and consumer involvement. Where appropriate regional work plans align with the work of the Commission and support quality improvement as a fundamental part of planning and implementation.

FIGURE 5 THE TRIPLE AIM

Health Equity

The improvement of Māori health outcomes is a combined responsibility across the health and social sectors. He Korowai Oranga, New Zealand's Māori Health Strategy, sets the overarching framework that guides the government and the health and disability sector to achieve the best health outcomes for Māori. Updated in 2014 He Korowai Orangais Pae Ora (Healthy Futures) builds on the initial foundation of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments).

To achieve Pae Ora a wider response of all sectors is required. Structured inter-sector approaches that ensure crown agencies are aligned and working together to support the aspirations of whanau and communities is essential. He Korowai Oranga provides clear strategic guidance for DHBs to enact.

The integration of actions and measures that clearly align with He Korowai Oranga goals are Whānau Ora (Healthy Families, Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments). These are central to addressing current inequities across the Central Region.

We know Māori communities across the region have significantly higher health and social needs. Our health systems and services need to ensure that equity of health outcomes across communities is on every agenda and that there are specific actions and measures for increasing Māori health gain.

There is recognition that the Māori equity issues vary across our region. Our response needs to be one that supports local solutions which are resourced and integrated with regional capacity and planning.

The Central Region is committed to maintaining its focus on Māori health by ensuring that the RSP contains actions that accelerate Māori health gain and contribute towards equity. The region will strive towards increasing ethnicity data usage in performance dashboards to better monitor relevant indicators.

A regional summary of performance dashboards will be provided at the end of quarter two and four to compare trends and share learnings.

DHB General Managers of Māori Health will continue to partner with the networks for each priority area to ensure there is sound advice and support. General Managers of Māori Health will continue to implement the Pae Ora framework across DHBs and other sectors as appropriate for improving the health status of the region.

Workforce

The Central Region is committed to ensuring regional workforce development is aligned to service and population demands while remaining focused on improving recruitment, retention and distribution of health professionals. As practice evolves and models of care develop in response population need and innovation across health and care, the role and scope of practice of health professionals and the wider workforce must also change.

Workforce initiatives for the 2017/18 year build on the alliance formed between the six regional DHBs, Health Workforce New Zealand and the National Strategic Workforce Team. The work programme is underpinned by a focus on building capability and capacity, in particular within vulnerable workforces, leadership and the values and culture of the workforce. Where regional work programmes identify workforce issues these will be addressed as part of a collaborative planning process using regional and national data and networks to inform innovative and flexible regional solutions.

Our regional workforce programme will continue to strengthen the support for vulnerable workforces while continuing to build on existing recruitment and retention strategies aligned to changing scopes of practices and emerging models of care.

In 2017/18 key workforce actions are the re-establishment of the Central Region workforce hub to ensure alignment across the DHBs and priority areas, collection of ethnicity data and planning to increase Māori and Pasifika participation in the workforce. Workforce development areas include midwifery workforce and palliative care planning. Please refer to the Workforce section on Page 67 for further information.

Information Communication Technology

The Central Region Information Systems Plan (CRISP) - Phase 1 commenced in 2010 and had a proposition to move the Central Region DHBs from a current state of disparate, fragmented, and in some cases obsolescent, clinical and administrative information systems to a future state of shared, standardised and fully integrated information systems that will enhance clinical practice, drive administrative efficiencies, enable regionalisation of services and reduce current operational risks.

CRISP (rebranded to Regional Health Informatics Programme - RHIP in 2016) sought to:

- provide mobility and access to information across the Central Region as needed
- improve data quality
- optimise resources
- support the regional clinical outcomes
- support greater collaboration between clinicians and patients.

The key aims of the programme were to deliver a clinical framework that enables:

One Portal,

One Password,

One Patient Record

For every Clinician

At every Facility

Across the Central Region

The Central Region is addressing a number of IT delivery challenges through implementation of an operating model that leverages and empowers current regional forums or groups, enabled through a set of principles which guide how the region will collaborate with clearly defined roles, accountabilities and responsibilities including the delegations of such.

The Central Region has agreed a funding pathway until the end of 17/18, with the expectation that the region will create the appropriate business case/s for approval and commencement in the 2018/19 financial year aligned the planned Regional Digital Health work programme development and resulting investment roadmap. Furthermore, it is anticipated that this will also be aligned to and support the National Health and Digital Health Strategies, the National eHR project, and the Regional Service Plan. Please refer to Figure 6 for the Central Region Digital Health Operating Model.

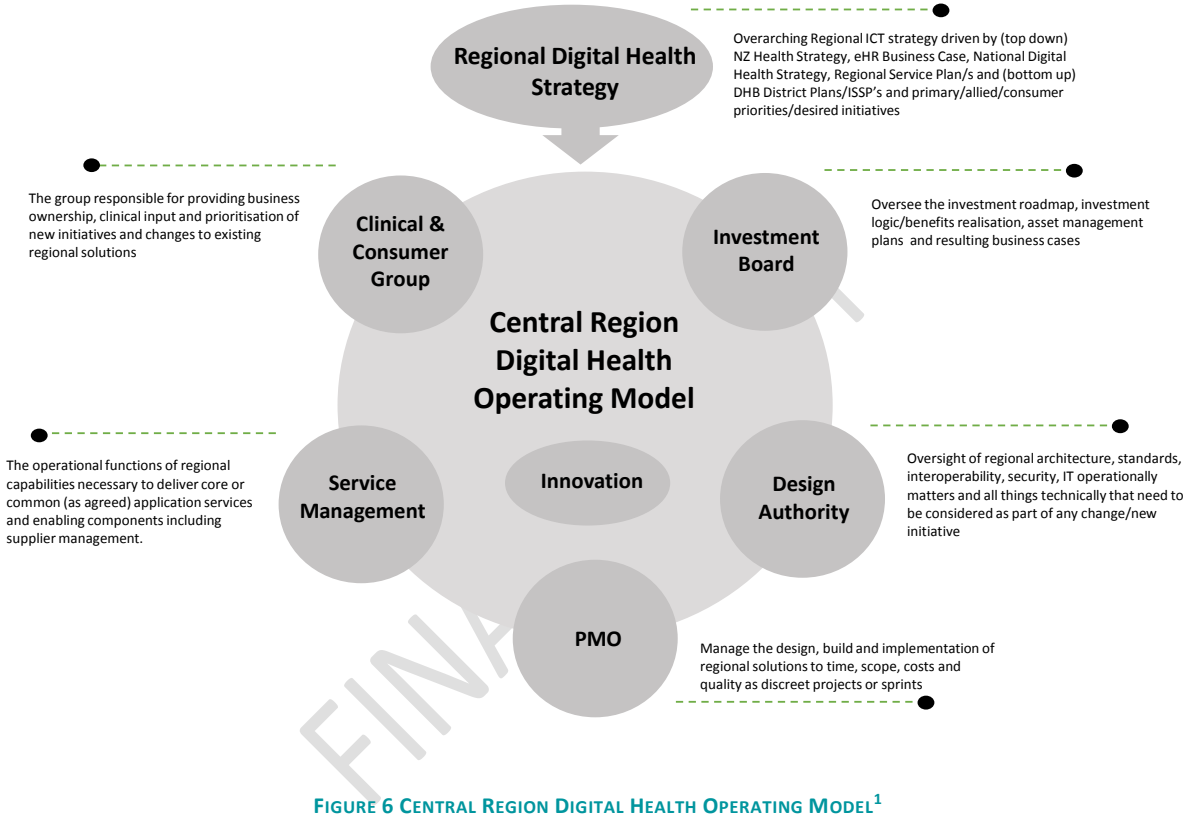


FIGURE 6 CENTRAL REGION DIGITAL HEALTH OPERATING MODEL[1]

[1] Please see Page 43 for further information on ICT.

Regional Priorities – Work Programmes

Programme	Sponsor	Programme Lead	Programme Manager
Cancer Services	Debbie Chin CCDHB	Nicholas Glubb MDHB	Jo Anson CCN
Cardiac Services	Debbie Chin CCDHB	Nick Fisher NMDHB	Jeanine Corke TAS
Diagnostic Services	Ashley Bloomfield HVDHB	James Entwisle CCDHB	Jeanine Corke TAS
Elective Services	Kevin Snee HDHB	Chris Lowry CCDHB	Stephanie Calder TAS
Healthy Ageing	Julie Patterson WDHB	Lesley Maskery CCDHB	Kendra Sanders TAS
Hepatitis C	Debbie Chin CCDHB	Russell Cooke CCDHB	Sheryl Gibbs Compass Health
Information and Communications Technology (ICT)	Kath Cook MDHB	Steve Miller TAS	Steve Miller TAS
Major Trauma	Debbie Chin CCDHB	Chris Lowry CCDHB	Renate Donovan CCDHB
Mental Health and Addiction	Julie Patterson WDHB	Alison Masters CCDHB	Josh Palmer TAS
Health Quality and Safety	Adri Isbister WaiDHB	Sandy Blake MDHB	Coordination TAS
Stroke Services	Ashley Bloomfield HVDHB	Jeremy Langford CCDHB	Stephanie Calder TAS
Palliative Care / End of Life Care	Adri Isbister WaiDHB	Vacant	Jo Anson CCN
Regional Workforce	Julie Patterson WDHB	Roy Pryer HVDHB	Bridget Smith TAS
Sudden Unexpected Death in Infancy Prevention Programme	TBC	TBC	TBC

16.2

Cancer Services

CE Sponsor: Debbie Chin CCDHB
Programme Lead: Nicholas Glubb MDHB

Introduction

The cancer programme of work aligns with the *New Zealand Cancer Plan Better, Faster Cancer Care 2015-2018* (NZ Cancer Plan) which provides a strategic framework for an ongoing programme of cancer related activities for the Ministry, DHBs and regional cancer networks so that all people have increased access to timely and quality services that will enable them to live better and longer. The NZ Cancer Plan sets out the cancer related programmes, activities, expectations and services that are to be implemented over the next three years. Cancer networks work across boundaries to improve the outcomes for patients by:

- reducing the incidence and impact of cancer
- increasing equitable access to cancer service and equitable outcomes with respect to cancer treatment and cancer outcomes.

This programme of work will be facilitated and coordinated by Central Cancer Network (CCN). It should be noted that CCN also covers Taranaki DHB for the purposes of cancer services due to the range/volume of tertiary services provided for their patients in the Central Region.

In 2017/18 the network will focus on achieving the Faster Cancer Treatment Health Target, working regionally to ensure patients have timely access to appointments, tests which detect cancer and cancer treatment. Work will be undertaken to ensure that patients are well supported in their cancer journey and that equity of access issues are addressed. Model of care work and addressing unwarranted variation in non-surgical cancer services will drive standardisation across the region. In addition all DHBs will be preparing to roll out the bowel screening programme, with the exception of HVDHB and WDHB who will already be live with the programme, and establishing the Bowel Screening Regional Centre (BSRC).

Regional Outcomes
Implementing the priorities of the national Cancer programme remains the focus for regional planning, in particular to improve: • Equity of access to cancer services • Timeliness of services across the whole cancer pathway • The quality of cancer services delivered

Objectives for the Central Region in 2017/18
• DHBs achieve the Faster Cancer Treatment Health Target and implement the wider FCT work programme to improve the quality and timeliness of services for patients along the cancer pathway • Cancer service providers achieve equity of access and outcomes for people affected by cancer, focussing on Māori health gains • Quality and sustainable non-surgical cancer treatment services are delivered as close to home as possible. • Planning and implementation of the National Bowel Screening Programme in the region is undertaken in a coordinated manner.

Achievements to date

The Central Region has consistently met PP30: all patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.

Improved performance against the Faster Cancer Treatment (FCT) indicators (regional results for Quarter 2 2016/17):

- 75% of patients referred urgently with high suspicion of cancer and a need to be seen within two weeks who receive their first cancer treatment (or other management) within 62 days from date of referral (Health Target).
- 89% of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 31 days of decision to treat.

Completion of service reviews of against the Upper GI and Head and Neck standards (commenced 2015/16).

Delivery of the following projects supported by Ministry FCT funding to improve waiting times and to meet the new tumour standards:

- CCN - Priority Cancer Pathways Implementation Project (through HealthPathways and Map of Medicine) (ongoing 2017/18)
- CCDHB/HVDHB/WaiDHB - Emergency Presentation of Colorectal Cancer - Identifying Factors Affecting Late Presentation - How Can We Improve Patient Awareness and Health Seeking Behaviours to Improve Overall Outcomes (completed 2016/17)
- CCDHB/HVDHB/WaiDHB - Development and Implementation of a Pacific Faster Cancer Treatment Plan (ongoing 2017/18)
- MDHB - Secondary Services Pathways Development (completed 2016/17)
- TDHB - Defining the Uro-oncology Patient Pathway (completed 2016/17)
- WhaDHB – Individual cancer follow up plans (completed 2016/17)

Implementation of the newly funded psychological and social support initiative.

Implementation and evaluation of He Anga Whakaahuru - CCN Supportive Care Framework.

Joint cancer centre development activities including the regional implementation of Phase II of the eviQ Antineoplastic Drug Administration Course (ADAC) for nursing and service reviews against the National Chemotherapy Nursing Administration Standards.

Cancer Services

Agreed objectives and key actions Cancer Services	Quarter of completion	Measures	Accountable Roles
Objective 1: DHBs achieve the Faster Cancer Treatment Health Target and implement the wider FCT work programme to improve the quality and timeliness of services for patients along the cancer pathway.			
1. CCN to work with DHBs to support them to meet the Faster Cancer Treatment target and work programme by:			
a. Work with the Ministry and RHIP team to implement new MDM business processes and data requirements identified from the MDM Future State gap analysis completed in 2016/17 (within existing resources)	Q4 Q4	DHBs MDM business and data processes are modified to better align with MDM Future State requirements	DHBs / CCN DHBs/CCN
b. Implement regional improvement plans identified from regional service reviews (Bowel, Lung, Breast Gynae, Upper GI, H&N)	Q4	Regional improvement plan actions completed within existing resources	DHBs/CCN
c. Work with the Ministry to develop tools within the national tumour standards work programme (MDM prioritised access guidance / FU and Surveillance guidance / tumour specific dataset and commence the review and finalisation of the standards) and commenced implementation in the Region	Q4	National tumour standards guidance implemented (awaiting programme timeframes from the Ministry)	CCN / Regional Radiology Group
d. Develop and implement the following nationally developed guidance for cancer imaging: • CT/MRI pathways and protocols for cancer investigation and staging • Quality framework and principles of follow-up imaging	Q2 (Health Pathways) Q3 (CCP)	Cancer imaging guidance implemented (timing dependant on national processes)	CCN / HealthPathways / Collaborative Clinical Pathways (CCP)
e. Complete the Priority Cancer Pathways project to deliver cancer pathways via Health Pathways and Map of Medicine and to implement additional education resources to promote the use of the following pathways • Health Pathways : new Urology, Upper GI, Head & Neck pathways and review existing Bowel and Breast pathways • Collaborative Clinical Pathways: new Head and Neck, Melanoma, Lymphoma, Myeloma, Thyroid, Sarcoma		Pathways developed and implemented including education sessions	

Agreed objectives and key actions Cancer Services	Quarter of completion	Measures	Accountable Roles
Objective 2: DHBs achieve equity of access and outcomes for people affected by cancer, focussing on Māori and Pacific health gains			
1. CCN to work with DHBs to continue to support regional implementation of the following equity focussed initiatives: a. Review services against the He Anga Whakaahuru – CCN Supportive Care Framework which guides supportive care service planning and delivery b. Cancer Nurse Coordinators (CNC) identify and remove barriers that are preventing Māori and Pacific peoples benefitting from more coordinated cancer care c. Participate in the national evaluation of the Psychology and Social Support Initiative and provide ongoing regional engagement opportunities d. Conduct a regional service review against the Service Provision for Adolescent and Young Adult Cancer Patients in New Zealand including Standards of Care - Provisional 2016 and develop an implementation plan to address gaps e. Implement components of the national Early Detection of Lung Cancer Guidance (guidance due for completion 2016/17) where priorities are identified f. DHBs and Cancer Society partner to deliver Kia Ora E Te Iwi programmes (Māori survivorship focused programme) in each district	Q4 Q2 Q4 Q2 Q2 Q4	Services reviewed against He Anga Whakaahuru – CCN Supportive Care Framework Increased utilisation of CNC services for Māori and Pacific Objectives of the initiative are met Review completed and implementation plan developed to address gaps to inform 2018/19 RSP. Improvement activities commenced within existing resources Identified priorities implemented within existing resources Minimum of one programme delivered in each district	DHBs/CCN
Objective 3: Quality and sustainable non-surgical cancer treatment services are delivered as close to home as possible			
1. CCN will work with the two cancer centres to: a. Develop models of care and service to ensure that quality and sustainable non-surgical cancer services are delivered as close to home as possible b. Implement the national Radiation Oncology Plan 2016-21, including addressing unwarranted variation as identified by the national Radiation Oncology Work Group	Q4 Q4	Models of Care developed Identified unwarranted variation is addressed	WBCC / RCTS / CCN

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Agreed objectives and key actions Cancer Services	Quarter of completion	Measures	Accountable Roles
Objective 4: Planning and implementation of the National Bowel Screening Programme in the region is undertaken in a coordinated manner			
1. CCN to work with DHBs to implement the National Bowel Screening Programme, including: a. CCDHB/HBDHB/MDHB/WhaDHB implement the national bowel screening programme (order and timing yet to be determined) b. Establish the Bowel Screening Regional Centre (BRSC) at HVDHB	Q4 Q1	Bowel screening implementation activities underway across the region BSRC established	CCDHB/HBDHB/MDHB/ WhaDHB HVDHB / CCN

Performance indicators to be reported on
• 90% of patients referred urgently with high suspicion of cancer and a need to be seen within two weeks receive their first cancer treatment (or other management) within 62 days from date of referral (Health Target) • 85% of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 31 days of decision to treat

Input/Resources	
Costs	Overall project management, clinical leadership, facilitation and coordination costs for the programme of work will be met within the CCN and DHB operational budgets. **Specific Ministry funded initiatives included in the plan:** • Psychological and social support initiative • Bowel Screening Programme • Priority Clinical Pathways project – fully funded by Ministry RFP funding and CCN supplementary funding **Additional DHB funding requirements:** • Kia Ora E Te Iwi programmes – DHBs may need to contribute $1000.00 per programme dependant on Cancer Society contribution
People or Teams	• Project management, clinical leadership, facilitation and coordination functions for the programme of work will be primarily undertaken by the CCN management team • Bowel Screening – new project managers and clinical leadership required during the business case, planning and set-up phase for the Bowel Screening Regional Centre (BSRC) roll out. Once live, ongoing clinical leadership, management, administration and governance roles will be required

Enablers required to achieve regional priorities	
Workforce	N/A
IT	RHIP ability to support the MDM business and data processes (Cancer Health Information Strategy) National Bowel Cancer Registry implementation
Capital	N/A

Linkages	
National IT Plan	N/A
Health Workforce New Zealand	N/A
Capital	N/A
Health and Safety Commission	N/A

End of Cancer Services

Cardiac Services

CE Sponsor: Debbie Chin CCDHB
Programme Lead: Dr Nick Fisher NMDHB

Introduction

The Central Region Cardiac Network (the Network) will commence the implementation of the recently developed Cardiac System of Care Strategy (the Strategy) in 2017/18. The Strategy takes a whole systems approach and identifies that there is significant inequity and inequalities that exist for Māori across the Region. Priority areas will focus on improving screening and management of 'at risk' patients in primary care with atrial fibrillation or heart failure. Other challenges are the timeliness of cardiac interventions and access to diagnostics such as echocardiography so that delivery is consistent across the Region.

The Network will engage with primary care in the Region to develop a clinical audit tool that identifies barriers that may exist to accessing diagnostics and for screening 'at risk' patients with atrial fibrillation or heart failure. The Network will support this initiative by working alongside primary care to build upon the already existing CME/CNE primary care heart health training that will enhance the delivery of consistent quality of care across the primary care sector.

For Secondary and Tertiary Care the focus will be on building an evaluation tool that collects data associated with the National Expected Clinical Standards. The first step will be to develop a regional dataset for echocardiography to determine the level of service delivery and unmet need.

Recalibrating the sub regional networks across the Central Region is seen as a vehicle for progressing the development of sub regional shared rosters and waiting lists for echocardiography. In addition to this, building interventional services in sub regional centres such as MidCentral and Hawke's Bay DHBs is key. These priorities are seen as a way of improving equitable and timely access to cardiac services across the Region.

Alignment with health system outcomes

a) Reducing the incidence of stroke by improved diagnosis and risk management of atrial fibrillation
b) Improved heart failure diagnosis and treatment by improved access to echocardiography
c) Improving outcomes for patients with ST elevation myocardial infarction by working with percutaneous intervention centres (PCI) and St John to improve timelines from diagnosis to treatment in line with National Expected Clinical Standards
d) Improving outcomes for patients diagnosed with acute coronary syndrome by improving equity of access to interventional procedures
e) Reducing heart failure prevalence by improving myocardial salvage by achieving c and d (above)
f) Improving equity to cardiothoracic interventions by recognising the need for improved access to echocardiography as a necessity in diagnosis of valvular heart disease
g) Improved ischaemic heart disease management with pharmaceuticals has a strong evidence base and is a low cost option that is cost effective

The Network's programme of work aligns with the Ministry of Health high-level outcomes by taking a whole systems approach and identifies areas that need improvement across the system to address disparities, achieve timely access and consistent quality of care in a sustainable manner.

Regional Outcomes
• Improved and timelier access to cardiac services, particularly in areas where inequalities exist for Māori • Improved identification, management and treatment of 'at risk' patients with atrial fibrillation and heart failure in primary care • Improved access to diagnostics no matter where the patient lives • Regional consistency of National Expected Clinical Standards and Clinical Pathways

Objectives for the Central Region in 2017/18
• Implement the Cardiac System of Care Strategy • To reduce inequity and improve timeliness of Acute Coronary Syndrome interventions across the Region • Enhance the Palliative Care requirements for Cardiac in the Central Region

Achievements to date

The National Expected Clinical Standards that were developed by the Network have now been endorsed by the National Cardiac Network and National Chief Executives.

The completion of the Cardiac System of Care Strategic Plan 2016 – 2021 that entailed a whole systems approach and brought together stakeholders from primary, secondary, Māori, consumers, national cardiac network, Heart Foundation and all DHBs in the region to set a strategic direction.

The endorsement of an Acute Coronary Syndrome Contingency Plan by Chief Operating Officers and General Managers Planning and Funding which utilises the interventional capacity across the region allowing for patients to be transferred in a timely fashion to Nelson Marlborough if access to the tertiary hospital becomes an issue.

The continued monitoring of Key Performance Indicators on a quarterly basis to determine areas of improvement.

Cardiac Services

Agreed objectives and key actions Cardiac Services	Quarter of completion	Measures	Accountable Roles
Objective 1: Implement the Cardiac System of Care Strategy			
1. Engage with primary care on the implementation of the National Expected Clinical Standards (Standards) a. DHBs will meet with their PHOs to discuss the implementation of the Standards as part of the clinical pathways process	Q3	Referrals from Primary Care to specialist services are improved and appropriate Less referrals from primary care are declined by specialist services	DHB Clinical Leads/GPs within the Cardiac Network
2. The Network will work with DHB/PHOs to ensure that every primary care team or practice has access to atrial fibrillation diagnostics such as an ECG machine. a. Complete a stocktake to identify current access to ECG machines available in primary care b. Identify solutions (if required) to improve primary care access to diagnostics c. Analyse population data including ethnicity data to assess improved access	Q3 - Q4	A greater number of atrial fibrillation patients will be diagnosed and treated in primary care Improved ischaemic heart disease management with pharmaceuticals has a strong evidence base and is a low cost option that is cost effective	Network, DHB/PHO Clinical Pathway representatives
3. DHB Cardiology Services will deliver consistent Heart Failure education and training across the region. a. Training sessions will include identifying appropriate intervention such as BNP blood test for patients with suspected Heart Failure	Q4	Primary Care is able to effectively diagnose, treat and manage heart failure patients Improved ischaemic heart disease management with pharmaceuticals has a strong evidence base and is a low cost option that is cost effective	Network, DHBs Clinical Leads and PHOs
4. Develop joint DHB oversight of shared echo waiting lists in the region to improve access to vulnerable echocardiography services. a. Confirm joint partnerships b. Develop a proposal that describes the feasibility of having a shared waiting list and seek COOs and GMs approval before implementation.	Q4	A shared echo waiting list will ensure that all patients get timely access to echocardiograms, no matter where the patient lives. The quality of echocardiograms will be improved across the region	DHBs and Network

Agreed objectives and key actions Cardiac Services	Quarter of completion	Measures	Accountable Roles
5. Implement the National Expected Clinical Standards a. Design an evaluation tool and define data items for collection b. DHBs collect echocardiography data and deliver reports to TAS for analysis each quarter c. Network reviews collected data to identify gaps and solutions	Q4	The echocardiography evaluation tool will show unmet need and inequity across the region. Data will demonstrate the link between the volume of echocardiograms and cardiothoracic procedures performed in the region	DHBs and Network
6. Continue to support DHBs in developing percutaneous coronary intervention business cases that will be shared across the region	Q4	Amenable mortality attributed to ischaemic heart disease will be significantly reduced through timely access to interventional services Enhanced quality of care and reduced inequity across the region	MidCentral, Hawke's Bay and Capital and Coast DHBs
Objective 2: To reduce inequity and improve timeliness of Acute Coronary Syndrome interventions across the Region.			
1. Review and confirm the delivery of after hours on call rosters across the region a. Propose a cost effective model to address any issues, such as DHBs or inter-DHB partnerships having a STEMI Coordinator as part of their Cardiology on call roster in place prior to implementing the pathway b. Seek approval from COOs and GMs P&F before implementation	Q4	A needs assessment with key issues and proposed solutions to address these is tabled at the COOs and GMs Forum for further discussion, implications and approval	DHBs and Network
2. To explore appropriate Māori indicators that will accurately measure Māori uptake of cardiac rehabilitation for ischaemic heart disease (IHD)	Q3-Q4	A greater number of Māori patients will access cardiac rehabilitation programmes following discharge from secondary care services	DHBs and Network
3. Address the inequity and inequalities that exists across the Region a. Analyse of ANZACS QI data to identify unmet need b. Develop solutions to address issues	Q1-Q2	Inequity of care will be addressed across the region	DHBs and Network
Objective 3: Enhance the Palliative Care requirements for Cardiac in the Central Region			
1. Cardiac Network and CRPCN to develop locally, regionally and nationally agreed protocols, guidance, processes and systems to ensure optimal management of patients with heart failure	Q4	Model of care developed and implementation considerations identified to inform 2018/19 planning	Cardiac and Palliative Care Networks

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Performance indicators to be reported on

Secondary Services
• Standardised intervention rates.
  ○ Cardiac surgery: a target intervention rate of 6.5 per 10,000 of population will be achieved.
  ○ Percutaneous revascularisation: a target rate of at least 12.5 per 10,000 of population will be achieved
  ○ Coronary angiography: a target rate of at least 34.7 per 10,000 of population will be achieved
• Proportion of patients scored using the national cardiac surgery Clinical Priority Access (CPAC) tool, and proportion of patients treated within assigned urgency timeframe
• The waiting list for cardiac surgery remains between 5 and 7.5 percent of planned annual cardiac throughput, and does not exceed 10 percent of annual throughput
• Patients wait no longer than four months for a cardiology first specialist assessment, or for cardiac surgery
ACPPs
• Report quarterly on regional activity that supports ACPP quality improvement
ACS
• Each Region will have established measures of ACS risk stratification and timeliness for patients to receive appropriate intervention
• 70 percent of patients will receive an angiogram within 3 days of admission ('Day of Admission' being 'Day 0') reported by ethnicity
• Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days
Over 95 percent of patients undergoing cardiac surgery will have completion of Cardiac Surgery registry data collection within 30 days of discharge

Inputs/Resources	
Costs	Business cases for PCI services to be developed and funded by MidCentral and possibly Hawke's Bay DHBs
People or Teams	Business Intelligence resource is required to collect and analyse datasets for echocardiography, acute coronary syndrome and atrial fibrillation

Enablers required to achieve regional priorities	
Workforce	Work with the Regional Workforce Group to progress the Echocardiography Workforce Proposal Paper
IT	N/A
Capital	N/A

Linkages	
National IT Plan	N/A
Health Workforce New Zealand	N/A
Capital	N/A
Health and Safety Commission	N/A

End of Cardiac Services

Diagnostic Services

CE Sponsor: Dr Ashley Bloomfield HVDHB
Programme Lead: Dr James Entwisle CCDHB

Introduction

The Central Region has a strategic framework for diagnostics (Framework) and it illustrates a five year plan that is aligned to the New Zealand Health Strategy's five strategic themes.

The Framework (please see Page 30) aligns to the objectives covered in this year's RSP, which are to:

- Progress workforce recruitment and retention initiatives with a particular focus on vulnerable workforce to improve patient outcomes

To support the implementation of Regional Radiology Information Service (RRIS), diagnostic teams across the Region will work together to develop consistent policies and procedures that support a regionally co-ordinated system. This will also involve identifying how a sustainable mechanism for informatics can be established. The rollout of RRIS presents multiple challenges for the Region, particularly the transition of six siloed information systems to an integrated regional platform, creating policies and procedures that unite the Region and workforce roles that will both be regionally and locally focussed. Overcoming these challenges will mean that the Region will have a health system that places patients at the centre by providing greater visibility of patient records no matter where the patient lives in order to improve timely access to diagnostics, health and wellbeing.

Workforce is viewed as a key enabler to achieving the desired vision set out as part of the implementation for RRIS and essential in building capacity to address growing demand on services. Particular professions within diagnostic imaging sector are still seen as vulnerable. In the Central Region these include radiologists, sonographers and nuclear medicine MRTs. Ultrasound workforce numbers are a significant issue for the Region and nationally. Premised on the training programmes and recruitment initiatives carried out by the Region, the next step is to continue with this work and complete an evaluation to track sonographer trainees once they have qualified and to assess the level of supervision capability that is available across the Region.

Key achievements

The Central Region attended a British Medical Ultrasound Society conference in the United Kingdom as part of the Central Regions' recruitment drive to attract international sonographers to New Zealand. As part of this campaign, the region works in conjunction with KiwiHealth Jobs to link interested international applicants to register via a website link.

A review of positron emission tomography (PET) service requirements was completed. Currently, the six DHBs have individual contracts with Pacific Radiology for PET services. The review outlined that there is significant cost savings for the Region to move to a regional contract. The Region is currently in the process of initiating a regional negotiation process to progress this matter.

Regional Outcomes
The implementation of RRIS will enable the Region to achieve the following outcomes: • Faster access to diagnostics to improve people's treatment, health and wellbeing • Enhanced efficiency and demand management by resources being concentrated on effective examinations
Objectives for the Central Region in 2017/18
• Ensure that the implementation and business as usual processes for the RRIS provides optimal benefit for the Region • Progress workforce recruitment and retention initiatives with a particular focus on vulnerable workforce • Maximising diagnostics capacity and capability to improve patient outcomes

Central Region Radiology Strategic Framework

New Zealand Health Strategy – Five Strategic Themes	Why	How	When
People Powered	People need to be given greater control of their own health by making informed choices and the opportunity to design services that meets their needs	Access to patient information, radiology and treatment Enabling individuals to make choices about their care – implementing Choosing Wisely across the region	2017 - 2019
Closer to Home	Volume of diagnostics conducted by the Tertiary Centre that can be done by domicile DHB	Patients imaging is closer to home and at their domicile DHB	2017 onwards
Value and High Performance	An inefficient system, poor patient health outcomes due to delays in accessing diagnostics	Reducing low yield interventions as part of Choosing Wisely Organisational approach to Demand Management	2017 - 2020
One Team	Vulnerable Workforce e.g. Sonography, MRTs	The region will operate as one team and the emphasis will be on building the capacity and capability of our workforce	Ongoing
Smart System	Siloed Radiology Information Systems current exist in the region.	Deliver a modern regional platform to assist with domicile scanning. Set up a mechanism for informatics and decision support to address demand management. Improved integration with DHBs and private.	Implementation of RRIS over the next few years – 2016 - 2019

Diagnostic Services

Agreed objectives and key actions Diagnostic Services	Quarter of completion	Measures	Accountable roles
Objective 1: Ensure that the implementation and business as usual processes for the Regional Radiology Information System (RRIS) provides optimal benefit for the Region.			
1. Develop BAU policies and procedures to assist Central Region DHBs to move to a regional platform a. Policies and procedures are completed on time b. Set up a regional process to review and monitor the transition of DHBs to RRIS to ensure that benefits are being maximised	Q3	The Region will be able to utilise capacity and capability across the Region, not just at their domicile DHB. There will be greater timeliness to diagnostics for the patient, closer to home The radiology workforce will be shared across the Region providing greater capacity and capability DHBs continue to work in a collaborative fashion and are able to reduce demand management and improve workflow through the use of RRiS	Operations & Governance RIS/PACs Working Group and Regional Radiology Steering Group (RRSG)
2. Develop and implement a process to monitor and report RRIS service data to assist with demand management a. Collate, analyse and develop a report bi-annually	Q3 and Q4	Data is collated, analysed and reported on time Improved informatics will assist with demand management by providing the capability to identify issues that exist across the Region and allow solutions to be developed to address these.	RRSG
Objective 2: Progress workforce recruitment and retention initiatives with a particular focus on vulnerable workforce			
3. Identify up and coming Ultra Sound conferences for the region to advertise regional vacancies a. Carry out a stock take of staff attending international conferences to have a 'go to' person to answer any questions b. Develop an evaluation process to monitor sonographer trainees in region and assess the level supervision capacity available c. Collate data and report on evaluation findings to RRSG d. Raise the profile regionally and internationally and ensure there is linkage with the regional Workforce Group's activities	Q3 and Q4	The profile for ultrasound in New Zealand is increased internationally DHB trainee investment is realised and retained within the region Evaluation findings will inform the appropriate trainee model for the region	Regional Workforce Group and RRSG

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Agreed objectives and key actions Diagnostic Services	Quarter of completion	Measures	Accountable roles
Objective 3: Maximising diagnostics capacity and capability to improve patient outcomes			
4. Determine initiatives to maximise the investment made by DHBs with private providers a. Negotiate a regional contract with private providers b. Confirm a regional contract	Q1	Unit price per scan for the Region is consistent and is reduced as volume increases	RRSG

Performance indicators to be reported on
Waiting times: CT - 95% of people accepted for a CT scan receive their scan in 42 days (six weeks) or less MRI - 85% of people accepted for a MRI scan receive their scan in 42 days (six weeks) or less

Enablers required to achieve regional priorities	
Workforce	To complete an audit on sonographer trainees and supervision capability
IT	N/A
Capital	N/A

Input/Resources	
Costs	N/A
People or Teams	N/A

Linkages	
National IT Plan	Regional Radiology Information System is aligned to the National IT Plan
Health Workforce New Zealand	Sonography and MRT trainees
Capital	N/A
Health and Safety Commission	N/A
Other Networks	Cancer Network – Faster Cancer Treatment targets

End of Diagnostic Services

Elective Services

CE Sponsor: Kevin Snee HBDHB
Programme Lead: Chris Lowry CCDHB

Introduction

Key to the Central Region's elective services work is alignment with the National strategic direction for elective services for all New Zealanders which is improved and more timely access to elective services. The changing composition of our population is increasing pressure and demand on elective services and this has an impact on the level of unmet need.

The Central Region is therefore focusing on:

- More people receiving access to services which support New Zealanders to live longer, healthier and more independent lives
- Shorter waiting times for elective services and the achievement of good health and independence as soon as possible
- People with a similar level of need receiving comparable access to quality services regardless of where they live

To achieve this, the Central Region is working on an approach that focuses on establishing specific initiatives on an as needed basis to respond to specific areas of pressure. Such initiatives will draw on the expertise of the clinical specialty involved. As an example, such initiatives could be in relation to:

- Increases in elective surgery discharges
- Increases in first specialist assessments and reducing waiting times, via the development of clinical and patient pathways
- Improving the prioritisation of patients
- Supporting innovation and service development to address capacity and demand
- Supporting regional and national collaboration
- Equitable access to elective services between Māori and non-Māori

Achievements to date

A reduction in the variation of service provision and improvement in access for patients via the development of patient and clinical pathways in the ophthalmology, orthopaedics and otolaryngology specialty areas.

The establishment of sustainable clinical networks within DHBs, across general practice and across hospitals.

Strengthening a regional approach has enabled patients to be treated in a more timely way with a potential for DHBs to share capacity and resources.

The standardisation of approaches and pathways that align to work carried out nationally to determine eligibility for FSA and treatment enables processes to be more consistently applied and is more efficient than individual DHB approaches.

Regional Outcomes

- The Central Region DHBs will deliver elective volumes, including elective health targets and additional elective orthopaedic and general surgery discharges
- The population of the Central Region will receive improved equity of access to elective services
- Central Region DHBs will maintain the 4 month waiting time milestone for first specialist assessment and for treatment

Objectives for the Central Region in 2017/18

- Improve access to elective services
- Maintain reduced waiting times for elective first specialist assessments (FSAs) and treatment
- Improve equity of access to services so patients receive similar access regardless of where they live
- Support improved information management
- Maximise workforce resources to maintain a local and regional view of specialist workforce capacity and capability

Elective Services

Agreed objectives and key actions Electives Services	Quarter of completion	Measures	Accountable roles
Objective 1: Improve access to elective services, maintain reduced waiting times for elective first specialist assessment (FSA) and treatment and improve equity of access to services so patients receive similar access regardless of where they live			
1. Identify where there are pressures and barriers to access. a. Where appropriate develop a solution with a regional approach. This could include for example establishing a regional network in a specialty area in which pressures are identified, and develop consistent clinical and pathway patients	Q1-Q4	Patients wait no longer than four months for first specialist assessment (ESPI 2) Patients wait not longer than four months for treatment (ESPI 5)	Central Region COOs / GMs P&F
Objective 2: Maximise workforce resources			
1. On a quarterly basis report on local and regional specialist workforce capacity and capability	Q1-Q4	Region is informed about local and regional specialist workforce capacity and capability and able to respond accordingly Health targets are met	Central Region COOs / GMs P&F

Performance indicators to be report on
• Patients wait no longer than four months for first specialist assessment (ESPI 2) • Patients wait no longer than four months for treatment (ESPI 5)

Input/Resources	
Costs	N/A
People or Teams	N/A

Enablers required to achieve regional priorities	
Workforce	N/A
IT	N/A
Capital	N/A

Linkages	
National IT Plan	N/A
Health Workforce New Zealand	N/A
Capital	N/A
Health and Safety Commission	N/A

End of Elective Services

16.2

Healthy Ageing - Health of Older People

CE Sponsor: Julie Patterson, Whanganui DHB
Programme Lead: Lesley Maskery, Nurse Practitioner CCDHB

Introduction

The regional programme will take a focus on improving pathways for people with dementia, it will contribute to improving support for informal carers (care partners) and it will create cross sector conversations though the utilisation of interRAI data. The Region is linked into the National Health of Older People Strategic group (HOPSG) and will contribute as appropriate to discussions regarding home and community sector changes (regularisation of workforce, sustainability and equal pay negotiations).

In setting these priorities for older people, it is noted that the Action Plan for the New Zealand Healthy Ageing Strategy will be developed by Ministry and the sector in Q3-Q4 of 2016/2017. The HOP Network and its related reference/advisory groups will be involved in this activity.

Achievements to date

Regional achievements in 2016/2017 against the New Zealand Health Strategy are:

- **People powered:** Consumer voice/co-design present in regional health of older people projects.
- **Closer to home:** Engagement with the Office for Seniors and Health Quality Safety Commission on issues such as falls and enduring power of attorney; the Regional Advance Care Plan Reference group has raised awareness of ACP with health professionals and consumers.
- **Value and high performance:** Published a regional infographic on older people. Measures were sourced from the InterRAI Home Care (HC) data for the calendar year 2015 and are framed against the New Zealand Healthy Ageing Strategy themes. The regional infographic was an innovation that has been replicated nationally. The HOP Network has engaged in conversations with Treasury and MSD on social investment approaches.
- **One team:** Developed a regional medical leaders group for older people creating an opportunity to collaborate regionally and be an advisory group to the regional programme.

Regional Outcomes
• Local dementia pathways for older people are enhanced to support older people to live well, stay well and get well
• Key clinical leaders and stakeholders have a shared understanding of interRAI and how this supports a population view and influences service improvements
• Issues of inequity for Māori are identified through analysis of interRAI data used in benchmarking to influence conversations at a local and/or regional level

Objectives for the Central Region in 2017/18
• Collaborate regionally and with all regions to support improved pathways for those affected by dementia and their family/whānau, including active engagement with the National Dementia Education Collaboration
• Clinical leadership is evident within the region for health of older people
• Strengthen the equity focus for Māori in the regional infographic

Healthy Ageing - Health of Older People

Agreed objectives and key actions Healthy Ageing – Health of Older People	Quarter of completion	Measures	Accountable roles
Objective 1: Collaborate regionally to strengthen the implementation of the NZ Dementia Framework and the actions specific in Improving Lives for People with Dementia (action 11a Healthy Ageing Strategy)			
1. Implement the Central Region Action Plan as a result of the national survey results for the dementia education for informal carers	Q4	Regional and/or national guidance is developed on the content for informal carers education in the early diagnosis of dementia Education to support informal carers will be available to those who live in rural or remote areas	Regional Dementia Pathways Reference Group
2. Develop a communications plan and promote the "Goodfellow e-learning modules on Dementia" in the region which support early diagnosis of dementia	Q4	Report six monthly to DHBs and PHOs on the sector and volume of health professionals accessing e-learning	Regional Dementia Pathways Reference Group
Objective 2: Use of InterRAI Home Care data to support the identification of quality indicators, equity, population and service trends to improve outcomes for older people (Healthy Ageing Strategy action 8b)			
1. Utilise interRAI data (Home Care) to publish an infographic that is aligned to the NZ Healthy Ageing Strategy themes	Q1-Q4	Quarterly publication of infographic	Regional Benchmarking Group
2. Articulate access by Māori to interRAI assessments and identify any areas of inequity to inform local discussions	Q1-Q4	Quarterly publication of infographic	Regional Benchmarking Group
3. Regional Medical Leaders Group (RML) utilise interRAI data in their advisory capacity to the region to influence the clinical management of older people	Q3	Quarterly reports to the RML on data from the national interRAI Data Reporting and Analysis Service	Regional Medical Leaders Group

Performance Indicators to be reported on
No specific measures identified for Ministry reporting

Inputs/Resources	
Costs	• DHBs contribute clinical and non-clinical resource to support the work programme for older people • The Central Region provides a contribution towards costs for consumer and non-government sector engagement within the regional programme and fully funds costs associated with travel for these representatives • TAS, as the shared services agency for the Central Region is funded to support the development and implementation of the work programme
People or Teams	Project teams reporting to the HOP Network for 2017/2018 will be: • Regional Dementia Pathways Reference Group • Regional Medical Leaders Group • Regional Benchmarking Group • Regional Advance Care Plan Reference Group

Enablers required to achieve regional priorities	
Workforce	Support the Regional Training Hub to identify and plan the workforce needs for older people (Workforce as an Enabler)
IT	National interRAI Reporting and Analysis Service (Regional Benchmarking)
Capital	N/A

Linkages	
National IT Plan	N/A
Health Workforce New Zealand	N/A
Capital	N/A
Health and Safety Commission	N/A

End of Healthy Ageing - Health of Older People

Hepatitis C

CE Sponsor: Debbie Chin CCDHB
Programme Lead: Russell Cooke CCDHB / Sheryl Gibbs Compass Health

Introduction

The focus in 2017-18 for Hepatitis C (HCV) is to consolidate the engagement, assessment/testing and treatment pathways and related services consistently across the Central Region. These will be co-ordinated and integrated with community, primary care and specialist treatment services.

These services will provide early identification primarily through non-invasive liver scanning, which where possible is community based; diagnosis; assessment; triage; and management, including monitoring, support and education to people with Hepatitis C within the general practice environment.

Key challenges for the Central Region

- GP practices actively managing uncomplicated HCV patients
- Embedding Health Pathways into Primary Care

Change and alignment with the health system outcomes

New Zealanders live longer, healthier, more independent lives; the health system is cost-effective and supports a productive economy[2].

- Overcoming stigma and fear – of HCV itself, and about routes of infection
- Changing people's attitudes and behaviours around high-risk practices
- Educating people about the new Pharmac funded treatments may lead to an increase in testing and treatment rates
- The outcomes and benefits of will be greater wellbeing for people living with HCV, reduced costs to the health sector and wider economy and reduction in health and social problems associated with diagnosed and undiagnosed HCV.

Achievements to date

In January 2015, the Minister of Health approved that resources in the next three to five years will be primarily directed towards targeted detection, management and treatment of Hepatitis C to those at risk, and that primary and secondary care services will be extended to provide improved assessment and follow-up services for all people with Hepatitis C.

CCDHB was contracted by the Ministry in 2015 to support the planning, development and implementation of integrated Hepatitis C assessment and treatment services across primary and secondary care for the Central Region. The aims were to ensure continuity of care for patients in the pilot sites, and to increase the identification, assessment and treatment of new patients with Hepatitis C.

Progress made to date:

- Engagement and communication with services and other key stakeholders across the Region, including with specialist and primary services, needle exchange services and CADS, regarding the new service and transition of existing clients
- Analysis of service delivery across pilot/non-pilot sites, and extensive communication with stakeholders
- Assessment and treatment pathway developed, together with clinical and diagnostic capacity and capability requirements to deliver on it
- PHOs provided with details of The Foundation's patients by GP practice

16.2

[2] Statement of Intent 2015-19 (http://www.health.govt.nz/publication/statement-intent-2015-2019

- Updated HealthCare Pathway published, information sessions planned with primary care
- A sub-pathway for DAA treatment has been developed and being prepared for publishing
- Localised Map of Medicine information, and meetings held in each DHB in the Northern sub-region
- CCDHB extended Hepatitis Foundation contract to continue service provision under the pilot until 31 December 2016
- From November 2016 Compass Health, has been contracted by the Ministry to manage the service delivery across the Central Region

NB: Introduction of funded DAA treatments in 2016 has altered original timelines and expectations for service development and testing/treatment uptake.

Regional Outcomes
• A single clinical pathway for Hepatitis C care across all regions to provide consistent services • An integrated Hepatitis C assessment and treatment service across community, primary and secondary care services

Objectives for the Central Region in 2017/18
Priorities and objectives to support the implementation of integrated Hepatitis C assessment and treatment services include: • raising community and GP awareness and education on Hepatitis C and the risk factors for infection • providing targeted testing of individuals at risk for HCV exposure • providing community based access to HCV and liver elastography and care • establishing systems to report liver elastography to primary and secondary care • providing long term monitoring • providing good information sharing with relevant health professionals • working collaboratively with primary and secondary care to improve access to treatment.

Hepatitis C

Agreed objectives and key actions Hepatitis C	Quarter of completion	Measures	Accountable roles
Objective 1: Deliver integrated Hepatitis C virus (HCV) assessment and treatment services across community, primary and secondary care services in the Central Region			
1. Raise community and GP awareness of the Hepatitis C virus (HCV) and long term consequences and benefits of treatment versus non-treatment a. Provide community based ongoing education and support to needle exchanges, alcohol and drug services and other community social service agencies b. Establish and maintain systems to report on the delivery of liver elastography in primary and secondary care settings c. Provide good information sharing with relevant health professionals	Q1 - Q4	• Number of health professionals accessing e-learning • Number of community clinics run • Number of patients treated • Number of new diagnoses • Quarterly narrative reporting • Establish robust systems for information sharing	CCDHB as lead, Compass Health and Central Region DHBs, MoH
Objective 2: Provide and monitor targeted testing of individuals at risk for HCV exposure			
1. Provide community based access to HCV testing and care that will include liver elastography services Provide 6 monthly reporting on a. Number of HCV patients who have had a liver elastography scan in the last year (by age and ethnicity) for: a. new patients b. follow up b. Number of people diagnosed with Hepatitis C per annum (by age) c. Number of people receiving Pharmac funded antiviral treatment per annum (by age and ethnicity)	Q1 - Q4	Six-monthly reporting provided	CCDHB as lead, Compass Health and Central Region DHBs
2. Establish and maintain a robust database of patients living with HCV	Q1 - Q4	Long term monitoring provided (life-long in people with cirrhosis and until cured in people without cirrhosis)	CCDHB as lead, Compass Health and Central Region DHBs
Objective 3: Work collaboratively with primary and secondary care to improve access to treatment			
1. Raise Primary Health awareness and education about new HCV pathways and PHARMAC funded treatments a. Provide support for treatment in primary settings b. Regular information sharing seminars. Regular teaching sessions for PHO's. Regular updates via provider portals and Practice meetings	Q1 - Q4	Number of patients treated in primary care settings	All Central Region DHBs MoH, Health Pathways

16.2

Performance Indicators to be reported on	
Quarterly narrative report on progress of the key actions Report six monthly broken down by quarters on the following measures:	Data and Source
1. Number of people diagnosed with Hepatitis C per annum (by age and genotype).	Total number of people with a positive HCV PCR test in the DHB region (data from five reference labs provided to regional DHBs)
2. Number of HCV patients who have had a liver elastography scan in the last year (by age and ethnicity) a. new patients b. follow up	Total number of hepatitis C liver elastography scans performed annually (data from the delivery of liver elastography scans in primary and secondary care)
3. Number of people receiving PHARMAC funded antiviral treatment per annum (by age and ethnicity).	Total number of people prescribed antiviral treatment who have hepatitis C (data from PHARMAC provided to regional DHBs)

Input/Resources	
Costs	$748,000 over two years – i.e. $374,000 per annum (Direct funding from MoH)
People or Teams	N/A

Enablers required to achieve regional priorities	
Workforce	N/A
IT	Work is needed to ensure liver elastography data is uniformly recorded and accessible to primary and secondary care
Capital	Provision of liver elastography scanning equipment within contracted services may not be a sustainable solution. While the Hepatitis Foundation is sub-contracted to Compass to provide testing, the current fibroscan machines are owned by the Foundation and if something were to happen to that relationship there could be difficulty in accessing the machines.

Linkages	
National IT Plan	N/A
Health Workforce New Zealand	N/A
Capital	Liver elastography equipment requires a longer term solution
Health and Safety Commission	N/A

End of Hepatitis C

Information Communication Technology (ICT)

CE Sponsor: Kath Cook MDHB
Programme Lead: Steve Miller TAS

Achievements to date

The programme has now completed the build and deployment of region-wide systems including:

- Core Regional Solutions (a single vendor product, on an agreed regional version of the software, on the same regional hardware instance), with the following built and deployed and DHB implemented:
  - Clinical workstation and data repository / Clinical Portal (CP)
  - Radiology Information System (RIS)
  - Picture Archiving and Communication System (PACS)
  - All hosted on All of Government Infrastructure as a Service (IaaS)
  - Health Care Practitioners (HCP)
  - Regional Application and Data Access (RADA)
  - Regional IT service management framework covering Regional change, release and problem management
- Common Regional Solutions (a single regional vendor product, which each DHB will converge on an agreed regional version of the software, delivered on a local shared (sub-regional) hardware instance.
  - Patient Administration System (PAS)
  - ePharmacy

DHB on-boarding to the regional solutions commenced with Whanganui DHB with Clinical Portal in July 2016 and RIS in November 2016. Each DHB has commenced planning to on-board to the regional solutions with implementation expected to occur progressively over the next 18-24 months. Please see Page 15 for additional information in ICT.

Regional Outcomes

The Central Region is laying the foundation to remove the reliance on legacy EMR solutions by deploying more modern and integrated solutions to enable regional sharing of information, optimal use of scarce clinical resources and allow new models and processes of care to be supported.

With this foundation it is expected that in the next four years this will support the Central Regions' ability to:

- Digitise provider/patient/consumer interaction to support the move to care in the home and self-care
- Digitise end-to-end processes by implementing systems that enable electronic referrals, workflow, shared care and service coordination across and within care settings
- Improve the availability and quality of data for decision making through digital enablement, Population Health and System Performance analysis, and the use of electronic decision support at point of care
- Actively participate in the national eHR and Digital Health strategy's implementation, once defined.

Objectives for the Central Region in 2017/18
The focus for the next 18-24 months will be the individual DHB adoption of the Core and Common EMR Solution capabilities, the transition to a revised Regional operating model and maximising the Region's ongoing ICT investment. It is a priority for the region to ensure that there is alignment between local, regional and national activity and agreeing on a regional four year Digital Health work programme. In particular this includes: • **Implementation, optimisation and the sustainability** of regional clinical/business applications and systems, infrastructure and ICT operations with effective and efficient Regional Governance • **Delivery of the required activities to support the Central Region 2017/18 priorities including;**   ○ Elective Services, Cardiac Services Mental Health and Addictions, Stroke Services, Health of Older People, Major Trauma, Hepatitis C, Diagnostic Imaging and Palliative Care • **Alignment to and support** of the National Health and Digital Health Strategies, the National eHR project, and the Regional Service Plan.

Information Communication Technology (ICT)

Agreed objectives and key actions Information Communication Technology	Quarter of completion	Measures	Accountable roles
Objective 1: Implementation, optimisation and the sustainability of the Regional EMR Solutions			
1. DHB on boarding to all Core and Common Regional EMR solutions to obtain the benefits of our regional investment	Ongoing – expected conclusion Q4 FY18/19	• DHB implementation and use of the Regional solutions	All six Central Region DHBs
2. Implementation of the revised Regional Operating Model to effective and efficiently govern the ongoing delivery and enhancement of the Regional solutions	Q2	• Formalised Regional Alliance framework for Regional Service Management with clear lines of accountability, KPI's and performance measurement • Business ownership by the Clinical and Consumer group, supported by the Regional Design Authority and Investment Board (as required) to determine the prioritises of regional solutions enhancements to facilitate integration of secondary, allied, primary and specialist care and enable new models of care	All six Central Region DHBs and CTAS
Objective 2: 4 Year Regional Digital Health Work programme			
1. Regional engagement and consultation to define a set of prioritised strategic imperatives aligned to, and in support of the; • National Health Strategy • NationaleHR and Digital Health strategy, and • Regional Services Plan	Q3	• A regionally agreed four year Digital Health work programme supported by the necessary approved business cases • A set of prioritised strategic imperatives which directly contribute to the digitisation of provider/patient/consumer interactions and end to processes	All six Central Region DHBs and TAS

16.2

Input/Resources	
Costs	Operational funding for BAU operations for FY 17-18 in place and local DHB on boarding investment being scoped or is allocated. FY18-19 and beyond is subject to Regional Planning being undertaken in Q3/4 FY17-18
People or Teams	To be determined as part of RHIP transition planning to BAU operations, by individual DHB on boarding projects and Regional Planning in Q3/4 FY17-18

Enablers required to achieve regional priorities	
Workforce	To be determined as part of RHIP transition planning to BAU operations, by individual DHB on boarding projects and Regional Planning in Q3/4 FY17-18
IT	Core regional solutions of Clinical Portal, Radiology Information Systems and Picture Archiving Communications and common Patient Administration and ePharmacy solutions implemented by DHB's, and with solutions enhanced ongoing, to support local, regional and national initiatives and priorities
Capital	To be determined through Regional Planning in Q3/4 FY17-18

Linkages	
National IT Plan	Central Region ICT activities support the National Health Plan of 2010 and its update in 2013, and it is expected that these will also support the Central Region's contribution to the National eHR business case and Digital Health Strategy, once these National initiatives are completed
Health Workforce New Zealand	TBD
Capital	TBD
Health and Safety Commission	TBD

End of Information Communication Technology (ICT)

Major Trauma

CE Sponsor: Debbie Chin CCDHB
Programme Lead: Chris Lowry CCDHB

Introduction

Injury is the leading cause of death in young New Zealanders aged 0 – 44 years. Every year in New Zealand an estimated 1,800 people die from trauma, and a further 2,000 people are admitted to hospital with major trauma[1]. Injury is the third leading cause of health loss in children and young people, and the fifth leading cause of health loss for all age groups in New Zealand[2]. For those that survive, their injuries can have a profound and lasting impact on their life. Injured patients stand the best chance of making a good recovery if the trauma system performs well.

In June 2012, the Ministry of Health and the Accident Compensation Corporation established and jointly funded the Major Trauma National Clinical Network (MTNCN). This Network oversees and gives clinical leadership to major trauma services in New Zealand to help them deliver services in a planned and consistent way[1]. The Network has developed and implemented the New Zealand Major Trauma Registry (NZ-MTR), a national major trauma database. As the NZ-MTR evolves it will identify opportunities for trauma quality improvements and then, enable measuring of the effectiveness of subsequent quality improvement initiatives by DHBs and regions[1].

Aligned with the national major trauma strategy, in May 2015 the Central Region Trauma Network (CRTN) was established. In its first year of inception the CRTN has been focusing on:

- Establishing regional systems to report the elements of the National Major Trauma Minimum Dataset (NMTMDS) for major trauma patients to the NZ-MTR
- Development of a central region major trauma destination policy.

Key achievements to date

- Establishment of a Central Region Trauma Network
- Allocated nursing FTE to collect the NMTMDS and enter data onto the NZ-MTR
- Development of a Central Region major trauma data collection form
- Regional training for the New Zealand Major Trauma Registry
- Agreed Central Region Major Trauma Destination policy for the national destination policy
- Central Region major trauma data summary reporting
- Annual Central Region Trauma Symposium

Regional Outcomes
• To implement a regional major trauma system that will result in a reduction of preventable levels of mortality, complications and lifelong disability of clients who have sustained a major trauma as defined by the Major Trauma National Clinical Network.

Objectives for the Central Region in 2017/18
• Report the elements of the National Major Trauma Minimum Dataset for major trauma patients to the New Zealand Major Trauma Registry • For the Central Region Trauma Network to provide clinical leadership to achieve a contemporary regional trauma system, including: ○ Agreed Central Region clinical guidelines and inter-hospital transfer processes to manage major trauma patients within the region

Major Trauma

Agreed objectives and key actions Major Trauma	Quarter of completion	Measures	Accountable roles
Objective 1: Report the elements of the National Major Trauma Minimum Dataset (NMTMDS) for major trauma patients to the New Zealand Major Trauma Registry.			
1. Collect and enter the NMTMDS onto the New Zealand Major Trauma Registry (NZ-MTR) no more than 30 days after discharge a. Amendments of data entered onto NZ-MTR generated from audits undertaken by Midland Trauma System who host the NZ-MTR will be completed by due dates set by Midland Trauma System b. The CRTN will develop and implement a six-monthly regional process to analyse and interpret regional major trauma data with mechanisms for quality improvement with generation of an annual Central Region major trauma report that will identify opportunities for trauma quality improvements in the region and in individual DHBs	Q2 and Q4	Data reported to the MTNCN via arrangement with Midland Trauma System will confirm data entry Audit amendments of data for the NZ-MTR to be achieved within set timeframes from Midland Trauma System Quarterly summaries to be sent to regional nurse lead 30 days following the end of the quarter. Quarterly summary reports to be provided at each CRTN meeting Annual report by end of Q1 of following year 2018/19 reporting *Analytical support required* Analysis of data will support identification of key areas for improvement and will commence on completion of the annual report	Midland Trauma System Regional DHBs Regional Clinical Lead Regional Nurse Lead Central Region Trauma Network Clinical Leads for trauma in each Central Region DHB Nurse Leads for trauma in each Central Region DHB
Objective 2: Provide clinical leadership to achieve a contemporary central region trauma system.			
1. Develop agreed regional clinical guidelines and inter-hospital transfer processes to manage major trauma patients within the region	Q2 and Q4	A trauma clinical guideline will be endorsed quarterly by the CRTN and adapted to meet each DHB's specific requirements	Central Region Trauma Network
2. Develop and implement a 6-monthly regional review process of the alignment of actual service delivery for major trauma patients with regional clinical guidelines and processes	Q2 and Q4	A biannual review of regional trauma processes will be developed	Regional DHBs

Performance indicators to be reported on
• Quarterly regional reporting of the New Zealand Major Trauma Minimum Dataset for major trauma patients to the National Major Trauma Registry no more than 30 days after patient discharge • Develop and implement a six-monthly (minimum) regional process to analyse and interpret regional major trauma data with mechanisms for quality improvement • Develop and implement a six-monthly (minimum) regional review process of the alignment of actual service delivery for major trauma patients with regional clinical guidelines and processes

Input/Resources	
Costs	N/A
People or Teams	N/A

Enablers required to achieve regional priorities	
Workforce	Analytical support to analyse the region's major trauma data with generation of an annual central region major trauma report that will then identify opportunities for trauma quality improvements regionally and in individual DHBs
IT	N/A
Capital	N/A

Linkages	
National IT Plan	N/A
Health Workforce New Zealand	N/A
Capital	N/A
Health and Safety Commission	N/A

End of Major Trauma

Mental Health and Addiction

CE Sponsor: Julie Patterson WDHB
Lead/Chair: Alison Masters CCDHB

Introduction

Demographics are changing across Mental Health and Addiction (MHA) service populations resulting in higher complexity of experience for people entering services[3], population and acuity changes in prisons[4], and increased numbers of tāngata whaiora (service users) accessing services[5]. A total of 34,591 individual tāngata whaiora were seen by MHA services across 2015/2016, equating to 3.9% of the total Central Region population.

Models of care and new data have supported services to react and adapt where need is identified while workforce continues to be an area of focus, due to ageing workforce populations, increased service use, and movement to enhance peer support provision.

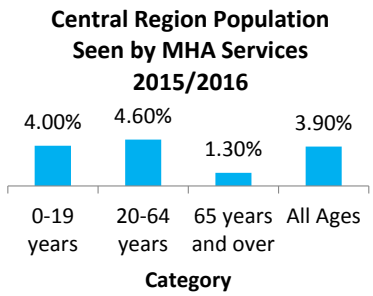
The Central Region Mental Health and Addiction Leadership group (MHARL) has replaced the Mental Health and Addiction Network (MHAN)[6] enabling stronger inclusion of mental health, addictions, Māori, Pacific, family whānau, Non-government Organisation (NGO) and primary care perspectives. These perspectives have allowed more system wide discussions to take place, and this new way of working will continue to build over time.

Achievements to date

Co-designed models of care have aimed to enhance the region to provide the right service at the right time. Realisation of these outcomes will emerge when these models of care have been fully embedded. Closing gaps and completing reviews have resulted in the development of information documents, referral pathways, regional decision making and peer support opportunities, each enhancing the ability for services to interact and to ensure people using services have the smoothest journey as possible. It has been noted that improved IT systems will enhance the ability for the sector to share and collaborate.

Other achievements within the Region include, but are not limited to:

- links with Health Pathways and Map of Medicine primary care platform development
- building collaborative spaces with providers and stakeholders for regional approaches
- co-designing developments to service design and improvement
- models of care work has been begun for youth alcohol and other drug (AOD) and youth acute response alongside the process of implementing the regional model of care for adult residential AOD
- enhancing maternal health regional services through technology improvement



[3] Ministry of Health. 2012. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017*, Wellington: Ministry of Health.

[4] Department of Corrections, *Prison Statistics*, various years.

[5] Ministry of Health, *Mental health service use series,* various years.

[6] Change of network initiated 1 July 2016.

What will the future hold?

Leadership across the Region identified the upcoming priorities. These were seen as outcomes that may require more than one year to complete. The Regional Service Plan 2017/2018 is a collection of the initial steps to move towards each one.

Regional Outcomes

- Develop regional modelling through identification of localised exemplar services to provide gains across the region.
- Enable and enhance regional collaboration and connection across the sector
- Utilise enablers such as IT and workforce to enhance service performance

Objectives for the Central Region in 2017/18

- Enhancing the use of data and information to support services to more deeply understand the range of services, how they are utilised and how they are meeting the needs of the community (Forensics, Eating Disorders, Maternal Mental Health)
- Regional forums exploring ways to improve physical wellbeing held, enabling stronger integration and providing support to the region on ways to plan to respond to the physical health of people who use mental health and addiction services
- Enhance models of care to enable services to meet the needs of the community (Youth Acute Response, Youth Alcohol and Other Drug, Residential Alcohol and Other Drug, including the provision of the new substance use legislation (SACAT))
- Service exemplars, innovations in regional investment and the development of regional guidance documents will support the enhancement of multiple service areas with innovative ways to provide for the community

Mental Health and Addiction

Agreed objectives and key actions Mental Health Addiction	Quarter of completion	Measures	Accountable roles
Objective 1: Utilise enablers such as workforce, IT, and data reporting to enhance service performance			
1. Achieve regional agreement to the user requirements and benefits from a regional electronic health record encompassing mental health and addictions, specifically identifying any requirements that will not be met by the regional patient management system and clinical portal	Q4	A user requirements document is agreed, completed and delivered to the Regional IT programme	Mental Health and Addictions Regional Leadership group (MHARL)
2. Identify high priority workforce development actions from the National Workforce Plans and Regional Workforce Plans	Q4	Implementation plan in place to meet identified high priority areas within the national workforce plan and regional workforce plans	Mental Health and Addictions Regional Leadership group (MHARL)
3. Quarterly reports reflect data requirements from the Ministry of Health regional planning guidelines 2017/2018	Q1-Q4	Increased access rates to Youth Forensic services and data reflecting Māori and Pacific access rates Improved access to a range of Eating Disorder services and data showing Māori and Pacific access rates Increased access and community contacts, alongside reduced wait times and admissions for Maternal Mental Health acute services including data reflecting Māori and Pacific for these measures Reduced wait times and waiting lists for Adult Forensic services and data reflecting Māori and Pacific waiting times and waiting lists	Regional Portfolio Manager
Objective 2: Enable and enhance regional collaboration and connection across the sector			
1. Regional Forums held to address social determinants and physical health for people with mental health and addiction needs	Q4	Forums held and regional action plan created to improve outcomes for this population group	Mental Health and Addictions Regional Leadership group (MHARL)
2. Align regional investment with the National Commissioning Framework	Q4	Regional decision making process outlined, and at least one service aligned with the process	Mental Health and Addictions Regional Leadership group (MHARL)

Agreed objectives and key actions Mental Health Addiction	Quarter of completion	Measures	Accountable roles
3. Review regional services guide documents to enhance utilisation of service pathways information	Q3	Regional services guide disseminated to all MHA services and service feedback indicates increased awareness of pathways options	Regional Portfolio Manager
4. Develop a regular newsletter process to share regional success stories including workforce	Q2, Q4	Two newsletters per annum are disseminated across the region. At least one example of new application based on shared success stories summarised	Mental Health and Addictions Regional Leadership group (MHARL)
Objective 3: Develop regional modelling through identification of localised exemplar services to provide gains across the Central Region			
1. Regional addiction service capacity and capability planning continues through enhance model of care and incorporates provision for Substance Addiction (SACAT) legislation	Q2 - Q4	Model of care implementation plan is agreed across the region including Each DHB has an implementation plan for local application, including how to meet the requirements of SACAT	Portfolio Manager and Alcohol and Other Drug (AOD) Network
2. Regional discussion held regarding Youth Acute Response (YAR) and Youth Alcohol and Other Drug (YAOD) models of care across the central region	Q4	Regional agreement by MHARL regarding models of care and proposed implementation plan created for future development	Youth and Whānau Network
3. Develop an example hub and spoke service model based on the Specialist Maternal Mental Health Services (SMMHS) hub and spoke modelling process	Q2	Exemplar document available to the region At least one service running or moving towards a hub and spoke model summarises their enhancements to delivery based on learnings from the SMMHS model	Youth and Whānau Network
4. Enhance the ability for the Central Region to provide Regional Perinatal Mental Health Services by: a. Clarifying the current usage of regional perinatal mental health Acute Packages of Care that support mothers and their whānau. b. Identifying areas to enhance the Perinatal Mental Health Clinical Network and regional education / training provision to ensure it meets the region's needs	Q4	Trend analysis for usage of Regional APOC collated and recommended actions provided Stocktake current provision of the regional clinical network and education provision with recommendations provided for improvement	Youth and Whānau Network
5. Examples of services providing out-of-hours service are shared to enhance ability of others to explore options	Q4	Exemplar document available to the region. At least one service summarises the enhancements to their out of hour's service provision utilising regional examples	Regional Clinical Directors Group / Regional Service Managers Group

Performance Indicators to be reported on
A reduction in waiting lists and times for people in prisons requiring assessment in forensic services. For example: a reduction in waiting lists from x to y with targets set for each quarter.
Increased access to community youth forensic services through the development of sustainable youth forensic services. Measure and report improved youth forensic access rates overall including increases in all three settings (court liaison, Child Youth and Family youth justice residences, and community).
Increased access in the North Island to perinatal and maternal mental health services, increased number of contacts in the community, decreased wait-time (time from referral to first contact), decreased adult admissions. For example: x being current numbers to be increased to y with progress measured each quarter.
Report progress on developing a plan to improve the physical health of people with low prevalence disorders.

Input/Resources	
Costs	TAS, as the shared service agency for the Central Region is funded to support the Central Region DHBs with the developments and implementation of the work programme.
People or Teams	As described in accountable roles.

Enablers required to achieve regional priorities	
Workforce	N/A
IT	Enhance links with Regional IT programmes to ensure MHA input is strengthened in any relevant future developments
Capital	N/A

Linkages	
National IT Plan	N/A
Health Workforce New Zealand	N/A
Capital	N/A
Health and Safety Commission	N/A

End of Mental Health and Addiction

Health Quality and Safety

CE sponsor: Adri Isbister WaiDHB
Programme Lead: Sandy Blake MDHB

Introduction

Clinical leadership and person/family-centred care are internationally recognised as key drivers of improved patient outcomes and effective clinical governance.

Clinical governance systems within health care form the foundation of safer processes for people, their families/whānau and staff. The aim is to work in partnership to improve the quality of care and to reduce patient harm.

The Central Region Quality and Safety Alliance (CRQSA) was established June 2014 with the overarching aim of continually improving the quality and safety of care and providing positive patient experiences for people and their families/whānau.

The CRQSA provides a multidisciplinary cross sector forum and a voice for clinical leaders across the Region to positively influence planning, accelerate Māori health gain and strive to achieve equity of health outcomes for all New Zealanders.

Partnership between the CRQSA, HQSC, ACC and MoH quality programmes has been established and will be strengthened through active participation, information sharing and collaborative initiatives that reduce harm and improve quality of care.

Regional outcomes

- Provide effective regional quality and safety planning, advice and recommendations to the Central Region Chief Executives
- Promote and implement processes for sharing quality and safety information and learnings that support a regional view on patient safety issues
- Influence and support alliance members to improve patient safety and quality of care by implementing systems and processes within their own organisations

Objectives for the Central Region in 2017/18

- Maintain leadership in quality improvement and patient safety by establishing collaborative relationships, through regional linkages
- Share tools and expertise to build capability and capacity to improve the quality and safety of care
- To promote the principles of patient/whānau centred care, share learnings and success stories
- To continue and strengthen partnerships with HQSC, ACC and MoH quality improvement and patient safety programmes to address areas of high patient harm across the Central Region

Health Quality and Safety

Agreed objectives and key actions Health Quality and Safety	Quarter of completion	Measures	Accountable roles
Objective 1: Strengthen partnerships to promote quality improvements and patient safety across the region			
1. Disseminate key messages and communication after each meeting to chairs of PHOs and clinical governance, DHB Māori managers, interested groups and the CEs a. On a quarterly basis have face to face meetings with the CE sponsor to ensure communication of successes and challenges to the CE group b. Analyse data received from HQSC, MoH and ACC c. Support as required the development of regional working groups for collaboration and learning d. Benchmark Central Region against other regions for performance against the national quality and safety process markers and outcome measures	Q1-Q4	The Central Region is committed and proactively works with the HQSC, ACC, chairs of PHOs, clinical governance, DHB CE's, the MoH and other interested parties to reduce patient harm and improve quality of care	CRQSA
2. Develop reporting schedules between the Alliance and the Central Region CEs and Ministry of Health	Q1-Q4	Report quarterly to: • Chief Executives • Ministry of Health	CRQSA
3. Alignment with HQSC work a. The central region partnership with HQSC is demonstrated by HQSC attendance at each alliance meeting b. All HQSC programmes of high harm have a regional work group established or being established, with reporting relationship to the alliance	Q1-Q4	We will continue to monitor and support the Region via the Alliance • A fixed 45 minutes time slot on every agenda • Quarterly quality and safety regional reports from the HQSC are standing item	CRQSA
4. One central region DHB participates in the HQSC trial of the new EWS chart	Q1-Q4	Action completed by Q4	CRQSA

Agreed objectives and key actions Health Quality and Safety	Quarter of completion	Measures	Accountable roles
Objective 2: To promote the principles of patient/whānau centred care, share tools and stories, expertise and learnings to build capability and capacity to improve the quality and safety of care			
1. Discuss, identify and distribute regionally successes, learnings and challenges from patient safety and quality groups a. Support and encourage commitment to and participation in the priority areas of patient safety and quality	Q1-Q4	The Central Region is aware of the patient safety and quality groups across the region, the responsibilities of these groups and how they can be engaged for knowledge sharing and capability building. Key successes, learnings and challenges of the Central Region are known and continuously updated and shared across the region. The regional working groups are pivotal and leading in supporting and encouraging commitment to patient safety and quality across the region (the working groups are as following: falls, pressure injuries, deteriorating patient, medication safety, infection control, quality managers, maternity quality and safety, safety, Central Region CEs, quality improvement advisors).	CRQSA
2. Implement training package to support the implementation of a person and whānau-centred approach	Q3-Q4	Training package promoted and implemented across the Central Region	CRQSA
3. Analyse, learn from and share region-wide patient experience survey data	Q1-Q4	Learnings from patient surveys are shared and discussed with the Central Region	CRQSA
4. Each district represented by the alliance members will share their consumer partnership including partnership with Māori consumers and their whanau, framework for regional learning	Q3-Q4	Consumer partnership will on the agenda of each meeting: • District frameworks will be discussed and successes and challenges shared • Agenda item for each meeting to highlight examples of quality and safety improvement for Māori	CRQSA

Performance Indicators to be reported on
N/A

Inputs/Resources	
Costs	N/A
People or Teams	N/A

Enablers required to achieve regional priorities	
Workforce	N/A
IT	N/A
Capital	N/A

Linkages	
National IT Plan	N/A
Health Workforce New Zealand	N/A
Capital	N/A
Health and Safety Commission	Central Region partnership with HQSC

End of Health Quality and Safety

Stroke Services

CE Sponsor: Ashley Bloomfield HVDHB
Programme Lead: Jeremy Lanford CCDHB

Introduction

Stroke is the third most common cause of death after heart disease and all cancers combined and is a major cause of long-term adult disability. Lifetime costs per stroke patient in New Zealand are estimated to be $73,600 per person. Effective early intervention is required to promote maximum recovery, prevent costly complications, improve independence and reduce the stroke burden.

While overall the Central Region continues to meet its targets for stroke, inequities persist in relation to access in some areas which require ongoing support in the delivery of specialist stroke services. For example, in relation to community based rehabilitation for younger stroke patients vocational support and mental health services (for example) are available in some DHB Regions but not in others. This has an impact on recovery and ability to re-enter the workforce following stroke.

The Central Region is also experiencing challenges in relation to the stroke data collected which is not sufficient to inform service planning and delivery. There is also a need to build on work started to continue to strengthen linkages across other sectors such as primary care, NGOs and iwi providers.

Key areas of focus for 2017/18

Access to accurate quality data for ongoing service improvement, to monitor the quality of service delivery and to ensure equity of access and improved patient outcomes. This will assist to address the current situation where the stroke data collected at a regional level is for compliance and reporting purposes and is not sufficient to support the region's understanding of service delivery. The current stroke data collection cannot be matched with data in other areas such as cancer and cardiac. If the data collection could be matched it would be possible, for example, to understand the patient journey.

Exploring options to ensuring equitable access to thrombolysis and thrombectomy services. Some DHBs in the Central Region struggle to provide 24/7 access to a neurologist or physician specialising in stroke to provide expert supervision for both thrombolysis and thrombectomy. The implementation of telestroke regionally, and the development of a business case for a regional thrombectomy service plan will work towards ensuring equitable access to all patients in the region and improve patient outcomes.

Key Achievements

During 2016/17, the Central Region continued a focus on the implementation of the New Zealand Stroke Foundation Guidelines (2010). Key highlights for the year included:

- Participation in the national telestroke pilot which resulted in a rise in thrombolysis rates from 7% to 14.5% (which exceeds the national target of 6%) and improved access for patients.
- Collection of specific data on Māori and Pacific stroke patients to work towards understanding the linkages between stroke and other health conditions for Māori and improving the use of this data.
- Development and implementation of a communication plan which included strategies to support the TIA (transient ischaemic attack – or mini-stroke) tool in primary care. This tool has been developed to support general practitioners in the assessment, diagnostic testing, management and referral of TIA and stroke patients. Evidence demonstrates that the use of this tool reduces treatment costs and reduces the risk of further TIA and stroke.
- A needs analysis to determine the requirements for community based rehabilitation for stroke patients.
- Completion of a recommended strategy for thrombectomy since it is a treatment which has been shown to reduce hospital costs; and have better patient outcomes including an increased number of patients who are able to be independent and have fewer disabilities.

Regional Outcomes
• Equity of access to thrombolysis • Stroke patients admitted to an acute stroke unit or recognised stroke pathway • Equity of access to rehabilitation and community based stroke services • Improved linkages with primary care

Objectives for the Central Region in 2017/18
• Improve primary and secondary stroke prevention and reduce stroke related disability and mortality • Ensuring access to quality assured organised acute, rehabilitation and community stroke services • Ensuring all stroke patients have access to high quality stroke services regardless of age, gender, ethnicity or geographic domicile

Stroke Service

Agreed objectives and key actions Stroke Network	Quarter of completion	Measures	Accountable roles
Objective 1: Improve primary and secondary stroke prevention and reduce stroke related disability and mortality			
1. Telestroke implemented across the Central Region	Q1-Q4	Eligible patients have access to thrombolysis 24/7 across the region 8% or more of eligible patients' thrombolysed	Central Region Stroke Steering Group and Central Region District Health Boards
2. Develop a business case to explore options for a regional thrombectomy service to the Central Region	Q3	Business case developed which will inform decision on next steps	CCDHB
Objective 2: Ensure that all patients have access to quality assured organised acute, rehabilitation and community stroke services regardless of age, gender, ethnicity of geographic domicile			
1. Collect and report on data by ethnicity which measures access to early active rehabilitation	Q1-Q4	All eligible people with stroke receive early active rehabilitation services supported by an interdisciplinary stroke team	Central Region Stroke Steering Group Central Region DHBs
2. Collect and report on data by ethnicity which measures access to community stroke services	Q1-Q4	All eligible people with stroke have equitable access to community stroke services	Central Region Stroke Steering Group Central Region DHBs
3. Develop a regional workforce plan that supports the delivery and achievement of sustained, consistent and safe thrombolysis and comprehensive evidence based interdisciplinary acute and rehabilitation stroke care provision	Q4	A regional workforce plan is developed which informs decisions on next steps and prioritisation	Central Region Stroke Steering Group
4. Develop requirements for an integrated approach to improve stroke data collection and analysis including opportunities to better analyse ethnicity data	Q1-Q4	Improvements are made in Central Region's ability to collect, report and review data, and in particular, ethnicity data	Central Region Stroke Steering Group

Performance Indicators to be reported on
• 8% or more of eligible patients thrombolysed • 80% of stroke patients are admitted to an acute stroke unit or organised stroke service • 80% of stroke patients transferred to inpatient rehabilitation within 7 days of acute admission

Inputs/Resources	
Costs	TAS, as the shared services agency for the Central Region is funded to support the development and implementation of the work programme
People or Teams	TAS Planning and Improvement Manager TAS Business Intelligence Analyst Central Region Stroke Steering Group

Enablers required to achieve regional priorities	
Workforce	As described in objective 2, action 3
IT	As described in objective 2, action 4
Capital	N/A

Linkages	
National IT Plan	N/A
Health Workforce New Zealand	N/A
Capital	N/A
Health and Safety Commission	N/A

End of Stroke Services

Palliative Care / End of Life Care

CE Sponsor: Adri Isbister, WaiDHB
Programme Lead: TBC

Introduction

The Central Region (including Taranaki DHB) is taking a more regionally coordinated and strategic approach to palliative care including end of life care planning in the region. During 2016/17 discussions were had between the Central Region Palliative Care Network (CRPCN) and Central Region clinical networks (HOP, MHARL, Cardiac, Stroke), DHB executive groups and Taranaki stakeholders to identify where the challenges are and the types of activities that would benefit from a regional approach These conversations included stakeholders from:

- DHBs from a population responsibility perspective
- Hospices and Hospital Palliative Care Teams as specialist service providers
- Secondary and Tertiary care providers including the cancer centres
- Primary care and Aged Residential Care as primary providers of palliative care.

Key drivers for regional palliative care and end of life service planning

People powered

- Addressing persisting inequities for Māori in relation to access to and experience of services.

Closer to home

- The importance of agreed models of care for different patient groups to support early access to palliative care and equity of access.

Value and high performance

- DHB level data shows significant increases in projected deaths, palliative care need and projected increases for the various services due to the aging population and increasing prevalence and duration of long term conditions in the population requiring palliative care management.
- Addressing the significant healthcare costs that are consumed in the last two years of life.

One team

- Need to develop capacity and capability in primary care and Aged Residential Care to enable these services to appropriately drive the palliative approach.
- The need to undertake workforce planning at both a local and sub-regional level.

Recent national work in this policy area

- The Minister's disestablishment of the Palliative Care Council and the Ministry's establishment of the Palliative Care Advisory Panel
- $76M additional funding for hospices over the next four years to address workforce investment and improve community palliative care services – ($13M per annum for sustainable funding of hospices and current services and $7M per annum for new initiatives). These new innovation funded projects to support new, innovative and ongoing services working with aged residential care and primary care are underway across all districts
- New Zealand Health Strategy: Roadmap of Actions 2016 identifies actions relating to 'support for the final stages of life' that focus on advance care planning and review of adult palliative care services. This review aims to ensure equitable, high quality care and improved service integration over the next 3 to 5 years. It will also consider projected needs for palliative care services over the next 10 to 20 years (due for completion late 2016)
- Healthy Ageing Strategy includes a section on 'Respectful End of Life' and includes activities relating to advance care planning, workforce development and improving the quality and effectiveness of palliative care.
- HWNZ three year pilot of the Lower North Island Palliative Care Managed Clinical Network across CCDHB/HVDHB/WDHB which runs through until mid-2017. The network has agreed the Living Well, Dying Well – A Strategy for a Palliative Care Approach 2017-20 which will drive the approach for the sub-region.

- HWNZ investment in additional RMO trainee positions to address forecast vulnerabilities in the SMO workforce. The Central Region has agreed in principle a business case to implement three additional roles in the region, one of which has been able to be progressed to date.
- The Resource and Capability Framework (MoH 2012) was developed to provide guidance to funders and policy makers with respect to strategic planning and the purchasing of accessible and equitable palliative care services for New Zealanders.
- Development of Specialist Palliative Care Service Specifications – these are currently 'recommended' only as the DHB palliative care portfolio managers have agreed that this service specification was still not fit for purpose. It was decided that no further work would be done to try and resolve the issues with the service specification until the outcome of Ministry's Review of Adult Palliative Care Services is final.
- Te Ara Whakapiri - Principles and Guidance for the Last Days of Life has been completed and the Palliative Care Advisory Panel is expected to provide implementation advice in 2016/17.
- The Need for Palliative Care in NZ (MoH 2016) provides DHB level data relating projected deaths, palliative care need and projected increases for the various services that provide palliative care services to support workforce and service planning.
- The Faster Cancer Treatment health priority identifies early access to palliative care services as one of the first treatments in relation to the 62 day Health Target. Currently no DHBs in the region have achieved the 85% target.

Whilst implementation of many of these initiatives is already underway at district and sub-regional levels under the guidance of palliative care provider governance groups, stakeholders have identified that there would be value in working regionally on specific activities including workforce education and planning, quality standards and models of care.

Regional Outcomes

Outcomes aligned with the Palliative Care Outcomes Framework (PCC 2012):

- Sufficient capacity - sufficient capacity refers to the resourcing of the palliative care system to meet the need generated by patients with a life-limiting or life-threatening illness whom would benefit from palliative care
- Appropriate referrals - referrals are the mechanism by which a patient accesses palliative care 'services'; as such 'appropriate referrals' contribute to access to palliative care
- Continuity and Coordination of care - patients receiving palliative care may require a number of different types of care from different providers. It is important that these providers and services are aware of and responsive to the various facets of care that the patient requires that are provided by another part of the health system.
- Best Practice is followed - Best Practice refers to palliative care being provided in a way that aligns with evidence-based Best Practice. Implementing best practice ensures that patients receive the care most likely to meet their needs.
- Palliative care meets the needs of patients, family and whanau. Palliative care must meet the unique needs of the patient, their family and whānau, no matter what their religious, cultural, ethnic or socioeconomic background or geographic location/rurality.

Objectives for the Central Region in 2017/18

- Quality palliative care services are delivered by an appropriately resourced, positioned and well educated workforce
- Appropriate models of care are developed to enable patients and their whanau to have early and equitable access to palliative care services across the region

Palliative Care / End of Life Care

Agreed objectives and key actions Palliative Care / End of Life Care	Quarter of Completion	Measures	Accountable Roles
Objective 1: Quality palliative care services are delivered by an appropriately resourced, positioned and well educated workforce			
1. Develop a workforce plan to ensure that those working with clients requiring palliative care services, including last days of life care, have the training, resources and support they require to deliver high-quality, person-centred care, by: a. Identify the work forces working with clients requiring palliative care services and their family/whānau/informal carers* b. Facilitate a regional forum to share progress on the seven Hospice led innovation funded projects that commenced in 2016/17 c. Develop a 3yr regional workforce plan* *For CCDHB/HVDHB/WDHB implementation of the Living Well, Dying Well – A Strategy for a Palliative Care Approach 2017-20 has already commenced this work in 2016/17 and this work will inform the approach for the region	Q1 Q2 Q4	Workforce stocktake completed Regional forum held Workforce plan completed	CRPCN (CCN) / Regional Director of Workforce Planning (TAS)
2. DHBs work with Hospices and HWNZ to reconfirm the requirements for and implement the remaining two additional three year RMO positions as approved in principle in 2015/16	Q1 (Jul rotation) Q4 (Dec rotation)	One additional RMO across CCDHB/HVDHB/WDHB (if requirements are reconfirmed) One additional RMO across MDHB/HBDHB/WhaDHB/TDHB (if requirements are reconfirmed)	DHBs / Hospices / HWNZ
Objective 2: Appropriate models of care are developed to enable patients and their whanau to have early and equitable access to palliative care services across the region			
1. Cardiac Network and CRPCN to develop locally, regionally and nationally agreed protocols, guidance, processes and systems to ensure optimal management of patients with heart failure	Q4	Model of care developed and implementation considerations identified to inform 2018/19 planning	Cardiac Network (TAS) / CRPCN (CCN)

Performance indicators to be reported on
No specific measures identified for Ministry reporting

RSP Input/Resources	
Costs	Action 1: Workforce stocktake and plan (covered by CCN/TAS) • Stocktake – project management cost • Forum – approx $5,000 to deliver a single regional forum – this will be funded by CCN in 2017/18 • Develop plan – project management cost Action 2: additional SMO positions • Costs for the two additional RMO positions are dependent on any potential additional HWNZ funding and partnership arrangements that can be made across DHBs and Hospices. If no additional HWNZ funding is identified then DHBs could make this cost neutral if existing RMO positions are reprioritised. Action3: Heart failure model of care (covered by CCN/TAS) • Development - project management
People or Teams	It is appropriate for the CRPCN to be formally established under the regional clinical network structure as its own Clinical Network – this will require a change to the TOR, membership etc. The requirements will need to be scoped up and a business case proposed to the regional governance for approval.. In the interim CCN will continue to provide this support.

Enablers required to achieve regional priorities	
Workforce	Additional RMO positions (as identified through reconfirming requirements) Regional workforce plan
IT	N/A
Capital	N/A

Linkages	
National IT Plan	N/A
Health Workforce New Zealand	Additional RMO positions (as identified through reconfirming requirements) Regional Workforce Plan
Capital	N/A
Health and Safety Commission	N/A

Regional Workforce

CE Sponsor: Julie Patterson WDHB
Programme Lead: Roy Pryer HVDHB
Regional Director: Bridget Smith TAS

Introduction

Workforce is a pivotal consideration to ensure the clinical and financial viability of services on a sustainable basis. In response to the challenges of workforce in the future, the Central Region will need to consider which changes are required at a service by service level.

Clinical workforce issues, regulated and unregulated, will be the single most significant driver which will change the way clinical services are delivered across the Central Region. Whilst defining a model of care is important to meet health need demand, in many instances the workforce availability is a key factor which will influence and be influenced by models of care.

Health Workforce New Zealand's focus continues to be on strengthening the health and disability workforce by improving the recruitment, retention and distribution of health professionals especially in vulnerable professions.

The planning acknowledges the alliance formed between the six DHBs, Health Workforce New Zealand and the National Strategic Workforce Team. For 2017/2018 this will further be strengthened with Workforce as an enabler across the clinical networks and the need for data requirements and sharing. Please refer to Page 15 for additional information on workforce as an enabler.

Regional Outcomes

The regional clinical and professional networks have work plans in place looking at several streams of work which contribute to the two top priorities for the Region regarding workforce development in 2017/2018. These two priorities are Vulnerable Workforce and Leadership Development.

1. Vulnerable workforce

The Central Region across professional groups and clinical networks has already identified a number of staff groups where for a number of reasons, there is a shortage enough and recruitment proves difficult. The Central Region Statistics New Zealand population data sourced through TAS identifies an increase in the aging population and from 2020 onwards, a decrease in the 20-60 age groups. This will affect the labour market participation rates and increase pressure on staff recruitment and retention. Utilising business intelligence, workforce strategy data and local information it will be crucial to analyse future predictions and the need to meet rising demand across health and social care.

What we want to achieve:

A consistent and sustainable workforce for those staff groups who are presently either vulnerable or hard to fill.

Importance to the Region:

- Regional collaboration and efficiency in sharing staff as required
- Clinical Governance ensuring Quality and safety for the population
- Staff resource match demand and meets national requirements
- Faster access to diagnostics which enables faster treatment and increases health and wellbeing
- Increased efficiency and value for money in developing regional training, secondments, and staff development relationships
- Increased efficiency for tertiary providers and for out of area patients
- Increased ability to see more patients and prevent big shifts to private providers e.g. cancer treatments.

2. Leadership Development

Leadership is the most influential factor in shaping organisational culture. There is clear evidence of the link between leadership and a range of important outcomes within health services, including patient satisfaction, patient mortality, organisational financial performance, staff well-being, engagement, turnover and absenteeism, and overall quality of care.

What we want to achieve:

The Region needs to review and consider the current leadership programmes across the Central Regions DHBs. Aligned with the State Services Commission talent management framework will be our ability for investment in emerging leadership talent across the Region.

The aim is to achieve a positive work culture across all DHB's ultimately supporting wellbeing of staff.

Importance to the Region:

- To ensure a consistent approach that is aligned to the agreed National Leadership Competencies Framework and best practice
- Develop strong and committed leaders for the future across the region who contribute to a talent pool enabling sharing and transferability of skills and staff
- Create a strong succession pipeline for our DHBs
- Provide leadership that nurtures cultures that ensure the delivery of continuously improving high quality, safe and compassionate care.

Regional Workforce

Agreed objectives and key actions Regional Workforce	Quarter of completion	Measures	Accountable roles
Objective 1: Enable, maintain and support a consistent and sustainable workforce for those staff groups who are presently either vulnerable or hard to fill			
1. Work regionally and in collaboration with DHB shared services /HWNZ to identify and prioritise vulnerable workforces in workforce plans	Q4	DHBs will undertake evidenced based workforce planning following the provision of workforce data and intelligence that supports regions and DHBs	RDWD Strategic Workforce Services Central region Professional networks
2. Support enrolment in Postgraduate study and recognise qualifications obtained and provide opportunities for growth within clinical area of Midwifery	Q4	Note current enrolment and completion of Complex Care Course for midwives Identify outcomes for the midwives completing this course and the service outcomes/benefits	Regional Midwifery Group
3. Advanced practice roles developed in response to population need	Q3	Advanced practice roles across primary and community settings are implemented, e.g. Endoscopy (colorectal), Ophthalmology for Avastin procedures, NP in ED's	Directors of Nursing
4. Improved employee ethnicity data collected by the Central Region DHBs	Q4	Ensure all DHB employed workforce data on ethnicity is updated and collected in accordance with Ministry guidelines on ethnicity for 95% - 100% of the workforce by June 30 2018	DHB shared services Regional BI, HWNZ analysts, RDWD
5. Establish a Dedicated Education Unit for Māori and Pacific students to support a pipeline for Māori and Pacific workforce	Q4	80% of Year 3 Māori and Pacific students have placements in appropriate DEU Māori and Pacific Year 3 students have career plan and if they identify primary, work with TEP to enable most placements in that setting to support recruitment into Primary and NETP	CRDON's / GMs Māori and Pacific GMsHR Learning & development Managers
6. NEtP and NESP will positively discriminate through the ACE recruitment	Q3	Target is 40% Māori and Pacific	CRDONs
7. Identify current shortage of Māori midwifery workforce in the Central Region	Q4	Utilise TAS midwifery workforce projection tool to identify targets for each region	Regional Midwifery Group
8. Audit Sonographer trainees and supervision capacity in the region a. Continue to progress recruitment and retention initiatives for Sonographers, Medical Radiologic Technology Technicians and Senior Medical Officers	Q1 Q2 Q3 Q2 Q3	Establish an audit tool to monitor sonographer trainees and sonography supervisor's skill level and level of interest Promote the attendance at the national workforce forum Collate data and analyse results Share results with RRSG and the Regional Workforce Group Complete guidelines for supporting Sonographer training across the region Confirm regional gaps and develop recruitment initiatives Implement regional initiatives	Regional Workforce Group SWG CR Diagnostics Network

Agreed objectives and key actions Regional Workforce	Quarter of completion	Measures	Accountable roles
Objective 2: Enable, maintain and support a positive work culture across all DHBs ultimately supporting wellbeing of staff			
1. Support the Health and Wellbeing of all our staff	Q4	Operationalise core values across organisations	GMsHR
2. Review and continue to implement a cultural responsiveness programme	Q3 Q1 Q1 - Q4 Q2	Implement Wellness frameworks within all Central Region DHBs Identify CR DHB cultural responsiveness models and identify alignment to Te Tohu Whakawaiora Continue to develop and implement a regionalised cultural responsiveness programme Review the Te Tohu Whakawaiora framework	GMsHR
3. Advanced practice roles developed in response to population need	Q4	Advanced practice roles across primary and community settings are implemented, e.g. Endoscopy (colorectal), Ophthalmology for Avastin procedures, NP in ED's	CRDONs
4. Commence skills sharing programme to enable greater efficiencies between and within professions	Q1 - Q4	Calderdale Practitioners trained and commencing projects across the Central Region. TOR for both individual DHBs and cross DHB governance arrangements in place	Directors of Allied Health Central Region Inter-professional practice oversight group
5. Commence skills sharing programme to enable greater efficiencies between and within professions including the Khaiawhina workforce and linking to the Career force five year plan	Q1 - Q4	Governance across the central region- established. Over 100 staff trained at foundation level for the Calderdale Foundation in the Central Region	Directors of Allied Health Central Region Inter-professional practice oversight group
6. Ensure that the Healthy Ageing Strategy workforce as an enabler planning priorities are included in the RSP. These planning priorities are: a. identify the workforces working with older people and their family/whanau/informal carers - develop a workforce plan to ensure that those working with older people have the training and support they require to deliver high-quality, person-centred care b. develop a sustainable mechanism for collecting a minimum workforce data set on the health workforce working in health of older people outside the DHB provider arm by 30 June 2018	Q4	• Workshop planned for June 13th 2017 is carried out and findings used to inform next steps • Complete an integrated plan with South Island DHBs to sustain the use of the framework • This work will require a multi-agency approach across MOH, Regional Hubs, Strategic Workforce and HOP at a National level not just regional • The regional Directors have convened a workshop with all the above to discuss a way forward, data collected, engaging with key stakeholders. Data collection will require development but with focused engagement with the sector across communities	RDOW HWNZ SWG HOP

Performance indicators to be reported
• Ensure all DHB employed workforce data on ethnicity is updated and collected in accordance with Ministry guidelines on ethnicity for 95% - 100% of the workforce by June 30 2018 • 80% of Year 3 Māori and Pacific students have placements in appropriate DEU

Inputs/Resources	
Costs	N/A
People or Teams	N/A

Enablers required to achieve regional priorities	
Workforce	Palliative Care workforce in Palliative Care Section. Mental Health and Addictions workforce planning is under discussion as to lead following removal of funding (HWNZ/TePou) for key support person to lead this work at DHB shared services.
IT	N/A
Capital	N/A

Linkages	
National IT Plan	N/A
Health Workforce New Zealand	N/A
Capital	N/A
Health and Safety Commission	N/A

End of Regional Workforce

Sudden Unexpected Death in Infancy Prevention Programme

CE Sponsor: TBC
Programme Lead: TBC

Introduction

The Ministry has developed a new National Sudden Unexpected Death in Infancy (SUDI) Prevention Programme (NSPP) to be implemented from 1 July 2017. The new NSPP will continue to build on the Ministry's campaign to 'make every sleep a safe sleep' for babies with the aim of working with the wider Government sector to reduce the toll from SUDI. The NSPP includes a national SUDI Prevention Coordination Service and Regional SUDI Prevention Programmes delivered by DHBs and coordinated regionally. Each DHB will have a CFA variation that will agree how they support delivery of the Regional component of the NSPP and will detail reporting requirements.

The national SUDI Prevention Coordination Service will be responsible for providing oversight, monitoring, support, and resources to the Regional SUDI Prevention Coordinators and DHBs to establish and implement their Regional SUDI Prevention programmes.

Once the Regional SUDI Prevention Coordinators are in place, the Central Region will develop a Regional SUDI Prevention Plan by the end of quarter one 2017/18. Additional guidance and templates outlining what these plans are to include will be provided by the national SUDI Prevention Coordination Service once it is in place (expected from 1 July 2017).

Commitment to regional Sudden Unexpected Death in Infancy Prevention Programme

The Central Region will provide a Regional SUDI Prevention Plan to the Ministry by the end of quarter one 2017/18.

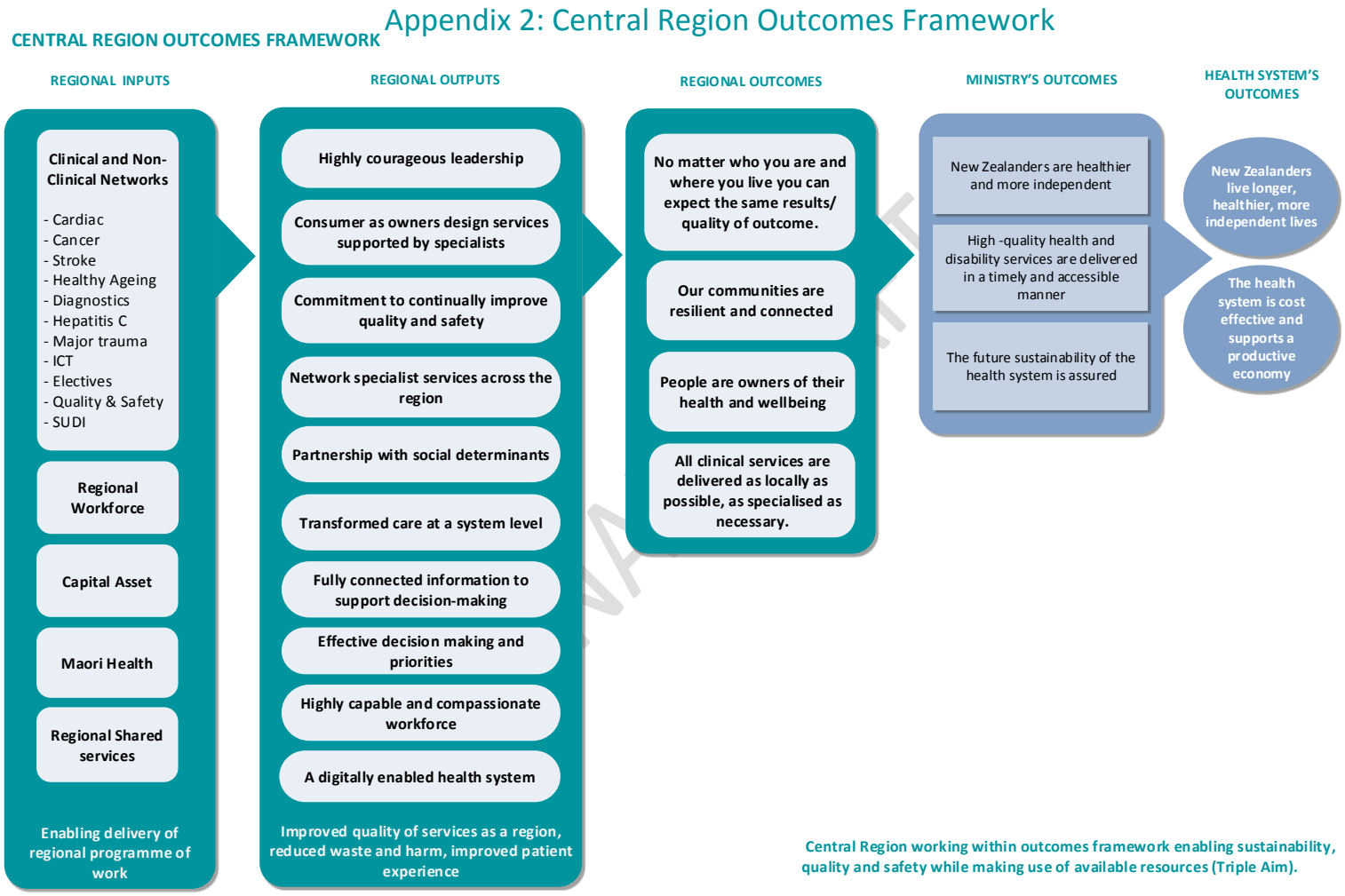
Appendices

Appendix 1: Central Region New Zealand Health Strategy Alignment

Programme	People powered	Closer to home	One team	Value and high performance	Smart system
Cancer	• Increased focus on supportive care • Consumer co-design	• Model of care work	• Maintaining performance against the health target	• Initiatives for equity of access and outcomes	• Alignment with health ICT work
Cardiac	• Consumer representation • Equitable care • Improved screening for primary care patients	• Integrated primary and secondary care services • Interventional capable centres	• Applied whole systems approach • Addressed disparities	• Developed indicators for performance improvements	• Developed audit tools and dataset for echocardiography
Diagnostics	• Patient centred	• Regional integrated model	• A Regional Radiology Service	• Improved Informatics intelligence	• Regional Radiology Information System
Electives	• Consumer representation	• Focusing on equity of access	• Improve on patient centred approach	• Better utilisation of resources	• Alignment with health ICT work
Healthy Ageing	• Consumer Voice	• Health professionals are trained in advance care planning	• A regional medical leaders group to support the regional work programme		• Publish a regional infographics on older people
Hepatitis C	• Overcoming sigma and HCV and its routes of infection	• Moving treatment into the community	• Educate on new Pharmac funded treatment	• Apply initiatives to address costs and issues	• Establish a dynamic accessible regional database of HCV patients
Information Technology	• Facilitate access to online information so people can find out about the choices	• Enhancement of shared-care plans to support improve connections between primary care and support services to	• An integrated co-design approach to design services enabled by appropriate technology solutions	• The portability and transparency of data and information to support ongoing monitoring and improvement of	• Delivery of regional solutions which directly contribute to the digitisation of provider/patient/consumer

Programme	People powered	Closer to home	One team	Value and high performance	Smart system
		enable delivery in people's homes and in the community		services at all levels of the system	interactions and end to processes
Major Trauma	• Increased access with MTNCN website • Engagement with ACC to improve injury prevention	• Trauma destination policy will guide best destination to meet patient needs	• Annual symposium provides education, and forum for relationship building	• Established regional review process with CRTN, including pre-hospital and ACC	• National Trauma Registry established and output data beginning to be received
Mental Health and Addiction	• Consumer representation at all levels of regional development.	• Developing Models of Care to assist care closer to home.	• Regional approaches addressing social inequity.	• Using high-performing exemplar services to enhance others	• Health Pathways and Map of Medicine. • Regional IT systems.
Health Quality & Safety	• Patient and whānau/familycentred care approach	• Across sector membership and partnerships	• Quality improvement leadership • Build capacity and capability across region	• Improved quality and safety systems and processes • Apply learning from experiences of people and their whānau/ families	• Working in partnership across sectors
Stroke	• Consumer participation	• Community based services	• Taking a patient centred approach.	• Better utilisation of resources	• Alignment with health ICT work
Palliative Care	• Addressing persisting inequities for Māori in relation to access to and experience of services	• of agreed models of care for different patient groups to support early access to palliative care and equity of access	• Undertake workforce planning at both a local and sub-regional level.	• Addressing the significant healthcare costs that are consumed in the last two years of life	
Workforce	• Fit for purpose workforce	• Skill sharing • Khaiwhina workforce	• Applied whole systems approach	• Work on the culture, behaviour and value	• Multi-discipline approach with technology

Appendix 2: Central Region Outcomes Framework



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Appendix 3: Central Region Demographics

Ageing population

Although total population growth for the region is estimated at 6%, growth in the older age groups is much higher, while younger age groups decrease in number. Life expectancy is estimated to be seven years longer for non-Māori than Māori.

FIGURE 1: ESTIMATED POPULATION CHANGE IN 20 YEARS, CENTRAL REGION

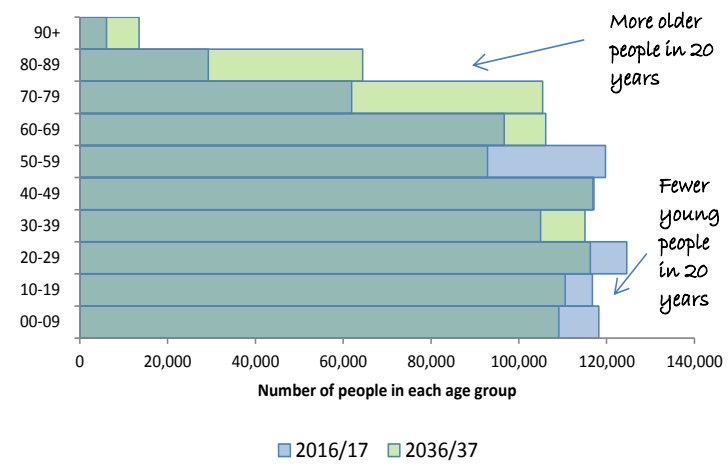
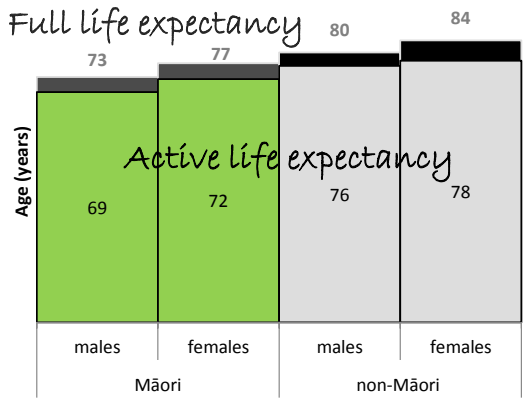


TABLE 1: PERCENTAGE CHANGE

Age groups	% change
90+	122%
80-89	120%
70-79	70%
60-69	10%
50-59	-22%
40-49	0%
30-39	10%
20-29	-7%
10-19	-5%
00-09	-8%

A large decrease in numbers in the 50-59 age group could impact on workforce capacity.

FIGURE 2: LIFE EXPECTANCY AT BIRTH, MĀORI AND NON-MĀORI, 2013



Source: Independent Life Expectancy in New Zealand 2013, MoH, July 2015.

The gap is biggest between Māori males and non-Māori females (11 years). Rates of mortality are higher for Māori than non-Māori (649 compared to 363 per 100,000 population).[7]

Main causes of death

Cancer | Ischemic heart disease | Stroke | Diabetes

[7] Age-standardised mortality rate (WHO World Standard Population). Mortality collection 2012. MoH December 2015.

Māori communities in the Central Region

Hawke's Bay DHB, Capital & Coast DHB and MidCentral DHB have the largest Māori populations in the region. Māori make up one in four people in Hawke's Bay and Whanganui.

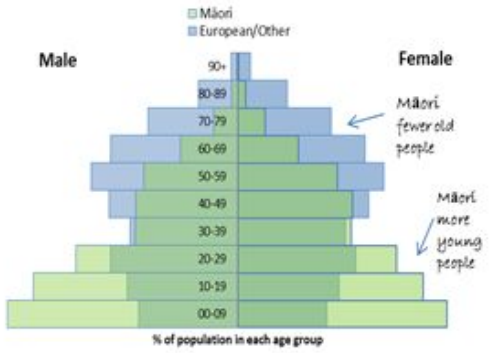
The Māori population has a greater proportion of children and young people and fewer older people than the European/Other population. The same is true for males and females. Pacific populations also have a younger age profile.

TABLE 2: MĀORI POPULATION BY DHB

DHB	Māori population	% Māori in a DHB
C&CDHB	35,200	11%
HBDHB	41,900	26%
HVDHB	25,200	17%
MDHB	34,700	20%
WaiDHB	7,700	18%
WhaDHB	16,600	27%

SOURCE: CENSUS 2013 PROJECTED TO 2016/17.

FIGURE 3: MĀORI AGE PROFILE AND EUROPEAN/OTHER BY GENDER, CENTRAL REGION

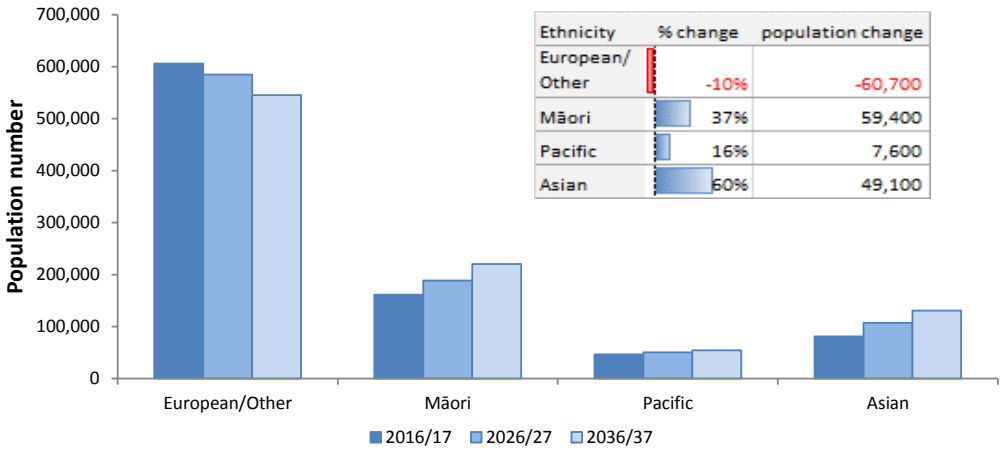


SOURCE: CENSUS 2013 PROJECTED TO 2016/17.

A more ethnically diverse population

In 20 years the region will have greater ethnic diversity as the Māori, Asian (and to a lesser extent Pacific) populations increase. Capital & Coast DHB is the only DHB expected to see an increase in their European/Other population. DHBs in the region will see the biggest population increase for Māori, except Capital & Coast DHB and Hutt Valley DHB which will see their biggest population growth in the Asian population.

Figure 4: Estimated population change over 20 years by ethnicity, Central Region



Source: Census NZ 2013 projected.

Geographical differences and access to services

Access to services close to home and travel times can be a challenge for DHBs with rural populations.

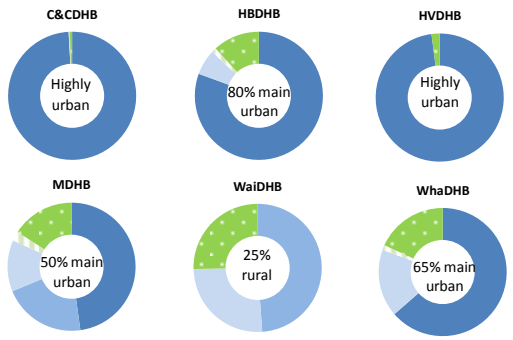


FIGURE 5: POPULATION BY URBAN/RURAL CATEGORIES BY DHB

SOURCE: CENSUS 2013.

FIGURE 6: POPULATION BY URBAN/RURAL CATEGORIES, CENTRAL REGION

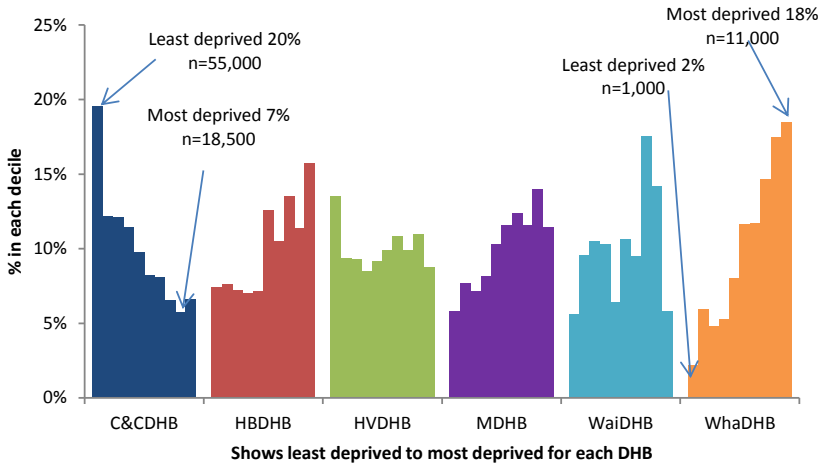
SOURCE: CENSUS 2013.

Main Urban Area | Secondary Urban Area | Minor Urban Area | Rural Centre | Other Rural

ECONOMIC AND SOCIAL DEPRIVATION

Socio-economic factors influence health status and life expectancy. The deprivation index produced from the census shows that CCDHB has a more affluent population profile than for example Whanganui (20% versus 2% in decile one least deprived). However, there are still significant pockets of deprivation in CCDHB local population, where for decile 10 (most deprived) 7% equals 18,500 people compared to Whanganui's 18% (11,000 people).

FIGURE 7: DEPRIVATION PROFILE BY DHB, CENTRAL REGION



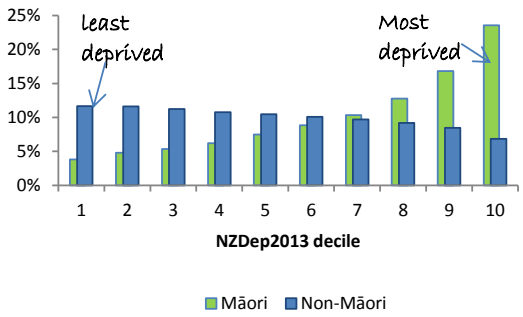
SOURCE: SOCIOECONOMIC DEPRIVATION INDEXES NZDEP2013, DERIVED FROM NZ CENSUS 2013.

Economic and social deprivation across our Māori and Pacific Communities

Deprivation manifests itself in a number of different ways in our region: obesity, household crowding and smoking tobacco.

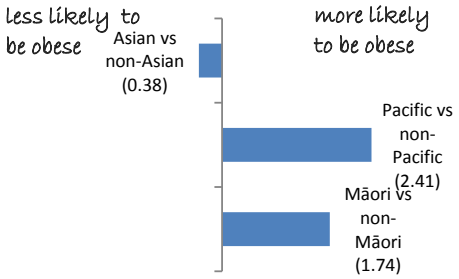
Māori are more likely to live in the most deprived areas in New Zealand. Socio-economic deprivation affects health outcomes such as higher rates of chronic disease, higher mortality rates and lower life expectancy.

Figure 8: Level of deprivation between Māori and non-Māori, NZ



Source: Census NZ 2013

Figure 9: Adjusted rate ratios of obesity by ethnicity



Source: New Zealand Health Survey 2014/15. National figures. Age, sex adjusted.

Obesity is a risk to health that is more prevalent in Pacific Peoples and Māori than the European or Asian population

Household crowding is linked to a number of poor health outcomes, including infectious diseases and rheumatic fever.

Crowding affects Pacific Communities and Māori more than other groups. Children are more likely to live in crowded households than other ages.

Household crowding as a percent of the local population has decreased in the Central Region since 2006.

Figure 10: Household crowding by ethnicity, 2013, NZ

Ethnicity	Percent crowded
European/Other	4%
Māori	20%
Pacific	40%
Asian	18%

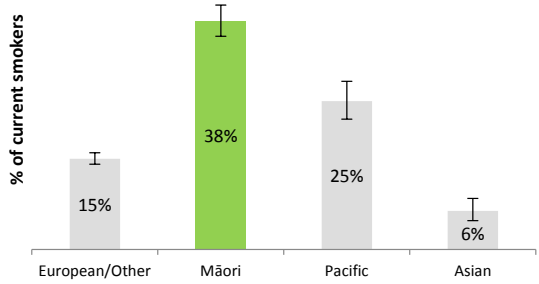
Source: MoH 2014. Analysis of Household Crowding (census 2013).

Figure 11: Household crowding by DHB, 2013, NZ

	Crowded in 2013		Change from
DHB	Number	Percent	2006
Capital & Coast	22,623	9%	-4%
Hawke's Bay	13,521	10%	-8%
Hutt Valley	12,696	10%	-8%
MidCentral	9,741	7%	-2%
Wairarapa	1,881	5%	-8%
Whanganui	4,077	7%	-5%
NZ	398,100	10%	-3%

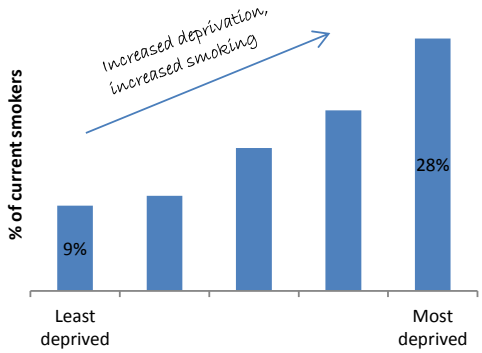
Source: MoH 2014. Analysis of Household Crowding (census 2013).

FIGURE 12: MĀORI ARE MORE LIKELY TO BE SMOKERS



SOURCE: NEW ZEALAND HEALTH SURVEY 2014/15. NATIONAL FIGURES.

FIGURE 13: SMOKING RATES INCREASE WITH DEPRIVATION*SOURCE: NEW ZEALAND HEALTH SURVEY 2014/15. NATIONAL FIGURES.*



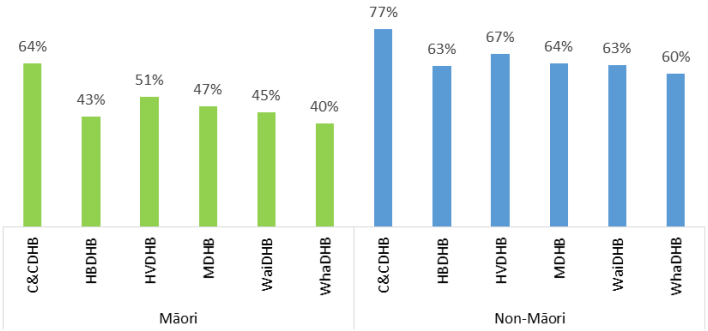
The smoking rate for Māori is significantly higher than other population groups. Smoking is a known risk factor for health, including higher incidence of cancer, cardiovascular and respiratory disease.

Smoking is also correlated with neighbourhood deprivation and Māori are over represented in the most deprived neighbourhoods.

EDUCATIONAL ACHIEVEMENT AND EMPLOYMENT ACROSS OUR REGION

The level of educational achievement is lower for Māori than non-Māori for each DHB in the region and nationally. Conversely the unemployment rate is higher for Māori than non-Māori.

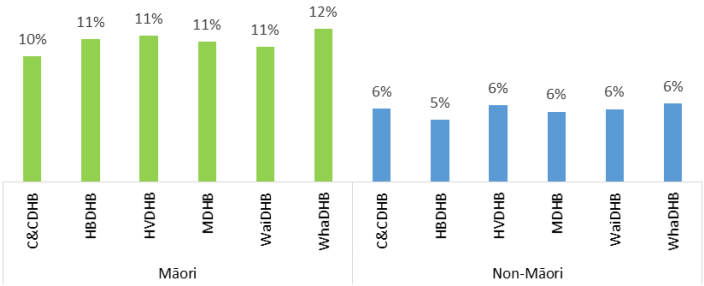
FIGURE 14: ADULTS AGED 18 YEARS+ WITH LEVEL 2 CERTIFICATE OR HIGHER, NZ 2013 CENSUS



A higher proportion of Capital & Coast DHB residents have Level 2 or above qualifications than other DHBs in the region. This is true for Māori and non- Māori residents.

Source: Māori Health Profiles 2015, Otago University for MoH. Rates are age standardised.

FIGURE 15: LABOUR FORCE STATUS UNEMPLOYED, ADULTS 15 YEARS AND OVER, NZ 2013 CENSUS



Source: Māori Health Profiles 2015, Otago University for MoH. Rates are age standardised.

The difference in education level and unemployment rate between Māori and non-Māori in each DHB was statistically significant.

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