Designing our Future Together

Allied Health Scientific & Technical 3DHB

Strategic Approach 2015 – 2025

Contents

MESSAGE FROM THE EXECUTIVE DIRECTORS

Kia Ora Koutou

It is a pleasure for us to introduce our first shared Allied Health Scientific and Technical (AHS&T) Strategic Approach for the three local District Health Boards; Wairarapa, Hutt Valley, and Capital and Coast.

Developing a shared strategic approach is a deliberate way of shifting from our practice to date, of pursuing joint working opportunities as they arise, into a more considered and agreed way of planning our direction together. Allied Health, Scientific & Technical professions make up a considerable proportion of the health workforce, and together deliver skills, value and expertise across all services. We are proud of the diversity across our professions, and of the considerable contribution we make to improve the health and wellbeing of our communities. With the challenges ahead for healthcare, we see our professions as key contributors, to embrace and deliver on the changes needed to ensure that our health system meets the future needs of communities and remains sustainable.

The plan is written for two key audiences; those who work within the Allied Health, Scientific & Technical professions, and those outside of the professions who lead, fund, interface, and design services with these practitioners. The approach we have taken of engaging with multiple people across the health system has meant that our end result is an open and transparent description of our current position. Many have chosen to share the challenges they face, and concerns they have about the future, so that we can focus our energies in the right places. After thoroughly reviewing our current state, we have deliberately chosen a 10 year time frame for planning, to inspire creative, purposeful and sustainable ideas to come to the fore.

As Executive Directors, we see this shared approach as a sign of our clinical leadership and commitment to work together to improve the ability of our professions to deliver high quality services. We trust that through reading our plan and discussing the content, you will see that it reflects the work we have done to date, and demonstrates the way we want to work together across the 3 DHBs in the coming 10 years. We are:

- Committed to providing a high quality and safe service to our patient, families, and communities
- Seeking to continuously improve
- Honouring the principles of the triple aim

Thank you to everyone who has given their time to the construction of this strategic approach document. It has been touching to see the enthusiasm and endorsement of this work from many of our colleagues (both within and beyond AHS&T). We have learnt a lot through the process, and are keen to share that learning with you. The work to construct the strategic approach has already prompted new connections and ways of improving our services. It will no doubt generate many more opportunities as we roll out, and then deliver

to this action plan. The action plan would not have been constructed at all had it not been for our fabulous project leader, Rachel Prebble, who has achieved 196 interviews, 9 workshops and 147 questionnaire responses. Thank you Rachel for all that you have contributed. We have appreciated your wisdom, persistence and diplomacy - all of which have been tested on many occasions!

Finally a plan is only a plan, we now have to use our road map to deliver better services, and for that we hand back to every Allied Health, Scientific & Technical practitioner in the sub-region, along with all our health colleagues. We are looking forward to using this plan to inspire and enable us all to continue to improve the way we deliver our services to 2025.

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The development of this strategic approach has been an opportunity for us to receive input and feedback from a wide range of sources. Much of the information informing this document is sourced directly from conversations, surveys and workshop discussions and does <u>not</u> form objective data. It is invaluable in prompting us to consider the perceptions and impressions of our collective AHS&T staff, but also that of the professionals working with us in DHB, primary health, NGO and community contexts as well as health service users.

INTRODUCTION

In December 2013 the Chief Executives of Wairarapa, Hutt Valley and Capital & Coast District Health Boards agreed and announced the need to work towards integrated service approaches to achieve three joint priorities:

Preventative health and empowered self-care

Provision of relevant services close to home

Quality health care, including highly complex care, for those who need it

Alongside these goals the health sector works within NZ triple aim principles of:

The Triple Aim challenges AHS&T services to examine our current capability to meet these aspirations and to seek to identify future concrete actions which will support attainment of the Triple Aim within the sub-region.

Development of the Strategic Approach

The Executive Directors of AHS&T determined that effective future planning should be based on a shared sub-regional strategic examination of AHS&T services. AHS&T leadership had developed a partnership over the previous 2-3 years; beginning with shared education opportunities, gradually increasing information flow and pragmatic activity sharing.

The AHS&T Strategic Approach project began with a stock take of the state of services across Wairarapa, Hutt Valley and Capital & Coast District Health Boards, including current configurations, workforce, strengths and vulnerabilities and future opportunities and risks. Within the 3DHBs, AHS&T staff number approximately 1600 and during the course of this project, 196 people were interviewed[1], 147 people contributed to an online survey and over 50 people attended 9 workshops to inform the stocktake, identify key priorities and drive the development of the subsequent action plan.

[1] Appendix 1 contains a list of the people interviewed for this project.

During the gathering of this data, staff were encouraged to give voice to emergent ideas and innovations, to inspire the vision for the wider AHS&T sector. In addition, a review of current trends in AHS&T both nationally and internationally was completed.

Analysis of these issues is referenced to geographical, service delivery and profession specific variables, so as to provide a pragmatic and localised reference for planning future direction.

Once the information was collected, collated and analysed, the combined AHS&T executive leadership teams[2] spent two days together reviewing, debating and developing the strategic priorities, vision, goals and actions contained in this plan. This process was directly referenced to the New Zealand Government goals for health, the Triple Aim Vision, Health Services Quality & Safety Commission Indicators and the 3DHB Vision.

The Strategic Approach provides:

An international and national context scan.

A comprehensive strategic overview of current AHS&T services across the sub-region District Health Boards, which identifies both broad themes and specific considerations for future development of AHS&T services.

A shared sub-regional AHS&T vision.

A clear understanding of the barriers and enablers to achieving the vision.

Identified priorities for action aligned with achieving the vision.

A structured action plan to achieve these priorities.

[2] See Appendix 2 for a list of the members of the AHS&T Strategic Approach Leadership Team.

ALLIED HEALTH SCIENTIFIC & TECHNICAL

The International Chief Health Professions Officers (ICHPO 2012) defines Allied Health Professionals as "a distinct group of health professionals, who apply their expertise to prevent disease transmission, diagnose, treat and rehabilitate people of all ages and all specialties. Together with a range of technical and support staff they may deliver direct patient care, rehabilitation, treatment, diagnostics and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive and social functions."

Professions

Allied Health, Scientific & Technical (AHS&T) encompasses almost 50 professional groups (See Tables 1 & 2) working in a wide variety of health and disability services. AHS&T staff deliver vital services, treatments and assessments and utilise technology to provide measurement, testing and treatment of patients and their health conditions[3].

Our workforce makes up 16% of the DHB workforce in the sub-region, as compared to 14% for medicine and 38% for nursing and midwifery[4]. It is of note that our workforce has reduced by 1% since 2010, while medicine, nursing & midwifery have increased by 2% over the same time period.

Table 1. List of Allied Health professions

Alcohol & Drug Clinicians	Optometrists*
Allied Health Assistants	Orthoptists*
Audiologists & Audiometrists	Pharmacists* & Pharmacy Technicians
Counsellors	Physiotherapists*
Dental Therapists	Play Specialists
Dietitians*	Podiatrists*
Family Therapists	Psychologists*
Genetic Associates	Psychotherapists*
Hand Therapists*	Speech-language therapists
Health Promotion Advisors / Public Health Advisors	Social Workers+
Needs Assessors / Service Facilitators	Health Protection Officers
Occupational Therapists*	Visiting Neurodevelopmental Therapists*

[3] Appendix 3 provides a Quick Reference Guide to Allied Health Scientific & Technical Professions.

[4] Jan 1 – March 31 2015.Data from the Health Workforce Information Programme, Strategic Workforce Services, DHB Shared Services. A national arm of Technical Advisory Services (TAS).

Table 2. List of Technical and Scientific professions

Anaesthetic Technicians*	Medical Physicists
Audiology Technicians	Medical Radiation Technologists* & Technicians
Biomedical Electrical Technician	Medical Photographers
Cardiac Perfusionists	Mortuary Technicians*
Clinical Engineer	New Born Hearing Screeners
Clinical Dental Technicians*	Phlebotomists*
Clinical Physiologists & Technicians (Respiratory, Neurology and Cardiac)	Radiation Therapists*
Cytogenetic Laboratory Scientists*	Scientific Officers
Dental Technicians*	Sonographers*
Laboratory Scientists, and Technicians*	Sterile Supply Technicians

* Registered under HPCA (Health Practitioners Competency Assurance) Act 2003
+ Registered under Social Workers Registration Act 2003

Qualifications

Pre-employment qualification requirements vary from no formal training requirement to NZQA Level 7 (undergraduate university qualification), level 9 (Master's degree) (See Table 3). A minority of AHS&T professionals hold Doctorate level qualifications. The majority of AHS&T staff enter at level 7.

TABLE 3 Descriptions of levels and qualification types on the New Zealand Qualifications Framework.

LEVEL	QUALIFICATION TYPES
10	**Doctorate Degree**
9	**Master's Degree**
8	**Postgraduate Diplomas and Certificates** **Bachelor Honours Degree**
7	**Bachelor's Degree** **Graduate Diplomas and certificates**
6 **5**	**Diplomas**
4 **3** **2** **1**	**Certificates**

CONTEXT

3DHB Vision

The Boards of the 3DHBs (Wairarapa, Hutt Valley and Capital & Coast) have agreed to consolidate their individual vision statements into a single operating vision for the purposes of joint planning.

The 2014-2015 Annual Plans for the 3 DHBs were prepared using a single process with significant parts of the document shared across the three DHBs, reflecting our collaborative approach to service planning and delivery.

The agreed priority areas across the 3DHBs are:

- Acute demand management
- Older people's health and wellbeing
- Health promotion and prevention
- Long term conditions management
- Improved health equity

The AHS&T 3DHB Strategic Approach seeks to ensure that all future planning for our professions and services, is aligned with the shared vision and priorities of the 3DHBs.

Minister of Health, Dr Jonathon Coleman in his Letter of Expectation to DHBs and Subsidiary Entities 2015-16, called for a team approach to continue to seek efficiency gains and live within budget, with a key focus on national, regional and sub-regional initiatives. Clinical leadership in service design and budgeting is to be fostered, with aligned governance, senior management and clinical leadership.

Director General of Health, Chai Chuah[5] identified key challenges for health services, in ensuring equity of access, to redress inequitable health outcomes. Key challenges have emerged in the management of non-communicable diseases, new infectious diseases and the re-emergence of communicable diseases. Mr Chuah also noted a shifting paradigm from illness to health and wellness, integrating health with other social services in partnership with the individual, family and community.

Dr Coleman's letter outlined an expectation that this will support the development of better integrated and earlier interventions, closer to home. Population based initiatives in the community with better integration between health and social services will result in better health outcomes and financial sustainability for the sector.

The health sector at this time is operating within a context of increasing expectations and ability to treat health concerns, and demographic changes which are adding complexity and volume of demand. Technological innovations and advances in treatment capabilities both drive up the cost of health care. Alongside these challenges sits the need to reduce growth in expenditure in order to deliver sustainable health services.

The Regional services plan (2013-2014), for the 6 central region DHBs noted "we simply cannot continue to do things as we have been doing. There are genuine threats to the sustainability of some of the region's health services. There is a major financial imperative for change and, most importantly, we can and should be delivering even safer and higher-quality services to the population of our region."

The implications of this are[6]:

- Prioritisation of funding to those most in need of health and disability services.
- Funding allocation to different services and different service providers based on the principle of addressing health inequalities and targeting at risk populations.
- The performance of the three DHBs' Hospital services relative to our peers. All three DHBs will continue to look for efficiencies in all that they do.
- On-going consolidation of provider contracts to increase economies of scale and reduce expenditure on administration will be required to ensure services are delivered to desired standards.

In thinking about health sector development and change, it is essential to view the sector as a complex adaptive system, with multiple dimensions and interdependent relationships. An innovation or change in one aspect of our social or health sectors will impact on health outcomes in other areas.

The Ministry of Health sets strategic priorities and direction for the District Health Boards both annually and for the longer term. The Ministry will be consulting on the next New Zealand Health Strategy in the coming weeks. AHS&T offer a comprehensive understanding

[5] Grand Round Hutt Valley Health 07 October 2014.

[6] Wairarapa, Hutt Valley and Capital & Coast DHB Annual Plans 2014-2015.

and awareness of health needs, at the ground level, across the health sector, which will enhance this process.

Keeping people well and managing long term conditions by providing appropriate and coordinated primary care should result in lower hospital admissions. This is likely to be both cost saving and preferable to the patient. Given the increasing prevalence of chronic and non-communicable diseases (NCDs), effective primary care provision is central to ensuring the long term sustainability of the health system. New Zealand has mixed results on these indicators, with marked (and worsening) ethnic disparities[7].

The focus of 'areas for action' in many commentaries point to an increased role for primary health in prevention and health service provision, with DHBs to play a more active role in developing new models of care which provide cost effective alternatives to secondary care.

A picture is emerging where people will receive the majority of their healthcare in a localised enhanced primary care practice, however may travel to secondary level centres for acute care, complex hospital procedures or specialist consultations and to small tertiary hubs which are regionally or nationally based for highly specialised care.

In 2013, the King's Fund (U.K.) visited Canterbury DHB to consider models of health service delivery. Figure 1 below, shows a pictorial representation of how health services might look in the future. This image has been resonant with many throughout the country and forms a key component of strategic thinking about our future and the role of AHS&T.

[7] New Zealand's health system: A discussion document on current performance and future directions (2014).

FIGURE 1: Visual representation of an integrated health services model[8]

International trends

Many of the themes expressed in different allied health plans internationally, are congruent with contextual trends in health care as a whole, reflecting primary themes of:

- Demonstrating the contribution of allied health services to the work of the health service as a whole
- Aligning health and social services
- Workforce capacity development and management
- Workforce capability – matching skills to the needs of the community
- Ensuring work ready training, education and regulation
- Providing a career framework to create depth and expertise within the workforce through increased retention
- Effective use of ICT in health care
- Responding to changing demographic needs and pressures
- Maximising resource utilisation in health care

[8] King's Fund. The Quest for integrated health and social care: a case study in Canterbury, NZ (2013).

- Promoting person centred care
- Delivering safe and effective practice
- Strengthening clinical leadership to design sustainable and responsive services for the future
- Improving the health of the public and reducing inequities
- Integrating care to ensure smooth transitions for patients throughout the system

When considering strategic development in the technical and scientific area internationally, planning appears to be generally carried out for individual professional groups rather than as a collective, or their potential research contribution or in terms of service delivery areas (e.g. cancer treatment). Repeated comments throughout the literature refer to the lack of published data about these workforces and the literature on strategic planning is sparse.

Health and Disability Service Users

The groups identified below are expected to be higher users of health and disability services, and in 2014/15 the 3 DHBs[9] are continuing to focus on:

Ageing population and older people: The proportion of older people in the population (including Maori) is increasing, resulting in escalating pressure on services for the elderly. This is set to continue over the next twenty years.

Disparities in Health Outcomes: There are noted disparities in health outcomes for certain population groups, including Maori, Pacific Peoples, people living in high deprivation areas, and people who have a disability. These groups have poorer health outcomes, and for certain conditions have a higher burden of disease. To ensure people receive services when they need them, services must be accessible and acceptable. This addresses things such as cultural competency, physical access and cost and other barriers.

Maori health: Many health conditions are more common for Maori adults than for other adults. These include ischaemic heart disease, stroke, diabetes, medicated high blood pressure, chronic pain and arthritis. Maori have poor health outcomes across most indicators although differences are reducing for some areas such as immunisations and oral health. The leading causes of death for Maori adults between the ages of 25-44 were due to external causes such as car accidents and intentional self-harm (suicide). The leading causes of death for Maori adults aged over 65 were due to circulatory system disease or cancer, with ischemic heart disease being the leading circulatory system disease. Each DHB has developed a Maori Health Plan (MHP), which sets out our intentions toward improving the health of Maori and their whanau, and reducing health inequalities for Maori.

Lifestyle factors affecting health: Lifestyle choices such as physical activity, healthy eating and not smoking can improve the health profile of individuals and the community as a

[9] Taken from the combined section of the Wairarapa, Hutt Valley and Capital & Coast DHB, Annual Plans 2014-2015).

whole. Maori have a lower prevalence of adequate fruit and vegetable intake, and Maori women have the highest percentage of smokers. Residents of the sub-region have lower levels of obesity than their New Zealand counterparts; however rates of physical activity have declined between 2006/07 and 2011/12 and are lower than the national average. In the sub-region there is a higher prevalence of hazardous drinking than our New Zealand counterparts.

Long term chronic conditions: The burden of long term conditions continues to increase. Diabetes prevalence is increasing, with rates for Wairarapa at 5.1%, Hutt Valley 4.6% and Capital & Coast 3.8% as compared to a national prevalence of 4.9%. Heart disease continues to be the leading cause of acute hospital admissions, and with increasing rates of obesity and physical inactivity further growth in diabetes and heart disease is expected. Respiratory conditions such as Asthma and Chronic Obstructive Pulmonary Disorder (COPD) also place a burden on patients. Management of these conditions is a focus of the DHBs' work, particularly in the community. With an ageing population, the number of patients with multiple long term conditions will increase and these patients' health needs will become more complex.

Children and Young People: While generally improving, health statistics for children in the sub-region are below national averages in some key areas. Children are more likely than adults to live in areas of high deprivation, they have high rates of hospitalisation and there are high and increasing child abuse notifications in the Wairarapa. Typically, children living in the most deprived areas have the poorest health status.

The demographics of the sub-region will change over the next ten to fifteen years, with varying rates of population growth but significant ageing across all three DHBs (as well as nationally).

The Maori population of all three DHBs will increase and while significant Pacific growth is projected in the Hutt Valley, very little is expected for the Capital & Coast population. The Asian populations across all three DHBs are projected to increase by around 30% between 2014 and 2026.

While one in five people were identified as having disabilities in the 2006 census, data collated over 2010/11 at Capital & Coast DHB by Press Ganey showed that an average 30% of the population of hospital users identified a range of issues linked to disability[10].

Inequities exist in both access to health services and the quality of health services available across the region. A significant number of the Central Region's population is currently not able to access the range of services that the majority of the region's population can, and a critical appraisal of the health services across the Central Region sees significant variations in the quality of services delivered. Māori, Pacific Peoples, those on low incomes, disabled people, older persons and the people of some of the region's rural communities are disadvantaged under the current configuration of health services[11].

[10] Sub-regional Disability Implementation Plan (2013-2018)

[11] Central Region Regional Service Plan

A Regional Maori Health Plan, Tu Ora, has been completed for the Central Region. Tu Ora aspires to guide an on going improvement in Maori health and Maori health outcomes. To enable change, Tu Ora identifies four focus areas as key areas of action:

1. Maori Workforce Development
2. Quality Service Provision
3. Collaborative Action
4. Sharing and Measuring Information

A core tenet is that of Whanau Ora for every person. "A whole of system approach that supports and maintains a whole of whanau/family". With this as an underlying principle, the opportunity exists for us to bring clinical strengths together with community, cultural and social strengths to provide for improved wellbeing and outcomes that whanau/family themselves will determine.

DHB Structural aspects

3DHB

Among the three DHBs, Capital & Coast DHB is the largest regional provider of hospital services, and has responsibility for providing a mix of specialist services to other DHBs in the Central Region. Hutt Valley DHB provides a smaller number of regional services, with specialist plastics and rheumatology services located at Hutt hospital.

In the coming 10 years, the three DHBs will operate in an environment where the cost of service provision continues to stretch our financial resources. Individually, and collectively through the 3DHB work programme, the three DHBs have set an ambitious financial target across the sub-region.

The vision for the Central Region's Regional Service Plan is that there will be a regionally integrated system of health service planning and delivery that will lead to on-going improvements in the sustainability, quality and accessibility of health services. With changing demographics, in particular an increasing proportion of older persons, and with difficulties in maintaining and supporting a high-quality workforce, an increasing number of the region's services will prove difficult to operate effectively into the future if we keep doing things just as we are now.

Over the past 3 years, a number of DHB functions have been brought together to form a 3 DHB frame on which to plan and deliver health care across the sub-region, for example Community and Public Health Advisory Committee (CPHAC), Disability Services Advisory Committee (DSAC) and the Sub-Regional Disability Advisory Group. Population Health (Regional Public Health, Community Dental Service, and Screening Services), People and Culture, Maori Health and Corporate Directorates, which encompass a range of enabler functions – Information Communications Technology (ICT), facilities, procurement and supply, property, Service Integration Development Unit (SIDU), Learning and Development (L&D), and Human Resources (HR) are operating at the 3 DHB level.

In February 2015, the launch of Mental Health Addictions and Intellectual Disability (MHAID) as a 3 DHB Directorate marked a significant point in the integration of services across the sub-region, with this being a directorate level integration process. In addition to MHAID, a number of other services also operate as national, regional or sub-regional entities (e.g. public health, school dental service, genetics, cancer centre, radiology). Approximately half of all AHS&T staff work within 3DHB services.

In early 2014, two of the District Health Boards (Hutt Valley and Capital & Coast DHBs) brought together their hospital laboratory services under one leadership structure. Since that time, an RFP process has been completed for all three hospital laboratory services, plus the community laboratories, in order to achieve one integrated laboratory service. This new laboratory service will be provided by Wellington Southern Community Laboratories and will proceed in this new configuration from 1 November 2015.

From 2013, the Chief Executive Officer and other senior executive leadership roles for Wairarapa and Hutt Valley DHBs were combined to operate as one team across both DHBs. In recent weeks, in response to the resignation of the Wairarapa/Hutt Valley DHBs joint CEO, Wairarapa DHB announced that they will recruit for a separate CEO for Wairarapa DHB.

Wairarapa and Hutt Valley DHB

In 2013 a joint Chief Executive Officer (CEO) for Wairarapa and Hutt Valley DHBs was appointed and a shared Executive Leadership Team was formed with the Executive Director of Nursing and Midwifery, Executive Director Allied Health, Scientific and Technical (EDAHST), and a Chief Medical Officer to provide clinical leadership across the DHBs. In addition to the professional accountability of the AHS&T workforce the EDAHST is also operationally responsible for many of the services that fall under the AHS&T umbrella.

The 2 DHB framework operates clinical directorates organised into a Surgical, Women's and Children's Directorate and a Medical and Community Health Directorate. Wairarapa and Hutt Valley DHB apply a matrix management structure to the directorates, with a Nursing Director, Clinical Director (medicine) and a Director of AHS&T working collectively with the Director of Operations in each directorate and reporting to the Executive Leadership Team. Alongside the clinical directorates, sit Clinical and Support Services, Pacific & Maori People's Health and Quality & Risk.

In Wairarapa, a hospital manager, a Nursing Director and Clinical Director (medicine) provide on site clinical leadership, while the AHS&T leadership is provided across both sites by the Executive Director and Directors of AHS&T.

At the team and service level, professional and operational leadership of AHS&T is combined, with the professional leaders holding line management responsibilities.

Capital & Coast DHB

Capital & Coast DHB operates an Executive Leadership Team with the Professional Head roles provided by the Executive Director of Nursing and Midwifery, Executive Director of AHS&T and the Chief Medical Officer. Collectively this team provides professional and

clinical leadership for all the clinical workforces in an integrated tri-partite model. The Professional Heads work closely with the CEO and COO.

The clinical work of the organisation is divided into a directorate structure with Surgical, Women's and Children's (SWC), Medicine, Cancer and Community Directorates (MCC), Clinical & Support Services, Quality Improvement Patient Safety (QIPS), and Pacific & Maori People's Health.

As described elsewhere, while it is a clinical service, Mental Health, Addictions and Intellectual Disability (MHAID) is a 3 DHB service.

Below the professional heads at Capital & Coast DHB, there are different leadership structures for each of the professional groups:

The nursing and midwifery workforce have professional leadership at the directorate level provided by the Associate Directors of Nursing (ADON) and one Associate Director of Midwifery. There are 4 ADONs- one for Surgical Women's and Children's (SWC), one of Medicine Cancer and Community (MCC) and two which cover practice and workforce development. There are other nursing leaders outside the directorate structure, for example 3DHB Director of Nursing (MHAID) and Director of Nursing, Primary and integrated Care (in SIDU).

The medicine stream has Clinical Directors that align with the directorate structure (2 for MCC, 2 for SWC, 1 for QIPS, and 1 for CSS). There are clinical leaders within each directorate for each medical speciality (approximately 42). These range in scale from very small specialty areas (e.g. Immunology) to much larger (e.g. Radiology, Child Health, and Orthopaedics).

AHS&T does not have a clear structure for our professions in the directorates. There is one Associate Director AHS&T. The equivalent to the operations manager layer (plus other layers in some cases) is absent for AHS&T.

At the team and service level, professional leadership and operational leadership are separated for a number of allied health professions (physiotherapy, occupational therapy, social work, psychology, dietetics, psychotherapy, alcohol & other drug (AOD) clinicians and speech-language therapy). For other AHS&T professions, often the team or service leader is the de facto professional lead.

AHS&T 3DHB Initiatives

In the past 3 years, AHS&T services across the sub-region have made significant gains in a number of work areas. Many of the achievements are noted elsewhere in this document, however it is useful to take note of the large number of projects in which AHS&T staff are closely involved, which are pivotal to the delivery of care by AHS&T practitioners and are currently underway. These projects are designed to increase consistency and integration of care across the sub-region, with some including a revision of organisational structures (e.g. MHAID, laboratories, and radiology). Table 4 lists some of the national, regional and sub-regional work in progress in our region of high relevance to AHS&T. It is by no means an exhaustive list.

TABLE 4: Current national, regional and sub-regional projects.

Project Title	Category
E-Pharmacy	National
National Data Collective	National
Cancer Network Project Ambulatory Model of Care	Central Region
Cancer Services psychosocial support	Central Region
Cardiac physiology and sonography sustainable training strategies	Central Region
Palliative Care Network Project	Central Region
ACC trauma work MHAID	Sub-region
Allied Health Career Progression Framework	Sub-region
AHS&T E-site "Sharepoint" across 3DHB	Sub-region
Child Health	Sub-region
Deaf Communication a review of services for deaf	Sub-region
Development of shared e-learning across 3DHB	Sub-region
Dietician in MHAID	Sub-region
Direction and delegation	Sub-region
Health of Older People Models of Care	Sub-region
Health Pathways	Sub-region
HWNZ trainee funding utilisation	Sub-region
Kaiawhina (Assistants) Stocktake	Sub-region
Learning and Development strategic planning	Sub-region
Medications Management	Sub-region
MHAID restructure	Sub-region
New graduate programme in MHAID (AH-NESP)	Sub-region
Policy Review Project 5 AH professions	Sub-region
Primary Care – exploration of integration opportunities	Sub-region
Professional registration for non-HPCA workforce	Sub-region
Self-management Programmes Exploration	Sub-region
Talking therapies work in MHAID	Sub-region
Technical Merit Progression	Sub-region

Primary health context

Each DHB operates its own governance mechanism in respect to supporting the primary/secondary integration work within the *Better, Sooner, More Convenient* suites of activity. In each DHB the Alliance Leadership Team (ALT) provides oversight of the work programme.

Alongside the horizontal integration occurring across the three DHBs, there have been steps made towards integration across the whole of the health system through these ALTs. The ALTs are made up of DHB and primary care leaders, charged with providing leadership and driving the vision of integrated health service provision.

Tihei Wairarapa started in 2011 and has succeeded in reducing acute demand in the Wairarapa as well as establishing a flexible funding pool to enable service devolution to primary care[12]. The Hutt INC (Integrated Network of Care) began in 2012 and has had successes reducing admissions for gastroenteritis and cellulitis, two of the leading causes of avoidable admissions[13]. The ICC (Integrated Care Collaborative) at CCDHB has undertaken work on health care pathways for frail elderly, and through the Diabetes Care Improvement Plan enabled diabetes specialist nurses to work with general practices to improve their capacity to manage patients with diabetes[14]. While good progress has been achieved through these programmes so far, we need to accelerate the pace of change.[15]

Hutt Valley DHB AHS&T has taken a lead in a co-design process, piloting with a Primary Health Organisation (PHO) Te Awakairangi Health and Hutt Valley DHB, by placing (with other DHB staff) a Director of AHS&T on site at Te Awakairangi Health PHO for 1 day per week. The key message is that of a whole of health system approach to change and future development. Sustainability of healthcare is dependent on all parts working together and acknowledgement that they are one part of a larger system.

This model suggests five key areas of focus;

1. A common vision for a patient centric system that guides all parts of the system.
2. Proactive support for developing high performing general practice clinical and business models.
3. Integration of DHB community services and primary care, including developing a co-ordination hub for community services.
4. Co-ordinated development of infrastructure to support the 'one system' vision – some of this infrastructure is already under development, but some requires effort in new areas.
5. Establishing a performance and evaluation framework, including a focus on reducing variation across practices and agreed 'whole system' measures.

[12] Wairarapa DHB has primary care services provided by Compass PHCN, which oversees 7 practices.

[13] HVDHB provides funding to one PHO: Te Awakairangi Health Network 23 practices (25 sites) and has 1 practice run by Cosine PHO in the area. Note: Cosine is a cross boundary PHO managed by Capital & Coast DHB including Ropata Medical Centre in Wairarapa and Hutt Valley DHB and Karori Medical Centre in Capital & Coast DHB.

[14] Capital & Coast DHB provides funding to four PHOs: Compass PHCN (52 practices), Cosine PHO (2 practices), Ora Toa PHO (4 practices), Well Health PHO (4 practices).

[15] From the combined Wairarapa, Hutt Valley and Capital & Coast DHB Annual Plans (2014/2015) and Statements of Intent (2014-2017).

Person-centered Acute Community Care (PACC) is a community based programme to be located in primary care. The co-ordination model that underpins this is currently being developed as a sub-regional service across Wairarapa, Hutt Valley and Capital & Coast DHBs, with a PACC Coordinator now in role in Hutt Valley. The aim of PACC is to provide a target population with timely access to primary, allied health and community health services through a central coordination hub. PACC is a service that is based in primary care and designed to support patients who can be safely managed in the community. The services are designed to be applied during an acute medical episode for a period of up to 5 days when a hospital presentation would otherwise be imminent.

At Capital & Coast DHB, PHO and DHB co-design work is in the early stages, with work focussed on the frail elderly being explored with Waikanae and Island Bay practices.

There are currently DHB allied health professionals working in clinics within primary health (e.g. physiotherapists, social workers and dietitians at Pomare Health Centre in the Hutt Valley) however these relationships can be tenuous and can rely on business imperatives for the GP practices (e.g. loss of co-location of services in Upper Hutt).

Another significant piece of work currently underway is the development of Health Pathways to identify systemic processes for the care of patients throughout primary and secondary care.

CURRENT STATE STOCKTAKE

AHS&T professionals provide a unique perspective across the whole health sector, which challenges traditional medical models of care, to stimulate consideration of the patient as an active agent in their own health and wellbeing.

AHS&T professionals work in all aspects of health, social and education services, and as such, add a cross-agency, integrated perspective for systemic change to maximise wellness in our populations. They provide a valuable understanding of the functional aspects of maximising not just treatment and recovery, but also independence in self-care, activity and occupation, social and community connectedness. Exploiting this multifaceted understanding ensures that the complexities of health service provision are factored into design and delivery modelling.

In addition, AHS&T provide strategic focus on the identification of practical and cost effective solutions to rising health costs, which employ strategies beyond the treatment framework inherent in much of traditional health service design (e.g. nutrition in hospital settings to enhance recovery, systems to prevent "social" hospital admissions, wrap around systems for rapid/accelerated discharge, access and utilization of diagnostics, integrated pharmacy processes).

AHS&T staff work in a wide range of services across the health sector both within the 3DHBs and in broader community settings. Hospital based, outpatient, primary care and community services, in team, service, DHB, 3DHB, regional and national contexts were considered in the stocktake.

Alongside the input from AHS&T staff and their managers, consultation with nursing, medical, operational and senior leadership personnel was completed. Beyond the DHBs; PHO, NGO and community services, consumers and broader government were included in the development of the plan.

The following pages collate and condense a huge volume of ideas, observations, celebrations and challenges, drawing from the 196 formal interviews, 147 surveys, 9 workshops and numerous informal conversations, to inform the stocktake, identify key priorities and drive the development of the subsequent action plan.

Strengths

- In the past 5 years, there has been a marked increase in the development of AHS&T leadership within New Zealand. Wairarapa, Hutt Valley and Capital & Coast DHB DHBs have increased the profile and presence of AHS&T at the senior leadership level with the introduction of Executive Director of AHS&T positions. This has led to an increased visibility and coordinated leadership of AHS&T professions within the DHBs.

- A national focus for increased quality and safety in health practice has been regulation under the Health Practitioners Competency Act (HPCA) (2003), which provides a framework for the regulation of health practitioners in order to protect the public where there is a risk of harm from professional practice. Appendix 6 provides a summary of the significant number of professional bodies, who provide regulatory oversight and/or act as governance bodies for the professions they represent.

- AHANZ (Allied Health Aotearoa New Zealand) is an incorporated society of professional associations which has formed to bring the different organisations together to work to promote, advocate for and support allied health professionals as a body. Current priorities include raising the profile of AHS&T, promote integration across discipline/professional groups and to support training and development at the university level to facilitate interdisciplinary working[16].

- Most AHS&T professions have their own professional association. Those who are registered under the HPCA Act also have a professional Board (Regulation Authority)[17]. For some professions, the DHBs are the main or largest employer (e.g. Play Specialists, Medical Physics). While for other groups, District Health Board employees make up relatively small numbers of those professions (e.g. Social Workers, Pharmacists).

- Health Workforce New Zealand (HWNZ) has the identified goal of ensuring that the workforce is appropriately trained and configured to meet current and future health needs, so that New Zealanders can be confident that they will receive the best health care possible. In a 'no holds barred' presentation in late 2014, Graeme Benny (Health Workforce NZ)[18] issued a challenge to AHS&T to recognise the urgent need for immediate change and to have the courage to make the change substantive.

- Health Workforce New Zealand has shown a commitment to support AHS&T by forming an AHS&T Taskforce to develop strategy and by opening up the Advanced Trainee Fellowship funding, from a previously medicine only frame. In addition, the regional pool of HWNZ funding for post-workforce entry training is undergoing transition to a more flexible but targeted approach.

- Sub-regional collaboration to improve quality and consistency (e.g. 3DHB social work registration policy, dietetics 3DHB malnutrition policy).

- Many professional groups, professional and team leaders meet periodically across the 3DHBs to share training and embark on joint improvement projects and in-service training.

[16] Personal communication Petrina Turner-Benny and Phillip Grant, AHANZ, 12/03/15.

[17] Please see Appendix 4 for a complete list of both Associations and Boards.

[18] The New Zealand Health Service: more of the same or something different? Presentation to AHANZ conference 02/05/15.

- 3DHB Career Progression Framework. Initially applying to specific professions, it is envisaged that this will be extended to include the broader AHS&T workforce[19]. This work will provide a transparent career framework for each profession. The framework is expected to support recruitment and retention in many areas, as well as supporting a culture of leadership and recognising AHS&T contribution to the broader organisation.

- Many allied health staff already work within multidisciplinary teams (MDT), particularly in MHAID and forensic services, but also in services for older people and rehabilitation, pain management and child development.

- Some technical workforces are developing a broader scope, which includes increased patient interaction skills and connects them to the broader work of the health service (e.g. bereavement skills in mortuary technicians, dental technicians educate public health nurses in aged residential care on denture care, psychosocial support for cancer patients provided by radiation therapists, Capital & Coast DHB).

- At the national level, Directors of Allied Health meet regularly to work towards nationally relevant advancements for AHS&T. A subsequent work group is the National Data Collective, which has finalized a national standardized data set[20]. This core data set will allow the development of national benchmarking in New Zealand for the first time. Allied health staffing levels are thought to be low by national comparisons (particularly at Capital & Coast DHB), and this is something that needs to be quantified. The recent incorporation of allied health activity into Trend-care at Hutt Valley DHB will enable analysis of the interaction between staff levels and flow, which has not been possible before.

- This has led to an increased focus on informatics with specific roles developed in, for example Canterbury DHB, to carry out this work. This group is working with the Health Roundtable to identify the right information to accurately reflect the work of AHS&T services.

- A number of service improvement initiatives have made significant progress in developing integrated care for patients, involving AHS&T, nursing, medical and operational components (e.g. Capital & Coast DHB have developed an orthopaedic pathway which involves a pre-surgeon physiotherapy consult). The pilot identified that 20% of those assessed did not then need to see a surgeon, thus freeing up capacity and saving money for the health system.

- AHS&T contribute directly to patient flow by ensuring optimal conditions for recovery. For example 30-35% of those admitted to hospital are malnourished.[21] Early identification and treatment has a direct impact on recovery and the nursing staff are now being taught to screen for this patient safety indicator. Wairarapa and Hutt Valley DHBs are piloting ERAS –

[19] The workforces involved in the first stage of the Allied Health Career Progression Framework are Alcohol & Other Drug Clinicians, Audiologists, Counsellors, Dietitians, Occupational Therapists, Physiotherapists, Podiatrists, Psychotherapists, Speech-Language Therapists & Social Workers.

[20] February 2015.

[21] Personal communication, Jo Stewart, professional leader dietetics CAPITAL & COAST DHB 02/10/14.

Enhanced Recovery After Surgery, with nurse, occupational therapist and/or physiotherapist working together to ensure optimised recovery is supported.

- AHS&T professionals continue to adapt scopes of practice over time to meet the needs of the population, system and individual people (e.g. ability to prescribe for certain professions).

- Allied health professions in particular, bring a bio-psycho-social paradigm to their work, with whole of system thinking inherent in this. They are used to working in teams and wrapping services around patient needs.

Challenges

- HWNZ (2014) highlighted challenges in developing our future AHS&T workforce, noting that many of the allied health professions do not have as high a public profile as other health professions such as doctors, nurses and dentists. School leavers considering health careers are often unaware of the range of allied health careers available.

- Scopes of Practice, as determined by the relevant regulation authorities, are at times more restrictive than the equivalent role overseas (e.g. Sonography, Anaesthetic Technicians). This can make both recruitment and retention of overseas trained staff more challenging.

- An additional consideration in the future capability of the AHS&T workforce comes at the tertiary training level. Table 3 illustrates that our workforce may enter DHB employment with anything from no formal training through to Doctorate level qualifications. While there are myriad training organisations within New Zealand offering qualifications at different levels for many of our professions, a small number of our professions have only one provider (e.g. radiation therapists) or have no New Zealand training options and must look overseas to train or for qualification examinations (e.g. cytogenetic scientists, genetic counsellors, cardiac perfusionists).

- Some professions, which have a limited pool of qualified professionals within New Zealand, report high international recruitment rates, with associated costs and delays of up to 12 months in processing immigration and professional regulatory requirements before new staff are in post (for example medical physicists, anaesthetic technicians).

- A lack of a well developed health specific training programmes and transparent registration processes mean that on-the-job training is required and this can impact on the productivity of a service (e.g. physiology, health social work). Some AHS&T work-forces report a difficulty recruiting to post, and the level of vacancies has been identified as impacting negatively on delivery of services in a number of areas.

- Many AHS&T professions work within almost all service areas and/or across multiple directorates (e.g. clinical support services such as laboratories, pharmacy, radiology and sterile supply). These services are often invisible in the smooth running and efficiency of our DHBs and therefore are at risk of being missed in planning and scoping processes.

- Services within the Wairarapa are challenged by needing to be able to cover the breadth of service need across the hospital and community settings with a very small workforce.

- The capacity of the allied health workforce, particularly those with small resource, can be limited in availability and flexibility, leading to difficulties responding to acute demand at times (e.g. high use winter demand, Christmas cover provision). There is a lack of agreed and consistently used tools to measure workflow, and associated workforce required for our professions.

- A competitive and constrained fiscal environment at times impedes increased integration opportunities, especially those which cross contracts or budgets. Tension occurs between the drive to develop and apply new models of care and the parameters of resource to achieve this.

- Practical resource constraints of cars, telephones, physical space and ICT to support mobile and flexible working.

- Lack of visibility of professions within the health system, to other staff, leadership, primary health and community and patients.

- Marrying the therapeutic/rehabilitation/professional models of allied health therapies with the operational imperatives of acute patient flow and the fiscal realities of modern health service provision.

- Finding the balance between specialist and generalist. In recent years, demand has increased in both volume and complexity. In order to manage volumes and flow, increased breadth of delivery is required, whereas the increase in complexity drives the development of more specialised or advanced skills. MHAID services have been seeking to address this challenge by implementing stepped care frameworks and utilising demand and capacity models such as CAPA (Choice and Partnership Approach). The application of evidence based practice to target efforts to maximise effectiveness within constrained time frames is another approach for consideration. While all make decisions regarding this, a formalised commitment to this brings ethical challenges for staff to be prepared to target key points for intervention and not intervene regarding others.

- In some areas, the nature of provision of any service is specialised (e.g. transgender counselling, physiotherapy in women's health, pain management, child development and specialist mental health services). In these instances, issues arise around sustainability (with perhaps only 1 specialist across the sub-region), indicating the need to think sub-regionally or regionally in the provision of these services.

- The scientific professions perform high precision tasks with rapid development of software and technical equipment (e.g. medical physicists have over 200 controls). In addition, many areas (e.g. laboratories and genetics) are utilising increasingly complex ICT systems. The training needs of this group are high, with limited local resources to provide it.

- The rapid increase in possible data that can be gathered about a patient, is leading to further development in informatics (management, analysis and communication of data) and

molecular diagnostics is a growing field. This is a very exciting development, however poses challenges for information governance and management.

- The Career and Salary Progression (CASP) system (in the PSA MECA), which was developed to provide a mechanism for career progression, has been in place for several years now, however is not well understood by managers, particularly where the manager is not of the same profession as their staff. A small number of managers reported success with the CASP system and showed good understanding of the process.

- The fact that CASP is covered within the joint Public Service Association (PSA)/DHB MECA only, highlights an additional challenge for AHS&T. A number of unions oversee these different work groups, with some professions served by multiple unions (e.g. psychology – PSA, APEX, NUPE and laboratory workers – NZMLW, PSA) and therefore multiple terms and conditions may exist in one workplace.

- Competition with private employers offering higher pay and better conditions, either in New Zealand or overseas, within universities or as self-employed private practitioners.

- A high proportion of part-time employees in AHS&T, particularly in the allied health professions.

- Regulatory requirements for each scientific profession, which reinforce siloing, and encourage staff to specialise in their scientific specialty rather than contribute to systemic and organisational development.

- Increasing technicalisation of the work of our technical workforce (e.g. CSSD at Capital & Coast DHB has hired 6 degree graduates to support increased complexity of processing). Training options or courses for technical up-skilling of the workforce are of limited availability.

- HWNZ is involved in budgets for post-graduate training in some areas (e.g. anaesthetic technicians, cardiac technicians, physiology technicians). A related challenge is the requirement to operate increasingly sophisticated ICT systems and processes. In some areas, the risk is that the role of technician will disappear completely due to automation (e.g. aspects of laboratory and pharmacy).

- Several technician workforces have high turnover, high sick leave and evidence of a lack of commitment to quality. This is seen as reflecting a lack of career framework, lack of incentives to extend scope, low pay and for some repetitive, low interest work.

- With the increasing demands of technical roles, contracts will need to be reviewed in order to facilitate recruitment of people with higher entry level knowledge and/or qualifications, and retention of a skilled workforce.

- Allied health services have a low community profile in many areas. Long wait times for physiotherapy and occupational therapy in particular were noted and the challenge of small resource (e.g. dietetics) in light of increasing needs.

- The challenge of accessing services for South Wairarapa residents, given the large geographical spread of a small population, was highlighted. From the primary health perspective, adolescent alcohol and drug services and child development services were seen as significant gaps in the Wairarapa.

- Also highlighted were some of the barriers to access of diagnostic services and information (e.g. radiology) for primary health practitioners, both medical and allied health across the sub region. Increasing accessibility to community radiology would reduce hospital admissions, by supporting diagnostics in primary care settings. Community pharmacy is a well established component of the health system, but is not well integrated into the wider health system. Becoming more integrated in planning for people with complex conditions, would enhance community management of long term conditions and reduce avoidable hospital admissions. Integrated laboratory services will, from November, enhance access across the system.

- In terms of primary/secondary integration work, AHS&T have at times not had substantive involvement in planning and design. An identified barrier to integration is identified as the very complex layers of AHS&T services within DHBs, which makes it difficult for primary care (and patients) to navigate to the right services. Education of the public and of primary care would be needed to enable AHS&T to become part of the primary care network more fully. Primary care providers encouraged recognition of the NGO sector as a crucial part of community services.

- Allied health practitioners in private practice provide significant levels of service to the community, however are often disconnected from DHB systems and services.

- In all DHB areas, lack of awareness amongst primary health practitioners, in terms of what allied health practitioners can offer can be a barrier to full utilisation of services. All 3 DHBs are looking at possible models to organise allied health and district nursing resource geographically around GP clusters to support more integrated care and strengthen community provision of care. In particular the need for allied health services to support people in aged care residences is of priority.

- A very practical consideration in service design for community and primary based care delivery, is the need for additional space, ICT and cars for a mobile workforce.

Opportunities

- To bring together and utilise the unique perspectives and knowledge of our diverse professions with those of our colleagues across the health and social sectors, to inform development of services to promote the overall health and wellbeing of our community.

- To promote mature and respectful partnerships among all health professionals, recognising the additive value of combining perspectives to create a whole person view of health, is essential to moving integrated service design forward.

- To increase consistency and equity in access processes, clinical practice and documentation and provide increased opportunities to share learning and development and professional development resource.

- Professional leadership is a mechanism for innovation and development at the professional and organisational levels. A recalibration of purpose of the different levels of AHS&T leadership is indicated in light of recent changes in healthcare, to enhance interdisciplinary working and to increase connectedness with operational goals.

- Explore more flexible work hour arrangements to be able to provide improved flow and service in the evenings and at weekends. Some staff indicated that they would like to work alternative hours and some trials have begun with extended hour services (e.g. Saturday social work in MAPU, Capital & Coast DHB).

- InterRAI assessments are seen as a possible vehicle to improve communication and planning throughout services, particularly for the elderly. These assessments can be completed by a range of other disciplines (e.g. social workers, occupational therapists) at any point in the process and are also central to Needs Assessment Service Coordination (NASC) planning.

- To increase consistency and parity in roles, titles, terms and conditions across the different DHBs.

- Significant efficiency gains could be achieved by streamlining information systems from referrals through assessments to discharge processes. A key component of this would be electronic record sharing, with the practical enabler of access to mobile devices capable of connecting to this and single information pathways across the health system.

- In addition to the efficiency gains, solving the issue of mobile communications and access to shared care records would enable rapid innovation in developing integrated community teams. Allied health professionals in conjunction with district and public health nurses are well placed to provide services in the home and community and both Hutt Valley and Capital & Coast DHBs have been exploring co-design models with primary health to enhance integrated community care.

- Developing single core assessment records and shared assessment components. Currently multiple assessments are completed by medical, nursing and allied health during the course of a patient journey. While some elements of the assessment are unique to the context of the interaction, consistent feedback from consumers (for example SRDAG[22]), speaks to the frustration and exhaustion that comes from having to state repeatedly, your history, for multiple clinicians. Multidisciplinary services have developed shared assessment templates into which different team members contribute (e.g. child development services and MAPU) however single discipline team structures provide a barrier to this kind of approach.

[22] Sub-regional Disability Advisory Group.

- An increasing focus on quality, with AHS&T quality performance measures aligned with organisational quality frameworks. A majority of the measures currently in use within allied health services relate to volumes and activity, rather than quality measures.

- Maximising resource within health services has been the development of the potential of assistant workforces to take on the less complex aspects of all areas of AHS&T. An audit of allied health therapist activities in ORA Services (March 2013) indicated approximately 8% of activities could be performed by assistants[23]. A review of the assistant workforce across the 3DHB is in the early stages, as there is currently not an understanding of the distribution of the assistant workforce and consequent needs.

- The scientific workforce have the capability to further develop systems to enhance care, such as becoming more mobile, supporting accurate information management and providing expertise resource directly to staff and patients (e.g. bedside assessment).

- To build workforce capability to provide culturally appropriate and responsive AHS&T services.

- It will be important for health pathways development work to focus on broad health priorities, with AHS&T viewed as an alternative option for care provision, moving the pathways into a more integrated view of person-whanau centred pathways.

- To create a workforce able to take an active role in working with our partners to identify, develop and implement new models of care. These will be designed to reduce demand on acute services, enable timely discharge and empower effective management of long term conditions and support independence and maximum function in our population.

Vulnerabilities

- For many services, the past 3 years have involved significant change. For Wairarapa and Hutt Valley DHBs, there has been significant change with the merging of the two.

- At Capital & Coast DHB, the setting up of ORA services in 2011 has incorporated a significant change process. Child Development Service (CDS) at Capital & Coast have completed a significant improvement project and Wairarapa and Hutt Valley DHBs allied health services are working together to increase access for Wairarapa children.

- AHS&T professionals working in MHAID, laboratories and radiology across the sub-region are undergoing a restructure of services to 3DHB.

- As with most other workforces globally, New Zealand's allied health, science and technical workforces are ageing. Regulatory authority data indicates that 59% of the clinical dental technician workforce is aged 50 years and over, and 31% of practitioners registered under the Medical Radiation Technologists Board are aged 50 years or over (HWNZ, 2014).

[23] Personal communication, Steve Whittaker, Manager ORA, Capital & Coast DHB 01/10/14.

- Many professions face the challenge of not having 'work-ready' graduates to hire. In some instances, on the job training is the only option for increasing the profession base, for others the existing training programmes are not tailored to the needs of the DHB.

- Many AHS&T professions have very small workforces, with more than 20 professions having less than 10 professionals spread across the 3 DHBs. Appendix 5 provides a snapshot of the approximate fte for each professional AHS&T group. Challenges resulting from these small numbers across some of our professions include; leave cover, vacancies , a small pool of people to provide supervision, leadership, quality, training and service improvement components. In addition, it is difficult for these groups to be present and visible in service or organisation projects, with their attendance at such events likely impacting on service delivery. This is an area in which AHS&T leadership is essential to provide representation and coordination.

- A lack of workforce capacity data, including the lack of benchmarking or safe staffing frameworks (as can be seen in nursing and medicine) contributes to the lack of visibility of contribution and therefore difficulties in ensuring maximum staff deployment.

- An added challenge is that the specialised skill sets of our different AHS&T professions (not taking into account service related skills and experience), combined with the limited number of people in the community with these skills, makes solutions such as 'agency' or 'bureau' options for backfill and cover impractical in many circumstances.

- In terms of specific profession vulnerabilities, there are national shortages of cardiac physiologists (6 fte vacancy at Capital & Coast DHB) and echo-sonographers. Training is available only in Australia. HWNZ and the Cardiac Network are working on strategies to address these issues. HWNZ have a budget to support post-graduate training for cytology, medical physicists, sonographers, radiotherapy, anaesthetic technicians and physiologists.

- Medical physicists and radiation therapists have had shortages in the past, but are keeping pace with demand currently. However, changes to cancer treatment protocols and proposed increases in demand for cancer treatment may increase vulnerability in the future.

- Professional associations and boards can make decisions in isolation from DHBs, which impact on our ability to meet the required standards of care (e.g. changing the scope of practice for audiometry so that they could no longer work with children, has resulted in more expensive solutions for DHBs, as Audiologists now have to undertake this work).

- A problem with the practice of new-born hearing screeners was triggered by discovery of poor practice in the U.K. and then at sites across New Zealand, which has led to a review of this workforce. Work continues to ensure protocols and supervision of practice ensures quality.

- Wairarapa DHB has been a particularly vulnerable site for Central Sterile Supply Department (CSSD), with outdated equipment and a lack of up to date training/methodology. A 2DHB manager has recently been appointed to assist with workforce and service development for CSSD.

RECOMMENDATIONS

A key theme to emerge throughout the literature, from overarching strategic documents and operational imperatives, is that health services are in a process of change. Seeking new models of care which allow for more patient-whanau centred, preventative and empowering, responsive health services is part of a continuous process of improvement and development. Improving health for all and in particular reducing health outcome disparities for Maori, Pacifica and people with disabilities is an essential tenet that is woven throughout our planning. All health services are faced with balancing changing demographic, social, technological and clinical factors with the need for sustainable health provision.

Our comprehensive stocktake has given us a detailed understanding of the strengths, challenges, opportunities and vulnerabilities of AHS&T. AHS&T are well positioned to work with our partners to identify, develop and implement new models of care which build resilience in our populations and in our systems of care.

We contribute a broad diversity of perspectives, which sit within a bio-psycho-social understanding of health and wellbeing. Incorporating those perspectives into health service design and planning will assist our organisations in delivering preventative health and empowered self-care, provision of relevant services close to home and quality health care, including highly complex care, for those who need it. In addition, by focussing on the development of new models of care as a priority, we are proactive members of the health care team, contributing to system wide initiatives to reduce avoidable admissions and facilitate timely discharge, by ensuring maximum coordination of assessment and intervention.

Any change to clinical care models, must occur with an overarching lens of quality and safety. Our stocktake has identified opportunities to enhance quality measures and we see significant benefits in integrating AHS&T quality measures more explicitly into our organisational quality frameworks.

Our diversity does also offer a challenge, in terms of the complexity of training, regulation, contract and practice that must be integrated into the whole of the health system. Ensuring that our AHS&T leadership roles are functional within the broader organisation will be essential to future development of this multifaceted workforce. Again, our stocktake identified an opportunity to more clearly align AHS&T leadership competencies and purpose to the needs of our integrated organisations.

Our AHS&T professionals work within the clinical pathways of patients, providing diagnostic, scientific and technical services, and clinical assessment and intervention. A number of professions are small, specialised and have low visibility. Several of

these professions are identified as vulnerable and will need specific strategies to increase their sustainability. Some of our larger professions combine broad assessment and intervention, with pockets of specialisation. Linking our identified skill bases to the needs of our changing populations will require robust workforce assessment and development frameworks.

A clear line of sight of the capacity, vulnerabilities and potential capabilities of AHS&T as a whole, is important for effective and efficient operational planning. Increasing our ability to provide clear and meaningful data and input for our organisations, is essential to support optimal resource utilisation and allocation.

A significant portion of our AHS&T services operate within multidisciplinary teams and over half in 3DHB services. Many initiatives and innovations are underway across the sub-region to adapt ways of working to support our organisational aims. Sharing this learning and coordinating innovation projects is valuable in reducing re-work and increasing the efficiency of change activities. Building capability and capacity to engage in continuous improvement activities, is seen as a way to ensure that our services optimise quality and function.

Therefore, with a clear line of sight to the strategic priorities of the 3DHBs and following a comprehensive stock take of the current workforce, a survey of staff and stake holders and a review of current literature in the broader context, seven key priority areas have emerged for AHS&T. These areas reflect the vision of our DHBS, with a specific focus on how the AHS&T workforce can create opportunities to enhance and increase effectiveness in attaining our organisational, sub-regional and regional operational goals.

KEY PRIORITY AREAS

1.0 Working with our partners to develop and implement new Models of Care

Demographic changes, economic parameters, social expectations and technological advances all create an environment that, as health service providers, prompts us to be creative in the development of new models of care for our populations. AHS&T have a significant contribution to make to the development and implementation of new ways of working. We are well placed to partner with our professional colleagues, our community partners, our patients and their whanau to create a responsive and sustainable health service for the future.

Emerging new Models of Care, share several key components, which form focal points for our thinking in this area:

- Increased integration of services, trans-discipline, trans- organization, trans-sector
- Person and whanau-centred care; closer to home, with faster access
- Right care, by the right people, in the right place, at the right time
- Preventative intervention; creating an environment to maintain health and well-being
- Empowering self-management
- Management of long term conditions; maximizing wellness and independence, reducing avoidable hospital admissions

Consideration of these components, along with our awareness of current strengths and vulnerabilities, allows us to identify 10 year goals, which represent our vision of how AHS&T services should look by 2025.

AHS&T Priority	Goals (10 years)
1.0 Working with our partners to develop and implement new Models of Care Increased integration of services, cross-sector.	1a. Non-acute health care is delivered in terms of integrated clusters of services (collocated or virtual).
	1b. AHS&T professionals have strong and sustained relationships with partners across the health, social service and education sectors.
	1c. AHS&T staff are recognised as having expertise and are routinely involved in the development and review of health pathways. This will ensure that for example, rehabilitation and long term conditions prevention and management are embedded and integrated into 3DHB health pathways.
Person and Whanau-centred care; closer to home, with faster access.	1d.One electronic shared plan of patient care is available for all health providers.
Right care, in the right place, at the right time	1e. Models of Care deliver effective and sustainable outcomes for complex and long term needs of our populations.
Preventative intervention.	1f.People with Long Term Conditions (LTC) can refer themselves directly to AHS&T outpatient and community services.
Empowering self-management.	1g. AHS&T staffing are able to respond quickly to changes in demand across service areas, ensuring that high quality and safe patient care is prioritised.
Reducing inequalities	1h. Where appropriate, AHS&T services will operate 7 day, extended hours services to meet patient need.

Drawing from this larger and longer term view of how the AHS&T workforce might be positioned within the broader health system and with a very detailed understanding of current capacity and capability, a practical, 12 month action plan for the 3DHB AHS&T Leadership Team, designed to begin the process and build the foundation for the achievement of these goals has been developed (see Appendix 6).

2.0 Quality

The development and implementation of any new models of care must be considered within a quality framework. Our stocktake of professions and services, identified potential for an increased rigour in the assessment of quality and value add of AHS&T. Current systems are focussed primarily on activity completion and we would like to connect AHS&T practice more explicitly with overarching organisational quality and risk systems and frameworks. Focussing on quality improvement will support the achievement of organisational goals of financial and clinical sustainability.

AHS&T Priority	Goals (10 years)
2.0 Quality Safe & high quality practice. Development and application of new Models of Care occur in a clinically safe and responsible way. Appropriate clinical governance structure, responsive to new initiatives evolving while in development. Quality Measures	2a. For every AHS&T practitioner we can access, demonstrate and communicate quality data & measures. 2b. There is a robust framework for utilising and responding to quality data & measures. 2c. The quality data & measures are used to demonstrate the value added by AHS&T.

Actions for the coming 12 months, will begin with an information gathering and sharing process, to review our current capability to demonstrate quality in practice and to explore with our organisational quality & patient safety services, how we can best evaluate and demonstrate that our AHS&T professionals are providing high quality health services (see Appendix 6).

3.0 Leadership

The development and implementation of new models of care, involves a process of significant change and transition. In order to ensure successful and sustainable change, it is essential to have strong and visionary leadership. Recognising that changes in configuration, situation and roles are all likely components of future AHS&T service provision, it is important to review the purpose and function of our leadership roles and to be proactive in developing competencies and skills aligned with organisational need.

AHS&T Priority	Goals (10 years)
3.0 Leadership AHS&T leadership purpose and function lead and support AHS&T staff effectively in light of changing Models of Care. Competencies match needs of workforce. Deliberately build leadership capability Executive Professional Operational Clinical + Inter-Disciplinary Team (IDT) Working	3a. All AHS&T professions have transparent career frameworks to improve the ability to retain good staff, skill mix, and recognise increasing capability.
	3b. Clear competencies for leadership are identified, at all levels.
	3c. Leadership structures and functions in AHS&T are designed to support Models of Care in service delivery.
	3d. A functioning and proactive talent management strategy.

As with Quality, we have identified opportunities to connect AHS&T more explicitly with the work of our human resources and learning and development teams to build capacity in this area. Our 12 month actions therefore reflect the desire to identify leadership competencies essential for AHS&T services in the context of changing models of care and to connect these into overarching strategies for leadership development across the 3DHBs (see Appendix 6).

4.0 Workforce development

Our workforce is our greatest asset and we are proud of the excellent service they provide to our local populations. AHS&T have a large number of different professional groups, working across the whole health system. Many of our professional groups are very small and are in a "behind the scenes" role. The context of changing models of care requires that we seek opportunities to develop our workforce to be increasingly flexible, responsive and innovative. It is essential that our future planning focusses on how to develop our workforce to be creative, proactive, confident to innovate, and resilient in an environment of rapid change. Extending our culture of continuous improvement, to support efficient and effective service provision is an important aspect of future workforce development.

AHS&T Priority	Goals (10 years)
4.0 Workforce Development Workforce positioned for change: dynamic and innovative. Able to flex and evolve to respond to changing needs. Ready to lead innovation. Ready to lead implementation of new models of care. Responsive to technological change and impact on roles. Creative in increasing efficiency and effectiveness.	4a. The AHS&T workforce is recognised as an integral partner in the achievement of optimal outcomes for our populations, at all levels within the DHBs and across the wider health community.
	4b.Successful continuous service improvement is embedded, coordinated and inclusive in all AHS&T services.
	4c.Mechanisms are in place to measure the ability of the workforce capacity to the needs of local populations (national workforce prediction model).
	4d.Every AHS&T workforce is able to use agreed data to identify vulnerabilities and can make use of an established action plan to mitigate the risks.
	4e.For every proposed workforce innovation, investment and disinvestment priorities are evaluated.
	4f. Best practice recruitment processes are being used.

Our immediate actions in the area of workforce development focus on aligning AHS&T more deliberately with each other and with the work of our organisations as a whole. Our 47 professions work in all areas and often in small teams with a specific focus. Increasing systemic connectedness will, we believe, position our workforce to be dynamic and innovative, building on their strong sense of the whole patient journey and the role of AHS&T in this (see Appendix 6).

5.0 Business Development

As the custodians of significant public resource, our DHBs have a weighty responsibility in the utilisation of public funds and the governance of health service provision. AHS&T have a responsibility to ensure that our clinical practice and service development initiatives line up with the financial and resource imperatives of our organisations, that we are as efficient and effective in our activities as possible. In addition, we have a responsibility to ensure that the services responsible for funding decisions and health service planning for the future have robust and transparent information about our services.

AHS&T Priority	Goals (10 years)
5.0 Business Development Business processes Data Resourcing innovation Infrastructure development Identity and Branding Communications (sector, clients, future workers, MoH, ELT) Integrated service profiling Profession profiling Recruitment Value for money investment capability	5a. AHS&T leadership have the capability and confidence to market services proactively and to maximise opportunities for business development (e.g. with commercial partners, confidence with investment/disinvestment decisions).
	5b. AHS&T are utilising existing resources to support maximal business development.
	5c. AHS&T are collecting a meaningful suite of data that supports informed decision making and planning, with automated reporting systems to support business and service development.
	5d. Senior leaders have confidence in managers to innovate within their own service sphere.
	5e. AHS&T professions are identified as desired career options in secondary/tertiary education sector.
	5f. AHS&T has a confident voice and clearly visible profile across the health system.

Our 12 month actions initially focus on developing the capacity of AHS&T to provide meaningful and relevant information to our broader organisations and funding arms. In addition, we will decant those skills to our professional and team leaders, to ensure that we have a depth of understanding and an increased capacity (organisation wide) to provide relevant information to support robust business decisions. We have identified a vulnerability in the small size of some of our workforces and so the promotion of AHS&T careers and recruitment strategies are elements we plan to explore further with our human resources services, training providers and high schools (see Appendix 6).

6.0 Strategic Innovation

AHS&T staff work within a complex adaptive system, with health practitioner and operational colleagues, our patients, our partners in primary health and community and NGO services, as well as those in the education and social service sectors. The stocktake of our services and professions, also highlighted the huge complexity of AHS&T itself, both in terms of the numbers of professions and range of service areas, but also the numbers of training providers, unions and professional bodies with which we interact.

Our approach to any innovation and change must start with a comprehensive consideration of the whole system and must be a coordinated and shared process, which is driven by an overarching vision of interconnected systems. In addition to this overarching view, innovation and change must be as efficient and effective as possible, with coordinated efforts, shared learning and measures to ensure continued capacity and resilience for change in our workforce. Our aim is to be the best in New Zealand, to instil pride and constantly strive for excellence within available resource.

AHS&T Priority	Goals (10 years)
6.0 Strategic Innovation Define, lead and support innovation. As a complex interactive system, we must be systematic and strategic. Coordination and oversight of change. Development of innovation capacity and resilience in workforce. Transfer of learning across AHS&T, 3DHBs.	6a. 3DHB AHS&T leadership work effectively together to maximise opportunities for strategic innovation with our partners across the sub-region.
	6b. Free transfer of knowledge and learning across the subregion at all levels.
	6c. AHS&T embodies a culture of learning and challenging the status quo, striving for excellence, to improve the health status of our populations, while living within our means.
	6d. Established mechanisms provide a forum to profile and highlight successes.
	6e. We have the best performing AHS&T services in New Zealand.

Specific actions to ensure that we are strategic in our innovation focus on coordination and prioritisation mechanisms and leadership. In addition, increasing information flow and awareness of activities across the sub-region will support better coordination of efforts and increased transfer of learning. Taking time to celebrate success is an essential component to supporting our workforce to be proactive and feel connected to the aspirations of the 3DHBs as a whole.

7.0 Improving health outcomes by increasing health equity

An essential component of all AHS&T work, is building capacity to improve health outcomes by increasing health equity. However it is valuable to consider this as a priority in its own right, as well as being woven into all other areas of work. AHS&T have a strong commitment to the principles of participation, partnership and protection and aim to ensure that future planning and development initiatives embody the concepts of Whanau Ora. In addition, proactive development of our workforce's capacity to be responsive and aware of cultural aspects of health and wellbeing is seen as a priority.
While the needs of people with impairments/disabilities are not the same as those for people of different cultures, ensuring accessibility and applying the principles of partnership, participation and protection also provide a sound base for improving outcomes for this population.

AHS&T Priority	Goals (10 years)
7.0 Improving health outcomes by increasing health equity Focus on Maori, Pacific Peoples and people with impairments/disabilities Participation in design and delivery of services Accessibility Partnership, with a responsive and aware workforce which reflects the population Protection of our vulnerable populations - reducing disparities	7a. All AHS&T health planning/innovation/service development is consistent with reducing health outcome disparities for Maori, Pacific Peoples and other ethnicities and people with impairments/disabilities.
	7b. Ongoing and substantive relationships with local iwi, Maori and Pasifika community providers and AHS&T.
	7c. Ongoing and substantive relationships with the disability community.
	7d. AHS&T are able to demonstrate that practitioners adapt practice to a person's needs, to deliver compassionate and responsive health services.

Immediate actions focus on creating visibility of the need to develop skills and practice in these areas. The ability to utilise existing learning and development resources within our 3DHBS, to increase the cultural competency and disability needs awareness of our workforce, makes it an ideal starting point. Proactively developing relationships with our partners in the broader health, social and disability communities will increase our ability to engage in true partnership for the design and development of future services.

CONCLUDING COMMENTS

Our professions have come a long way, given that most have only been in existence for less than 100 years. Our vision for the next 10 years is a considerable proportion of the lifespan of many of our professions. It is crucial that we continue to be focussed on quality, seeking continuous improvement, and understanding how best to make a positive difference to the health of our patients and communities.

As part of achieving our vision, this 3 DHB approach will need to be brought to life within each profession and service, in order to maximise our potential to make a difference. In many ways we have only reached the end of the beginning of our work. We encourage everyone, whether an AHS & T practitioner or other health professional, to activate this approach by using this document as a reference point and steer for their work.

We are of course open and keen to be contacted to answer any questions, and discuss how best we can achieve our goals together. So please do get in touch.

Thank you for your on-going commitment and hard work.

Russell and Catherine

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Catherine.Epps@ccdhb.org.nz

APPENDICES

Appendix 1: Interview Participants (between November 2014 - April 2015)

Note: some titles and positions may have changed. Those listed reflect the position of the person at the time of interview.

NAME (A-Z)	DESIGNATION
Paul Abernathy	Clinical Director Te Awakairangi Primary Healthcare Organisation (Hutt Valley)
Suzie Adamson	General Manager Hospice Wairarapa (Wairarapa)
Bridget Allan	Chief Executive Te Awakairangi Health (Hutt Valley)
Fiona Angus	Podiatry Coordinator (Hutt Valley DHB)
Rommel Anthony	Manager, Planning 3DHB ICT (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Astuti Balram	Project Support for Integrated Care Collaborative SIDU (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Diane Barker	Occupational Therapist (Therapies/rheumatology) (Hutt Valley DHB)
Iain Barnes	Team Leader Kapiti Community Mental Health Team (Capital & Coast DHB)
Tony Becker	G.P. Liaison Masterton (Wairarapa)
Graeme Benny	Director Health Workforce New Zealand (HWNZ) (National)
Ashley Bloomfield	Executive Director SIDU (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Ann Boland	Project Manager CAREFUL project (Capital & Coast DHB)
Kylie Bolland	Head Audiologist (Hutt Valley DHB)
Alwyn Bonderan	Team Leader CATT, HBT, Te Haika, mental health (Capital & Coast DHB)
Andrew Bos	Operations Manager regional Ambulatory Services (Capital & Coast DHB)
Sarah Boyes	Director of Operations Surgical Women's & Children's (Wairarapa and Hutt Valley DHBs)
Pauline Boyles	Senior Disability Advisor SIDU

NAME (A-Z)	DESIGNATION
	(Wairarapa, Hutt Valley, Capital & Coast DHBs)
Carolyn Braddock	Director of Operations Regional Plastics, Dental, Cancer, ENT, Opthalmology (Wairarapa and Hutt Valley DHBs)
Jenny Bradley	Social worker (Wairarapa DHB)
Colette Breton	Nursing Director Surgical Women's & Children's (Hutt Valley DHBs)
Clarissa Broderick	Team Leader Addiction Services (Capital & Coast DHB)
Yvonne Browning	Professional Leader Occupational Therapy mental health (Capital & Coast DHB)
Helen Bryant	Team Leader Older Persons Rehabilitation Service (OPRS) (Hutt Valley DHB)
Maria Campbell	Operations Manager, prison/courts and youth forensic & community (Regional) (Capital & Coast DHB)
Helene Carbonatto	Group Manager Service Development SIDU (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Sharon Cavanagh	Chief Executive, Well Health Trust Primary Healthcare Organisation (Wellington)
Derek Challenor	Team Leader Matairangi (inpatient mental health Wellington) (Capital & Coast DHB)
Debbie Chin	Interim Chief Executive Officer (Capital & Coast DHB)
Trish Chivers	Professional Leader Social Work (Wairarapa and Hutt Valley DHBs)
Alice Christian	Senior Genetic Associate/Counsellor (regional)
Clinical Advisory Group	Ora Toa Primary Healthcare Organisation (Porirua)
Ann Connell	Professional Leader psychology (Capital & Coast DHB)
Russell Cooke	Manager Laboratories (Hutt Valley and Capital & Coast DHB)
Jayne Coombes	Operations Manager, Adult Community Mental Health and Addictions MHAID (Wairarapa, Hutt Valley and Capital & Coast DHBs)
Peter Coombes	Clinical Nurse Manager Te Whare Ahuru (TWA) Inpatient Mental Health, Hutt Valley DHB
Carolyn Cooper	Interim Chief Operating Officer (Wairarapa and Hutt Valley DHBs)

NAME (A-Z)	DESIGNATION
Chantalle Corbett	Team Leader Wellington ORA (Capital & Coast DHB)
Steve Crewe	Director Health Services(Wairarapa DHB)
Andrew Curtis-Cody	Clinical Nurse Manager General Adult Mental Health Service (Wairarapa DHB)
Gillian Dawidowski	Charge nurse manager Te Mahoe Women's Services (Regional, Capital & Coast DHB))
Barbara Day	Professional Leader Physiotherapy (Capital & Coast DHB)
Ian Denholm	Clinical Director (Wairarapa DHB)
Jennifer de Ridder	Team Leader Radiation Therapy (Regional) (Capital & Coast DHB)
Joy de Villiers	Team Leader Social Work (Capital & Coast DHB)
Disability Advisory Group	Sub-regional Disability Advisory Group (SRDAG) (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Sue Doesburg	Professional Leader Physiotherapy (Wairarapa and Hutt Valley DHBs)
Helene Dore	Team Leader FOCUS (Needs Assessment Service Coordination) (Wairarapa DHB)
Sue Doris	Team Leader Child Development Service (Capital & Coast Health DHB)
Kim Drysdale	Manager Imaging Services (Wairarapa DHB)
Jamie Duncan	Radiology Services (Capital & Coast DHB)
Graham Dyer	Chief Executive Officer (Wairarapa and Hutt Valley DHBs)
Gail Edwards-Hughes	Team Leader Wellington Community Mental Health Team & South Community Mental Health Team (Capital & Coast DHB)
Catherine Epps	Executive Director Allied Health Scientific & Technical (Capital & Coast DHB)
Taima Fagaloa	Director, Pacific Health Unit (Capital & Coast DHB)
Nigel Fairley	General Manager MHAID (Wairarapa, Hutt Valley, and Capital & Coast DHBs)
Clive Felix	Genetics Service Leader (Regional)
Deidre Florance	Operations Manager, Te Korowai Whariki, mental health forensic (Regional)
Theresa Fowler	Nursing Director Primary Health & Integrated Care (Hutt Valley DHB)

NAME (A-Z)	DESIGNATION
Stephanie Fridd	Project Support SIDU (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Emma Garner/Stephen Gregory	Exercise Physiologists Respiratory (Wairarapa and Hutt Valley DHB)
Grace Garnham	Team Leader Child Development Service (Hutt Valley DHB)
Angela Geary	Senior Clinical Physiologist (Hutt Valley DHB)
Jo Gibbs	Team Leader physiotherapy, Keneperu (Capital & Coast DHB)
Peter Glensor	General Manager Hui-E! Community Aotearoa (National)
Max Goodall	Dietitian (Wairarapa DHB)
Cheryl Goodyer	Maori Health Development Unit(Capital & Coast DHB)
Philip Grant	Chief Executive Officer Allied Health Aotearoa New Zealand (AHANZ)(National)
Donna Gray	Clinical Lead Mary Potter Hospice (Wellington)
Ken Greer	Primary Health Advisor SIDU (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Ann Gregory	Team Leader Dietetics (Capital & Coast DHB)
Lynne Grieg	Medical Physicists, Chief Physicist Oncology (Capital & Coast DHB)
Tania Grieve	Theatre Manager (Wairarapa and Hutt Valley DHBs)
Peter Gush	Service Manager Public Health (Regional)
Tofa Gush	Director, Pacific People's Health (Wairarapa and Hutt Valley DHBs)
Michelle Halford	Nursing Director (Wairarapa DHB)
Andy Harris	Director AHS&T Medical and Community Health (Wairarapa and Hutt Valley DHBs)
Annie Hawkes	Team Leader social work (Wairarapa DHB)
Martin Hefford	Chief Executive Compass Health Primary Healthcare Organisation (Wellington, Kapiti and Wairarapa)
Dagmar Hempel	Team Leader Pain Management (Capital & Coast DHB)
Carrie Henderson	Director AHS&T Ambulatory Women's and Children's (Wairarapa and Hutt Valley DHBs)

NAME (A-Z)	DESIGNATION
Donna Hickey	Director Human Resources (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Emma Hickson	Clinical Nurse Manager Community Health (Hutt Valley DHB)
Sandra Hoggarth	Team Leader New-born Hearing Screening (Hutt Valley DHB)
Joanne Hughes	Team Leader Pain Management (Hutt Valley DHB)
Mike Hughes	Organisational Development Consultant, Human Resources (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Delwyn Hunter	Executive Director of Operations Surgical Women's and Children's (Capital & Coast DHB)
Shirley James	Professional Leader Speech-language therapy (Wairarapa and Hutt Valley DHBs)
Chris Jay	Manager Pharmacy (Hutt Valley DHB)
Rosanne Johnston	Operations Manager, Te Korowai Whariki, intellectual disability mental health (Regional),
Mal Joyce	Operational Manager Child Health (Capital & Coast DHB)
Molly Kalleson	Team leader Speech-language therapy (Capital & Coast DHB)
Ross Kelly	Team Leader Social Work (Hutt Valley DHB)
Anna Kempthorne	Team Leader Tane Mahuta Te Korowai Whariki, mental health forensic (Regional)
Chris Kerr	Clinical Services Director Compass Health (Wellington, Kapiti and Wairarapa)
Chris King	Associate Director Allied Health Scientific & Technical (Capital & Coast DHB)
Dennis Klue	Team Leader Rangipapa/Purehurehu Te Korowai Whariki mental health forensic (Regional)
Rob Kusel	Clinical Director Orthopaedics (Wairarapa and Hutt Valley DHB)
Lucy Laphen	Team Leader Rangatahi Adolescent Inpatient mental health (Capital & Coast DHB)
Kirsten Lassey	Clinical Nurse Manager, Respiratory (Hutt Valley DHB)
Melissa Lemond	Team Leader Kapiti Child Adolescent Mental Health Service (Capital & Coast DHB)

NAME (A-Z)	DESIGNATION
Tony Littlejohns	Operations Manager general adult mental health service (Capital & Coast DHB)
Chris Lowry	Chief Operating Officer (Capital & Coast DHB)
Jeremy Ly	Service Development Manager SIDU (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Andrea McCance	Executive Director of Nursing & Midwifery (Capital & Coast DHB)
Chris McCarrison	Professional Leader Alcohol & other drugs, (Wairarapa and Hutt Valley DHBs)
Sue McCullough	PSA Organiser (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Melita McDonald	Team Leader ORA, Kapiti (Capital & Coast DHB)
Angela McDonnell	Chief Neuro-physiologist (Capital & Coast DHB)
Donald McEhaney	Anaesthetic Technician (Hutt Valley DHB)
Ray McEnhill	Team Leader Early Intervention Service mental health specialty team (regional)
Susan McGready	Dental Service (Capital & Coast DHB)
Shannon McRae	Allied Health Rehabilitation Coordinator (Hutt Valley DHB)
Jenny Maley	Team Leader Wellington Child Adolescent Mental Health Service (Capital & Coast DHB)
Berni Marra	Project Manager Blood Cancer Renal (Capital & Coast DHB)
Andrew Marshall	Clinical Leader Child Health (Capital & Coast DHB)
Kate Marshall	Team Leader Keneperu, ORA (Capital & Coast DHB)
Sarah Martin	Speech-language therapist (Wairarapa DHB)
Michael Maurer	Biomedical Engineering Manager(Capital & Coast DHB)
Wilhelmina Mentz	Operations Manager Community and Clinical Support Services (Capital & Coast DHB)
Mair Moorcock	Clinical Nurse Manager Outpatients (Wairarapa DHB)
Angela Morgan	Cardiac-physiologist(Capital & Coast DHB)
Diana Murray	Charge Mid-wife manager New-born Hearing Screening, Pacific breastfeeding team (Capital & Coast DHB)
Shayne Nahu	Group Manager Child, Youth & Older People SIDU (Wairarapa, Hutt Valley, Capital & Coast DHBs)

NAME (A-Z)	DESIGNATION
Vicky Noble	Director of Nursing, Primary Care & Integration (Capital & Coast DHB)
Amber O'Callaghan	Executive Director Quality and Risk (Wairarapa and Hutt Valley DHBs)
Kym Park	Team Leader Porirua Community Mental Health Team, Service Coordination (Capital & Coast DHB)
Kuini Puketapu	Director, Maori Health (Hutt Valley DHB)
Sarah Quirke	Operations manager Blood Cancer Renal(Capital & Coast DHB)
Susan Reeves	Clinical Nurse Manager Medical-Surgical (Wairarapa DHB)
Joanne Reid	Group Manager Public Health (Regional)
Lucy Reynolds	Team Leader Infant Child Adolescent and Family Service (ICAFS) (Wairarapa and Hutt Valley DHB)
Natalie Richardson	Director of Operations, Medical and Community Health (Wairarapa and Hutt Valley DHBs)
Helen Rigby	Learning & Development Portfolio Leader AHS&T (Capital & Coast DHB)
Helen Rigby	Professional Leader speech-language therapy (Capital & Coast DHB)
Paul Rigby	Professional Leader Dietetics (Wairarapa and Hutt Valley DHBs)
Tina Ririnui	Director Operations Clinical Support (Wairarapa and Hutt Valley DHBs)
Nicky Rivers	Team Leader physiotherapy Wellington (Capital & Coast DHB)
Geoff Robinson	Chief Medical Officer (Capital & Coast DHB)
Helen Robinson	Anaesthetic Technicians(Capital & Coast DHB)
David Robiony-Rogers	Respiratory Service Leader(Capital & Coast DHB)
Rochelle Ross	Radiology Manager (Wairarapa and Hutt Valley DHB)
Wendy Ross	Nurse Service Educator Mental Health (Hutt Valley DHB)
Wakaiti Saba	Director Transcultural Services Mental Health(Capital & Coast DHB)
Marg Sanders	Team Leader Inpatient multidisciplinary AHS&T team, Keneperu (Capital & Coast DHB)

NAME (A-Z)	DESIGNATION
Kate Scott	Consultant Geriatrician (Capital & Coast DHB)
Kanchan Sharma	Group Manager Public Health (Regional)
Stephen Shirley	Team Leader Clinical Sterile Services (Capital & Coast DHB)
Adam Simpson	Operation Manager Regional Ambulatory Services (Capital & Coast DHB)
Jo Simpson	New-born Hearing Screener (Wairarapa DHB)
Russell Simpson	Executive Director Allied Health Scientific & Technical (Wairarapa and Hutt Valley DHBs)
Sargunam Sivaraj	Team Leader Audiology (Capital & Coast DHB)
Wayne Skipage	Group Manager, Sky team (Health Needs Assessment and Annual Plan) SIDU
Paul Skirrow	Professional Leader Psychology (Wairarapa and Hutt Valley DHBs)
Alison Slade &Tricia Martin	Charge Nurse Managers for Play Specialists (Capital & Coast DHB)
Stephanie Slater	Professional Leader Occupational Therapy (Wairarapa and Hutt Valley DHBs)
Cindy Smith	Professional Leader psychotherapy (Capital & Coast DHB)
Cindy Smith	Team Leader Maternal mental health specialty team (regional)
Francenne Smith	Professional Leader social work (Capital & Coast DHB)
Derek Snelling	Clinical Leader Surgical Women's and Children's (Capital & Coast DHB)
Martha Sorenson-Vincent	Team Leader occupational therapy and Regional Palliative Care Network project (Capital & Coast DHB)
Martha Sorenson-Vincent	Regional Palliative Care Project worker (regional)
Franky Spite	Team Leader occupational therapy (Wairarapa DHB)
Anne Stewart	Quality "The Voice" project leader. Consumer Council (Capital & Coast DHB)
Jo Stewart	Professional Leader dietetics (Capital & Coast DHB)

NAME (A-Z)	DESIGNATION
Iwona Stolarek	Chief Medical Officer (Wairarapa and Hutt Valley DHBs)
Lisa Stuart	Team Leader Older Person's Mental Health (OPMH) (Hutt Valley DHB)
Suzy Stubbs	AHS&T Learning & Development Advisor (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Andy Swain	Medical Director Wellington Free Ambulance And Emergency Department Consultant (Capital & Coast DHB)
Lauren Swan	Team Leader Older Persons Mental Health Services (Capital & Coast DHB)
Huia Swanson	Trend-care Coordinator (AHS&T) (Hutt Valley DHB)
Miriam Swanson	Team Leader Porirua Child Adolescent Mental Health Service (Capital & Coast DHB)
Linda Tatton	Team Leader physiotherapy (Wairarapa DHB)
Shelagh Thomas	Manager Central Sterile Supply Department (CSSD) (Wairarapa and Hutt Valley DHB)
Caz Thomson	Acting for Professional Lead Social Work Mental Health (Capital & Coast DHB)
Tom Thomson	Consultant, Medical Ward (Hutt Valley DHB)
Lisa Ternant	Human Resources Manager, Medicine, Cancer and Community, (Capital & Coast DHB)
Katherine Tonks	Physiotherapist, Medical Ward (Hutt Valley DHB)
John Tovey	Consumer Advisor Mental Health Services (Capital & Coast DHB)
Janet Turnbull	Geriatrician, CAREFUL Team (Capital & Coast DHB)
Petrina Turner-Benny	Chairperson Allied Health Aotearoa New Zealand (AHANZ) (National)
George Underhill	Team Leader Tawhirimatea Te Korowai Whariki, mental health forensic (Regional)
Carey Virtue	Executive Director Operations Medicine Cancer and Community(Capital & Coast DHB)
Peng Voon	Director, Business & Innovation (Wairarapa and Hutt Valley DHB)
Jo Wailing	Clinical Nurse Manager Acute Services (Wairarapa DHB)
David Walker	Technical Head Mortuary Technicians

NAME (A-Z)	DESIGNATION
	(Capital & Coast DHB)
Dianne Watson	Operations Manager School Dental Service (Regional) Hutt Valley DHB
Steve Whittaker	Service Manager ORA (Older persons and rehabilitation) (Capital & Coast DHB)
Lauren Wilkinson	Project Manager (MCC) – Assertive Inpatient Management Project(Capital & Coast DHB)
Sandra Williams	Group Manager Population Health & MHAID SIDU (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Glen Willoughby	Operations Manager 3DHB ICT (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Bruce Wilson	Project Manager, Palliative Care Managed Clinical Network. SIDU (Wairarapa, Hutt Valley, Capital & Coast DHBs)
Neville Winsley	Pharmacy (Capital & Coast DHB)
Joanne Witko	Professional Leader psychotherapy (Wairarapa and Wairarapa and Hutt Valley DHBs)
Raewyn Woodhouse	Team Leader Child Adolescent Mental Health Service (CAMHS) (Wairarapa DHB)
Nadine Woodley-Rideout	Team Leader Central Region Eating Disorder Service (CREDS) (Regional)
Sue Wragg	Social Work Director Cancer Care Network (Regional)
John Zonnevylle	Operations Manager Mental Health regional specialty teams (Capital & Coast DHB)

Appendix 2: Strategic Approach Development Team

Russell Simpson – Executive Director Allied Health, Scientific & Technical, Wairarapa and Hutt Valley DHBs

Catherine Epps – Executive Director Allied Health, Technical & Scientific, Capital & Coast DHB

Christine King – Associate Director Allied Health, Technical & Scientific, Capital & Coast DHB

Carrie Henderson –Director of Allied Health, Scientific & Technical, Ambulatory, Women and Children, Wairarapa and Hutt Valley DHBs

Andy Harris – Director of Allied Health, Scientific & Technical, Medicine & Community Health, Wairarapa and Hutt Valley DHBs

Steve Whittaker - Allied Health Manager, ORA – Allied Health Services, MCC Directorate, Capital & Coast DHB

Suzy Stubbs - AHS&T Learning and Development Advisor, Wairarapa, Hutt Valley and Capital & Coast DHB

Ann Connell – Director of Allied Health MHAID, Wairarapa, Hutt Valley and Capital & Coast DHB

Rachel Prebble – Project Leader AHS&T, Wairarapa, Hutt Valley and Capital & Coast DHB

Appendix 3: Quick Guide: AHS&T Profession descriptions

	DESCRIPTION OF PROFESSION
Alcohol & Drug Clinicians/AOD Clinicians	Alcohol and Drug Clinicians are skilled in the assessment and treatment of people experiencing difficulty with their own and/or others' alcohol and drug use.
Allied Health Assistants	Allied Health assistants are those who work under the direction of a supervising allied health professional.
Audiologists & Audiometrists	Audiologists and audiometrists; study, identify, measure and treat hearing disorders and loss. They also provide aids and/or other listening devices to assist patients who have hearing loss. Audiometrists practice under the direction and delegation of an audiologist.
Counsellors	Counsellors help people to deal with their feelings and responses, and decide on actions they can take to solve problems and create change in their lives.
Dental Therapists	Dental therapists provide children and adolescents with routine dental care. They may refer clients to dentists for more specialised dental treatment.
Dietitians*	Dietitians advise patients, communities and groups about their dietary requirements for maintaining good health, managing food services and food and nutrition issues.
Family Therapists	Family therapists work with families and couples to nurture change and development, with a focus on family relationships as an important factor in psychological health.
Genetic Associates/Counsellors	Genetic associates work with individuals, couples and families to provide risk assessment, genetic information and support for families with, or at risk of, a genetic disorder.
Hand Therapists*	Hand therapists are registered physiotherapists and occupational therapists who, through continuing education, clinical experience and independent study have become proficient in the treatment of upper extremity conditions resulting from trauma, disease and congenital deformity.
Health Promotion/ Public Health Advisors	Health promoters work with communities and groups to plan and develop ways to help people improve and manage their health. They also work with government and other agencies to improve environmental conditions that contribute to ill health.
Needs Assessors / Service Facilitators	Needs assessors work with individuals and families to find out and plan what supports or services are available to help meet the goals and needs of the

	DESCRIPTION OF PROFESSION
	individual/family. This includes 'natural supports' (family, whanau, aiga, community services, etc).
Occupational Therapists*	Occupational therapists assess and treat people who, because of illness, injury or circumstance, are limited in their ability to undertake activities of everyday life.
Optometrists*	Optometrists examine clients' eyes to diagnose and provide solutions for vision problems, such as prescribing glasses or contact lenses. They also diagnose, monitor and manage eye diseases such as cataracts and glaucoma.
Orthoptists*	Orthoptists are eye healthcare professionals who are trained in the assessment and treatment of patients with eye disorders.
Pharmacists* & Pharmacy Technicians	Pharmacy staff prepare and dispense prescribed medicines for all hospital patients. They also provide information on medicines to doctors and nurses, and prepares special medicines for particular hospital outpatients. The Pharmacy team also give patients advice about their medication and medical conditions and help to ensure patients know how to take their medication properly.
Physiotherapists*	Physiotherapists work to maintain and promote people's health. They also help restore function and independence when people have a disability or problem caused by physical, neurological (related to the brain and nervous system) or other disorders. Their work covers all ages from small premature babies to the elderly.
Play Specialists	Play Specialists provide therapeutic play and recreation programmes for infants, children and young people, both individually and in groups
Podiatrists*	Podiatrists diagnose, treat and prevent foot and lower limb problems. Their work includes routine foot care, the care of lower limbs for people with diseases such as diabetes, the diagnosis and treatment of sports-related injuries, nail and skin surgery, and biomechanical assessment.
Psychologists*	Psychologists investigate, assess and provide treatment and counselling for people's behavioural, developmental and mental health issues.
Psychotherapists*	Psychotherapists help individuals, couples or groups identify, understand, and manage emotional and behavioural problems.
Speech-language therapists	Speech-language therapists assess and treat people who have problems with communication or swallowing. This may include difficulties with speech, language and cognition (thought processes), or physical processes.

	DESCRIPTION OF PROFESSION
Social Workers+	Social workers provide advice, advocacy and support to people with personal and social problems related to their health and/or mental health.
Health Protection Officers	Health protection officers investigate and take action on public health concerns (issues that need attention to prevent the spread of disease or illness and keep people well in the community), provide advice and information, and contribute to the management of sustainable environments. They have roles under specific legislation to support this work.
Visiting Neurodevelopmental Therapists*	Visiting neurodevelopmental therapists are New Zealand registered occupational therapists or physiotherapists who work with children who have or who are at risk of developmental difficulties, alongside their whanau/family through
Anaesthetic Technicians*	Anaesthetic technicians assist anaesthetists and are responsible for a wide range of technology used for anaesthetic procedures within operating theatres and clinics.
Audiology Technicians	Audiology technicians provide technical support to audiologists for technical equipment associated with assessment and remediation of hearing (e.g. hearing aids and/or other listening devices).
Clinical Engineers and Technicians	Clinical engineers maintain complex mechanical and electronic medical equipment in hospitals and other health sector institutes. They may also make, modify or repair specialised clinical accessories, surgical instruments and surgical implants.
Cardiac Perfusionists	During heart surgery, blood is detoured outside the body though a machine in order to bypass the heart, allowing surgery to proceed. The perfusionist is the person who monitors and controls the flow of blood through this machine.
Clinical Physiologists & Technicians (Respiratory, Neurology and Cardiac)	Physiologists use a variety of technical equipment to monitor, record, measure and analyse the way patients' respiratory, neurological or cardiac systems are working to help doctors diagnose and treat patients.
Dental Technicians*	Dental technicians create and repair devices for the treatment, replacement and protection of damaged, badly positioned or missing teeth.
Clinical Dental Technicians*	Clinical dental technicians have the scope of practice of dental technicians, plus the fitting of complete removable dentures and the fitting of some other types of removable dentures and oral and extra-oral appliances under specific conditions.
Laboratory Scientists, Scientific Officers and Technicians*	Medical laboratory scientists work in a team with pathologists and carry out laboratory tests on blood,

	DESCRIPTION OF PROFESSION
	tissues and other samples taken from patients. Medical laboratory technicians help scientists and pathologists take samples, run tests, and complete other duties involved in the operation of a diagnostic medical laboratory. Cytogenetic scientists work within the genetics laboratory.
Medical Physicists	Medical physicists look after the technical aspects of treating patients using radiation equipment, which includes overseeing the equipment used, performing quality assessments and monitoring radiation output, treatment planning and the development of new techniques.
Medical photographers.	Medical photography is the production of images that truthfully record injuries and diseases, as well as documenting the progress of operations and medical procedures.
Medical Radiation Technologists* & Technicians	Medical radiation technologists use x-ray and other imaging equipment to take images of people's injuries and possible diseases.
Mortuary Technicians*	Mortuary technicians assist with post-mortem examinations, including forensic post-mortems, under the direction of the pathologist. They are responsible for collecting and despatching samples for toxicology testing. They are also involved in general day to day duties of running a modern hospital mortuary such as receiving and storing bodies, and making sure bodies that arrive or leave the mortuary are properly identified. In some mortuaries, embalming is also part of the mortuary technician's role.
New Born Hearing Screeners	New born hearing screeners conduct hearing assessments of infants as part of early detection and intervention.
Phlebotomists*	Phlebotomists collect blood and/or other body samples from patients for laboratory testing or for blood banks.
Radiation Therapists*	Radiation therapists are part of a team that uses radiation equipment to treat diseases, mostly cancers, in patients.
Scientific Officers	Radiation therapists plan a patient’s radiation treatment using computer technology and clinical information, before carrying out the radiation therapy using treatment machines.
Sonographers*	Sonographers are Medical radiation technologists who specialise in the use of ultrasound.
Sterile Supply Technicians	Sterilising technicians clean, sterilise and package surgical instruments and other hospital equipment, soft goods and linen in a sterilisation unit.

Appendix 4: Regulatory Boards, Associations and Membership Bodies for AHS&T professions

Sourced from Ministry of Health website – 2013

Professions Regulated Under the HPCA Act 2003

Profession	Regulatory Board
Anaesthetic Technology	Medical Sciences Council of New Zealand
Chiropractic	Chiropractic Board
Dentistry, dental hygiene, clinical dental technology, dental technology and dental therapy	Dental Council
Dietetics	Dietitians Board
Medical Laboratory Science	Medical Sciences Council of New Zealand
Medical Radiation Technology	Medical Radiation Technologists Board
Medicine	Medical Council
Midwifery	Midwifery Council
Nursing	Nursing Council
Occupational Therapy	Occupational Therapy Board
Optometry and optical dispensing	Optometrists and Dispensing Opticians Board
Osteopathy	Osteopathic Council
Pharmacy	Pharmacy Council
Physiotherapy	Physiotherapy Board
Medicine	Medical Council
Podiatry	Podiatrists Board
Psychology	Psychologists Board
Psychotherapy	Psychotherapists Board

Professions Regulated But Not Under the HPCA Act 2003

Profession	Regulatory Board
Social Work	Social Workers Registration Board

Professions not under HPCA Act or SW Registration Board Act

Profession	Professional Body/Association
Audiologists	New Zealand Audiological Society
Counsellors	New Zealand Association of Counsellors
Respiratory Physiologists	Registration Body- Clinical Physiology Registration Board
Speech-language therapists	New Zealand Speech Therapy Association
Genetic Associates	Human Genetics Society of Australasia (HGSA) Australasian Society of Genetic Counsellors (ASGC)
Play Specialists	Hospital Play Specialists Association
Cardiac Physiologists	Professional body -Society of Cardiopulmonary Technology (required for certification) Registration body - Clinical Physiology Registration Board
Orthoptists	New Zealand Orthoptic Society
Neurology Physiologists	New Zealand society of neurophysiology technologist
Pharmacy Technicians	Pharmacy Society of New Zealand
Medical Physicists	Australasian College of Physical Scientists and Engineers in Medicine (ACPSEM)
Alcohol & Other Drug Clinicians	Addiction Practitioners Association Aotearoa NZ
Cardiac Perfusionists	Australasian & New Zealand College of Perfusionists or equivalent USA or UK
Sterile Supply Technicians	NZ Sterile Services Association
Clinical Engineering Technicians	New Zealand Institute of Healthcare Engineering (NZIHE)

Appendix 5: Professions by FTE

Allied Health Professions – approximate staffing levels as at May 2015

PROFESSION	WAIRARAPA DHB (FTE))	HUTT VALLEY DHB (FTE)	CCDHB (FTE)
ALCOHOL & OTHER DRUG (AOD) CLINICIANS	0 Child Adolescent Mental Health Service has counsellors with AOD training.	2.8 FTE approximately	5.0 FTE 1.0 FTE in Forensic
ALLIED HEALTH ASSISTANTS	A stocktake of the Allied Health Assistant workforce is pending, so accurate data is not currently available with regard to FTE across the sub-region.		
AUDIOLOGISTS	0 (see Hutt Valley DHB).	4.0 FTE (includes 2 provisionally trained). Hutt Valley DHB covers complex cases and under 3-year olds for Wairarapa DHB - a private contractor provides the remaining service.	3.0 FTE
COUNSELLORS	1.0 FTE – Child Adolescent Mental Health Service	0	3 FTE approximately employed in Te Mahoe Womens' service.
DENTAL THERAPISTS **(Regional service provided out of Hutt Valley DHB)**	0	45.0 FTE + 45 Assistants	0
DIETITIANS	1.0 FTE in Allied Health Team.	7.0 FTE in Dietetics Team	14.0 FTE Most in WN Dietetics Team (2 working in Paediatrics), 2 in the

PROFESSION	WAIRARAPA DHB (FTE))	HUTT VALLEY DHB (FTE)	CCDHB (FTE)
			allied health inpatient team at Keneperu (1 of whom works in mental health at times) and 1 in Kapiti ORA community team.
FAMILY THERAPISTS	0	0	2.0 FTE within CAMHS service. 0.1 FTE within Wellington Community ORA
GENETIC ASSOCIATES/COUNSELLORS (Regional & National Service based out of Capital & Coast DHB)	0	0	3.0-4.0 FTE + 2 hosted by Canterbury DHB and 2 hosted by Auckland DHB.
HAND THERAPISTS	0.2 FTE (provided by Hutt Valley DHB)	1.0 FTE Physiotherapy 2.5 FTE Occupational Therapy	2.4 FTE
HEALTH PROTECTION OFFICERS **Regional service run from Hutt Valley DHB**	0	11.8 FTE	0
NEEDS ASSESSORS/SERVICE FACILITATORS	Run through FOCUS, while under the umbrella of AHS&T management, needs assessors are nurses.	1.0 FTE Occupational Therapist for Mental Health NASC. Private provider for General Health.	1 Occupational Therapist and 1 Social Worker in Mental Health (General Health Service Co-ordination is run by Capital Support, which does not come under the AHS&T service umbrella.)
OCCUPATIONAL THERAPISTS	4.0 FTE in Allied Health 0.5 FTE in Mental Health	22.9 FTE approximately in General Health across acute stroke, general surgery, community team, Older	47.0 FTE approximately in General Health

PROFESSION	WAIRARAPA DHB (FTE))	HUTT VALLEY DHB (FTE)	CCDHB (FTE)
		People & Rehabilitation Service, Older People Mental Health and hand therapy. 4 FTE Child Development Service 7 FTE approximately in Mental Health.	(Wgtn Inpatient Occupational Therapy Team, Keneperu inpatient multi-disciplinary Allied Health Team, the Community ORA teams at WN, Keneperu & Kapiti, the Pain Management Service and the Child Development Service). 4 occupational therapists are employed as Visiting Neuro-developmental Therapists at CDS, 2 as hand therapists, 2 as team leaders and 2 in AHS&T management positions. Approximately 49 occupational therapists, in Mental health + approximately 10 assistants.
OPTOMETRISTS	0	0	1 person employed
ORTHOPTISTS	0	0	1 person employed
PHARMACISTS	2.0 FTE	9.0 FTE	26 people are employed
PHYSIOTHERAPISTS	3.7 FTE	34.6 FTE (across Child Development Service, community and inpatient services	45.0 FTE approximately (60 people) across Child Development Service, community and inpatient services

PROFESSION	WAIRARAPA DHB (FTE))	HUTT VALLEY DHB (FTE)	CCDHB (FTE)
		(includes child), pain management	(includes child), pain management
PLAY SPECIALISTS	0	2 people employed	1.5 FTE employed within child health inpatient wards
PODIATRISTS	0 Contracts to private sector podiatrists for this service	1.9 FTE	0 Contracts to private sector podiatrists for this service
PSYCHOLOGISTS	5.0 FTE approximately. (2 FTE in Adult Mental Health, 3 FTE in CAMHS)	25 people approximately employed. 15 in Infant Child & Family Service, 4 in community adult mental health, 1 FTE + contractors in Child Development Service. Contractor for pain management service. Central Region Eating Disorder Service has 3 part-time.	76 people approximately employed across MHAID and General Health (consult liaison, neurology, LEAP, child health) and Child Development Service
PSYCHOTHERAPISTS	0	6.0 FTE in total. (4.0 FTE ICAFS (Infant, Child & Family Service) and in CREDS (Central Region Eating Disorders Service). There is also a doctor in adult mental health with psychotherapy training.	5 people are employed. (2 child psychotherapists employed – 1 in Kapiti Child Adolescent Mental Health Service and 1 in Maternal Mental Health).
PUBLIC HEALTH ADVISORS/ HEALTH PROMOTIONS ADVISORS (Working in Regional Public Health	0	35.7 FTE	0

PROFESSION	WAIRARAPA DHB (FTE))	HUTT VALLEY DHB (FTE)	CCDHB (FTE)
and dental services run out of Hutt Valley DHB)			
SOCIAL WORKERS	3.9 FTE (2.5 in rehab and wards, 1 person covers maternity and child, 1 covers community, oncology and palliative). There is 1 social worker in MHAID, but separate and managed by MHAID.	8 FTE across General Health and 8.75 FTE Mental Health. Most of the team cover Central Hutt and hospital. Working in PHO setting: 1 in Wainui and 1 in Upper Hutt.	47.0 FTE across Child Development Service, community and inpatient ORA (includes child). (Te Mahoe, Cancer services, Pacific Health Services and Whanau Care. Approx. 45-50 FTE in Mental Health.)
SPEECH LANGUAGE THERAPISTS	1.4 FTE	4.3 FTE in Hutt 1.0 FTE in Child Development Service	11.0 FTE (15 people) across Child Development Service, community and inpatient ORA, includes child.
VISITING NEURODEVELOPMENTAL THERAPISTS	0.5 FTE In allied health service	2.0 FTE In Child Development Service (1.2 FTE physiotherapy & 0.8 FTE occupational therapy)	4.0 FTE approximately. In Child Development Service (occupational Therapy)

Scientific Professions, approximate staffing levels as at May 2015

PROFESSION	WAIRARAPA DHB (FTE))	HUTT VALLEY DHB (FTE)	CCDHB (FTE)
CLINICAL PHYSIOLOGISTS (Respiratory, Neurology & Cardiac)	0 (see Hutt Valley DHB)	4.5 FTE cardiac physiology 2 exercise physiologists (respiratory) Also provide clinics in Wairarapa	19.9 FTE (cardiac & echosonographers) 3.5 FTE neurophysiology

PROFESSION	WAIRARAPA DHB (FTE))	HUTT VALLEY DHB (FTE)	CCDHB (FTE)
			6 fte Respiratory Physiologists
CYTOGENETIC LABORATORY SCIENTISTS	0	0	12.0 FTE approximately Regional service provided by Capital & Coast DHB
CLINICAL (BIOMEDICAL) ENGINEERS	0	1.0 FTE	2.0 FTE
LABORATORY SCIENTISTS	0	20.62 FTE	42.6 FTE
MEDICAL PHYSICISTS	0	0	12.0 FTE (8.5 Medical Physicists, 2.5 Medical Physicists Registrar, 1.0 Associate Physicist)
MEDICAL RADIATION TECHNOLOGISTS/TECHNICIANS	3.5 FTE approximately.	3.0 FTE (including sonographers)	45.0 FTE approximately + 3.5 MRI MRT + 4 Nuclear Medicine Technologists + 7 sonographers.
RADIATION THERAPISTS	0 (see Capital & Coast DHB)	0 (see Capital & Coast DHB)	34.0 FTE approximately, 2 co-ordinators for cancer planning multi-disciplinary team. Wairarapa & Hutt Valley DHBs access this service via Capital & Coast DHB
SCIENTIFIC OFFICERS	0	0	3.0 FTE in laboratories.

Technical Professions, approximate staffing levels as at May 2015

PROFESSION	WAIRARAPA DHB (FTE))	HUTT VALLEY DHB (FTE)	CCDHB (FTE)
AUDIOLOGY TECHNICIANS	0	1.0 FTE	0
ANAESTHETIC TECHNICIANS	0 (2 nurses are currently undergoing training to be anaesthetic technicians)	10.0 FTE approximately	38 people approximately + 5 trainees
AUDIOMETRISTS	0	0	1.5 FTE
BIOMEDICAL/CLINICAL ENGINEERING TECHNICIANS	0	1	4.0 FTE approximately
CLINICAL DENTAL TECHNICIANS	0	0	1.0 FTE
CLINICAL PHYSIOLOGY TECHNICIANS	0.5 FTE	0.75 Cardiac Physiology Technician	0
DENTAL TECHNICIANS AND ASSISTANTS	0	37.0 FTE Dental Assistants. Regional School Dental Service operated out of Hutt Valley DHB	1.0 FTE Dental Technicians Wellington & Keneperu hospital sites. 0.9 FTE Dental Assistants
LABORATORY TECHNICIANS AND ASSISTANTS	0	5.79 FTE Laboratory Technicians 0 Assistants	18.79 Laboratory Technicians 5.3 FTE Assistants
MEDICAL PHOTOGRAPHERS	0	1.0 FTE	1.0 FTE
MEDICAL RADIOGRAPHIC ASSISTANTS	0	0	2.0 FTE
MORTUARY TECHNICIANS	Wairarapa DHB utilise orderlies and local undertakers for storage and management	Hutt Valley DHB utilise orderlies and local undertakers for storage and management	3.5 FTE sub-regional service for coronial and forensic pathology.
NEW BORN HEARING SCREENERS	0.5 FTE	2.0 FTE	4.0 FTE

PROFESSION	WAIRARAPA DHB (FTE))	HUTT VALLEY DHB (FTE)	CCDHB (FTE)
PHARMACY TECHNICIANS AND ASSISTANTS		3.0 FTE Technicians	Approximately 12, 1 at Keneperu and supports long term rehabilitation for mental health.
PHLEBOTOMISTS	0	4.25 FTE	4.47 FTE
SIMULATION SKILLS TECNICIANS	0	0	1.0 FTE
STERILE SUPPLY TECHNICIANS	4.0 FTE approximately	14.0 FTE approximately	33.0 FTE approximately, with 3 based at Keneperu
VISION AND HEARING TECHNICIANS	See Hutt Valley DHB	7.2 FTE (Regional Public Health run out of Hutt Valley DHB)	See Hutt Valley DHB

Appendix 6: 12 Month Action Plan for 3DHB AHS&T Leadership Team

Priority | Goals | Actions May 2015

AHS&T Priority	Goals (10 years)	Actions (12 months)
1.0 Working with our partners to develop and implement new Models of Care Increased integration of services, cross-sector. Person and Whanau-centred care; closer to home, with faster access. Right care, in the right place, at the right time Preventative intervention. Empowering self-management. Reducing inequalities	1a. Non-acute health care is delivered in terms of integrated clusters of services (collocated or virtual).	1ai. Identify and document opportunities for integration of community based AHS&T teams with district nursing, regional public health and primary health. 1aii. Recommend alternative funding models for community allied health services (AT&R, Health of Older Person, Disability Support Services) in order to reduce waste and increase efficiency. 1aiii. Scope and employ dietitian role in MHAID. 1aiv. Pilot of a PACC position in primary health in Hutt Valley DHB.
	1b. AHS&T professionals have strong and sustained relationships with partners across the health, social service and education sectors.	1bi. Identify opportunities to strengthen relationships for AHS&T "beyond DHB" – community, PHO, GP, NGO, private practice AHS&T, professional bodies. 1bii. Structured shared communications plan for AHS&T leadership – identifying key people and organisations and a plan for developing and maintaining relationships.
	1c. AHS&T staff are recognised as having expertise and are routinely involved in the development and review of health pathways. This will ensure that rehabilitation and long term conditions prevention and management are embedded and integrated into health pathways.	1ci. Health pathways will be tabled at 3DHB AHS&T ELT meeting to identify which health pathways are being reviewed and the relevant AHS&T staff to advise the pathway.

AHS&T Priority	Goals (10 years)	Actions (12 months)
1.0 Working with our partners to develop and implement new Models of Care	1d.One electronic shared plan of patient care is available for all health providers.	1di. AHS&T will be represented on shared care record clinical governance group. 1dii. Systems to utilise Momentum software more fully to share clinical information and care plans across providers will be developed.
	1e. Models of Care deliver effective and sustainable outcomes for complex and long term needs of our populations.	1ei. Literature reviews will be undertaken to explore effective healthcare management of the older person, utilising new models of care. 1eii. Further exploration of models of care advances in self-management programmes will be completed. 1eiii. Active input into "Talking Therapies" programme implementation in MHAID. 1eiv. AHS&T representation on 3DHB Child Health work stream. 1ev. Project advisory support for subregional, regional, national projects looking at AHS&T work with long term/complex needs (e.g. palliative care, cancer). 1evi. Allied Health representation on the clinical networks.
	1f.People with Long Term Conditions (LTC) can refer themselves directly to AHS&T outpatient and community services.	1fi. Develop the criteria, systems and processes required to be ready to pilot a self-referral system for one long term condition in 2016.

AHS&T Priority	Goals (10 years)	Actions (12 months)
1.0 Working with our partners to develop and implement new Models of Care	1g. AHS&T staffing are able to respond quickly to changes in demand across service areas, ensuring that high quality and safe patient care is prioritised.	1gi. A variance response plan will be developed in each clinical and professional area which demonstrates activities that are critical, activities that can be shared across teams/services and activities that can be suspended when demand exceeds workforce capacity.
	1h. Where appropriate, AHS&T services will operate 7 day, extended hours services to meet patient need.	1hi. Identify services where extended hours would have most impact, referencing national list of services already on 7 day rosters. 1hii. Develop a framework for managers to scope costs and benefits of providing extended hours service. 1hiii. Support managers to implement opportunities for extended hours (within current MECAs). 1hiv. Partner with our with Unions to ensure AHST workforce are positioned to deliver 7 day a week services and extended hours (where applicable) within the fiscal envelope i.e. changes that lead to greater flexibility without additional costs.

AHS&T Priority	Goals (10 years)	Actions (12 months)
2.0 Quality Safe & high quality practice. Development and application of new Models of Care occur in a clinically safe and responsible way. Appropriate clinical governance structure, responsive to new initiatives evolving while in development. Quality Measures	2a. For every AHS&T practitioner we can access, demonstrate and communicate quality data & measures.	2ai. Identify a set of quality metrics to be collected in each AHS&T service. 2aii. AHS&T services to report the quality metrics to the Executive Directors AHS&T on a quarterly basis.
	2b. There is a robust framework for utilising and responding to quality data & measures.	2bi. Work with DHB leaders of Quality Improvement to develop a quality framework with key measures for AHS&T practice.
	2c. The quality data & measures are used to demonstrate the value added by AHS&T.	2ci. Identify quality measures and appropriate outcome measures that can be used to demonstrate the value added by AHS&T (professional, patient experience, service delivery).

AHS&T Priority	Goals (10 years)	Actions (12 months)
3.0 Leadership AHS&T leadership purpose and function lead and support AHS&T staff effectively in light of changing Models of Care. Competencies match needs of workforce. Deliberately build leadership capability Executive Professional Operational Clinical + Inter-Disciplinary Team (IDT) Working	3a. All AHS&T professions have transparent career frameworks.	3ai. The 3DHB Allied Health Career Framework will be implemented and in use by the end of 2015. 3aii. Progress next identified professions' work on development of career frameworks – sonography, clinical physiologists (national).
	3b. Clear competencies for leadership are identified, at all levels.	3bi. Work with Human Resources to apply Lominger Competencies to identify a set of leadership competencies reflective of AHS&T leadership functions. 3bii. Work with learning and development to develop mechanisms to support people to achieve and maintain the AHS&T leadership competencies.
	3c. Leadership structures and functions in AHS&T are designed to support Models of Care in service delivery.	3ci. Evaluate different leadership models, particularly with regard to MDT/IDT and integrated working (primary/secondary) models and make recommendations regarding effectiveness. 3cii. Bring professional & operational leads together to develop 3ci.
	3d. A functioning and proactive talent management strategy.	3di. Work with Human Resources to develop a framework and identify opportunities to support talent development.

AHS&T Priority	Goals (10 years)	
4.0 Workforce Development Workforce positioned for change: dynamic and innovative. Able to flex and evolve to respond to changing needs. Ready to lead innovation. Ready to lead implementation of new models of care. Responsive to technological change and impact on roles. Creative in increasing efficiency and effectiveness.	4a. The AHS&T workforce is recognised as an integral partner in the achievement of optimal outcomes for our populations, at all levels within the DHBs and across the wider health community.	4ai. Utilise 3DHB shared definition of the AHS&T workforce (ICHPO) with shared key messaging. 4aii. Create process map of patient journey in health services – incorporating all aspects of care provision. 4aiii. Respond to requests for increased visibility of EDAHS&T from survey results – identify areas requesting visits. 4aiv. Develop stakeholder communications plan for developing relationships. 4av. AHS&T represented at Orientation session at each DHB. 4avi. Develop profile of Director Allied Health MHAID. 4avii. Implementation of the AH-NESP Programme (Jan 2016).
	4b.Successful continuous service improvement is embedded, coordinated and inclusive in all AHS&T services.	4bi. Utilise 3DHB AHS&T newsletter to publicise training opportunities. 4bii. Review leadership requirements/skills in leading and supporting continuous improvement activities. 4biii. Establish 3DHB AHS&T project network to coordinate project initiatives across the 3 DHBs.

AHS&T Priority	Goals (10 years)	
4.0 Workforce Development Continued…	4c.Mechanisms in place to measure ability of workforce capacity to needs of local populations (Workforce prediction model).	4ci. Integrate Health Services Planning information (SIDU) into strategic planning and service design. 4cii. For outpatient and community Allied Health, explore effective models for scheduling. 4ciii. For Science & Technical, look at how to utilise scheduling data for workforce planning. 4civ. Complete 3DHB stocktake of the kaiawhina (assistant) workforce; current entry qualifications and pathways. Develop a plan for what is needed to fill gaps/ inconsistencies recognising differences across services/professions.
	4d.Every AHS&T workforce is able to use agreed data to identify vulnerabilities and can make use of an established action plan to mitigate the risks.	4di. Commence use of new - National 20 DHB Workforce planning tool - with known vulnerable professions. 4dii. Continue to deliver on the plans for the known vulnerable workforces listed in the regional services plan.
	4e.For every proposed workforce innovation, investment and disinvestment priorities are evaluated.	4ei. Project prioritisation process includes investment/disinvestment consideration.
	4f. Best practice recruitment processes are in place.	4fi. Continue with Role Descriptions review work. 4fii. Develop existing HVH "AHS&T Survival Guide" for new staff to utilise across 3DHB.

AHS&T Priority	Goals (10 years)	Actions (12 months)
5.0 Business Development Business processes Data Resourcing innovation Infrastructure development Identity and Branding Communications (sector, clients, future workers, MoH, ELT) Integrated service profiling Profession profiling Recruitment Value for money investment capability	5a. AHS&T leadership have the capability and confidence to proactively market services and maximise opportunities for business development (e.g. with commercial partners, confidence with investment/disinvestment decisions).	5ai. Case put forward to access specialist input to develop the capacity of the business knowledge and competencies of the leadership team.
	5b. AHS&T are utilising existing resources to support maximal business development.	5bi. Development methods to identify innovations and potential innovations in practice (e.g. Dragon's den, suggestion boxes, surveys).
	5c. AHS&T are collecting a meaningful suite of data that supports informed decision making and planning, with automated reporting systems to support business and service development.	5ci. In conjunction with other DHBs develop a high level National Minimum Data Set, for use locally, nationally and internationally. 5cii.Stocktake: who is not collecting data on their activities, what data is being collected. Reference Health Roundtable Data. 5ciii. Develop a 3DHB data reporting template that provides useful and meaningful information to AHS&T staff that supports business and service development.

AHS&T Priority	Goals (10 years)	Actions (12 months)
5.0 Business development continued…	5d. Senior leaders have confidence in managers to innovate within their own service sphere.	5di. Ensure that delegated responsibilities for decision making are supported by consistent top-down communication. 5dii. Ensure leadership at all levels are actively supported to develop confidence and competence in innovation as part of their professional development.
	5e. AHS&T professions are identified as desired career options in secondary/tertiary education sector.	5ei. Strategic communication plan developed for publicity and recruitment in secondary schools.
	5f. AHS&T has a confident voice and clearly visible profile across the health system.	5fi. AHS&T will input into the development of all relevant health pathways. 5fii. Active promotion of "good news stories" of innovations and activities. 5fiii. The ICHPO definition of AHS&T will be included in all correspondence (emails, notices, newsletters). 5fiv. Key descriptive points and vision will be identified for use in verbal presentations/communications. 5fv. Develop a series of visually represented patient journeys, showing role of all aspects of health services.

AHS&T Priority	Goals (10 years)	Actions (12 months)
6.0 Strategic Innovation Define, lead and support innovation. As a complex interactive system, we must be systematic and strategic. Coordination and oversight of change. Development of innovation capacity and resilience in workforce. Transfer of learning across AHS&T, 3DHBs.	6a. 3DHB AHS&T leadership work effectively together to maximise opportunities for strategic innovation with our partners across the sub-region.	6ai. Leadership team increase visibility as team across DHBs – appear together across sites. 6aii. Develop escalation process for conflict resolution. 6aiii. 3DHB project coordination oversight by 3DHB AHS&T leadership team. 6aiv. Development of 3DHB project prioritisation tool, project templates and documentation.
	6b. Free transfer of knowledge and learning across the subregion at all levels.	6bi. 3DHB AHS&T monthly ELT meeting continues. 6bii. 3DHB AHS&T HAC report. 6biii. 3DHB AHS&T newsletter. 6biv. Quality Accounts. 6bv. Investigate rotations across 3DHB/services, especially at new graduate level.
	6c. AHS&T embodies a culture of learning and challenging the status quo, striving for excellence, to improve the health status of our populations, while living within our means.	6ci. Develop project network. 6cii. Explore possible value of data analyst role to support effective utilisation of data (once data stocktake and data set work is complete).
	6d. Established mechanisms provide a forum to profile and highlight successes.	6di. Biannual 3DHB AHS&T awards continue.
	6e. We have the best performing AHS&T services in New Zealand.	6ei. Define “best”. 6eii. Identify examples where we are leading nationally.

AHS&T Priority	Goals (10 years)	Actions (12 months)
7.0 Improving health outcomes by increasing health equity Focus on Maori, Pacific Peoples and people with impairments/disabilities Participation in design and delivery of services Accessibility Partnership, with a responsive and aware workforce which reflects the population Protection of our vulnerable populations - reducing disparities Reflecting population	7a. All AHS&T health planning/innovation/service development is consistent with reducing health outcome disparities for Maori, Pacific Peoples and other ethnicities and people with disabilities.	7ai. AHS&T leadership will proactively work in partnership with Pacific & Maori Health Directorates to develop a plan for how AHS&T can achieve improved health outcomes for Maori & Pacific Peoples. 7aii. HR data clarification re the proportion of Maori & Pasifika AHS&T staff. 7aiii. Explore bilingual titling to increase profile and visibility of AHS&T for Maori. Look at existing models e.g. MHAID. 7aiv. Focus for AH-NESP programme on Maori and Pasifika new graduates to join the programme.
	7b. Ongoing and substantive relationships with local iwi, Maori & Pasifika community providers and AHS&T.	7bi. Proactive development of relationships with local iwi, community based NGO Health and Social Service providers.
	7c. Ongoing and substantive relationships with the disability community	7ci. Continue regular interaction with disability community via the Subregional Disability Advisory Group (SRDAG) 7cii. Project advisory support for Review of Access to Service for Deaf Population.
	7d. AHS&T are able to demonstrate that practitioners adapt practice to a person's needs, to deliver compassionate and responsive health services.	7di. Cultural e-learning (tikanga) currently available at CCDHB, made available to AHS&T across the 3DHB. 7dii. Increase AHS&T participation in DHB provided cultural competency training or service level training opportunities to enhance their knowledge of Whanau Ora and increase their competency in working with Whanau Maori. 7diii. Disability Responsiveness Training currently available at CCDHB, made available to AHS&T across the 3DHB. 7div. Explore feasibility of making Disability Responsiveness Training mandatory for all AHS&T.

Appendix 7: Bibliography

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